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Feb. 16, 2018

Brett Baker
Senior Health Policy Advisor
Senate Finance Committee Republican Staff

Dear Mr. Baker:

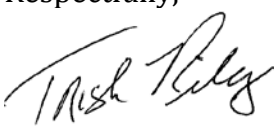
We at the National Academy for State Health Policy are very pleased that Sens. Orrin Hatch and Ron Wyden are seeking input regarding how best to address the opioid crisis through Medicare, Medicaid, and other human services programs.

At this time, NASHP can provide some examples of state activity addressing the crisis and hope this snapshot is of some value to the committee. (See attached.)

Please let us know if we can provide any additional information.

Thank you for your work on this critically important topic.

Respectfully,



Trish Riley
NASHP Executive Director

National Academy for State Health Policy Response to the Senate Finance Committee's Request for Input on the Opioid Epidemic

Question 1: How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing opioid use disorder (OUD) or other substance use disorders (SUDs)?

Complementary and alternative medication coverage approaches and programs to reduce opioid prescribing:

- **Rhode Island's Section 1115 demonstration project** authorizes certain individuals enrolled in Medicaid managed care delivery systems to receive complementary and alternative medicine (CAM) services for chronic pain. Rhode Island Medicaid has implemented this benefit through its Communities of Care program, a state initiative designed to reduce unnecessary emergency room utilization. Medicaid managed care enrollees with four or more emergency room visits within a 12-month period are eligible to receive alternative treatments, such as acupuncture, chiropractic, or massage therapy services.
- **Oregon**:
    - In Oregon, Medicaid covers benefits based on whether a treatment for a given condition meets cost- and clinical-effectiveness criteria warranting inclusion on the state's Prioritized List. The Prioritized List is composed of condition-treatment pairs of diagnosis and treatment codes used to define the services represented. Effective July 1, 2016, the Oregon Health Authority (OHA) covers many alternative pain management treatments for patients with lower back pain who are assessed to have a medium to high risk of a poor functional prognosis. Services include acupuncture, chiropractic manipulation, cognitive behavioral therapy, osteopathic manipulation, physical and occupational therapy, and, in limited cases, surgery.
    - Oregon Medicaid also recommends comprehensive pain treatment plans that may include yoga, rehabilitation, massage, and/or supervised exercise therapy, but Oregon's coordinated care organizations (CCOs) determine the availability of these services. CCOs are able to pay for non-Medicaid-covered services using a portion of their global budgets that are set aside for flexible spending.

Improving oversight and transparency of physician opioid prescribing practices and frequency:

- **Ohio** provides episode-based payment to reward cost-efficient, high-quality care. Episodes of care are meant to improve transparency of providers' opioid prescribing practices within eight clinically-relevant episodes of care, including orthopedics, primary care, and dentistry. Opioid-related quality measures are built into these episodes to provide transparency and enable provider behavior change.

Question 2: What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?

State budget constraints: Multiple states surveyed in a recent NASHP study indicated that budget constraints limit their ability to expand coverage for new alternative pain management services.

- Although the Washington State's Interagency Guideline on Prescribing Opioids for Pain recommended treating pain using a multimodal approach that includes both physical and behavioral health interventions, the state's Medicaid agency does not currently cover many of the encouraged alternative treatments.
- Alabama's Medicaid agency also reported in the NASHP study that adding or expanding coverage for additional non-opioid therapies would require additional funding.

Utilization limits: Coverage and utilization management policies for CAM services vary widely in states. All but six states reimburse providers for at least one category of CAM services (physical therapy, psychologist, occupational therapy services, and chiropractic services). However, fee-for-service remains the predominant reimbursement strategy for these services, which may impact how these services are used to treat pain. For example, states that reimburse for a psychologist may not necessarily reimburse for cognitive behavioral therapy to treat pain.
States also have varying policies related to limits on service days and prior approval requirements.

Evidence-based policymaking requirements can impede coverage of non-pharmaceutical approaches: Policymakers may hesitate to support some alternative, non-pharmacological pain management therapies without clearer evidence. Even when alternative services are explicitly recommended in practice guidelines, insurers have acknowledged the need for more research. For example, the Neighborhood Health Plan of Rhode Island (Medicaid)'s Clinical Practice Guidelines authorize referrals for acupuncture and massage for neck pain, but the guidelines note that there is "insufficient evidence to support or refute [acupuncture]," and that inconclusive evidence for massage "does not exclude the possibility that massage may provide an immediate or short-term benefit."

Vermont recently concluded a $200,000 pilot program that offered acupuncture to Medicaid enrollees diagnosed with chronic pain. Although participants reported less fatigue, pain interference, sleep disturbance, anxiety, and depression, as well as an increase in physical function, there was no decrease in utilization of emergency room, primary care, psychiatric, or physical therapy services. The state concluded that more study of acupuncture was needed.

Question 3: How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?

Incentivize screening for substance use disorders: A number of states use Screening, Brief Intervention, and Referral to Treatment (SBIRT) as a performance metric in pay-for-performance managed care organization (MCO) or accountable care organization (ACO) programs.

- **Oregon**'s 2015-2019 state health improvement plan includes reducing alcohol and substance misuse as a top public health priority. A number of the strategies included in the report incorporate partnerships with CCOs:
    - Screening for alcohol or other substance misuse has historically been a CCO measure, and a new electronic health record-based SBIRT measure will be an incentive measure again in 2018.
    - CCOs are required to develop community health needs assessments and community health improvement plans – some of which focus on SUDs. Some CCOs engaged their local public health districts in meaningful ways while others did not.

- **Arizona**'s Delivery and System Reform Incentive Payment (DSRIP) 1115 waiver program requires managed care plans to provide financial incentives to Medicaid providers who meet state-defined performance thresholds related to integrated care (called "Targeted Investments" strategy). One of the measures is utilization of opioid prescribing guidelines for chronic pain, in addition to numerous other metrics centered around integrated care, screening, and population health management, such as screening for depression, drug and alcohol misuse, anxiety, developmental delays in infancy and early childhood, and suicide risk.

Target treatment using the Medicaid Health Home State Plan Option (more information about health and medical homes).

Missouri has two effective health home programs:

- In its Community Mental Health Center Health Home Program, providers receive a supplemental per member per month (PMPM) payment to provide care coordination and other health home services to a target population, which includes those with a mental health condition and/or substance use disorder. Health homes must meet specific quality metrics. Program staffing requirements, along with the quality metrics, incentivize the integration of physical, as well as behavioral health and substance use, treatment.
- Primary care Health Home providers (based in Federally Qualified Health Centers) also receive a supplemental PMPM payment to provide care coordination and other health home services. Target populations can include individuals with mild to moderate behavioral health needs or substance use disorders in addition to at least one other chronic physical health condition (e.g., diabetes). This program's strategically designed staffing requirements and quality metrics are designed to incentivize providers to identify patients in need of behavioral health services and in some cases provide integrated medicated-assisted treatment (MAT).

Maryland's health home program is designed for Medicaid beneficiaries with an opioid use disorder or a severe and persistent mental illness diagnosis who qualify for psychiatric rehab program services. Under the program, opioid treatment programs can serve as health homes. Health homes receive a monthly per-enrollee payment if they provide at least two health home services per month, as well as a one-time intake patient assessment. The state incentivizes health homes to take a "whole person" approach to care by integrating both behavioral health and physical health quality metrics into their program design.

Vermont's Hub and Spoke model provides supplemental payments to primary care practices that agree to serve as "spokes" and provide buprenorphine treatment to individuals with substance use disorders in the community.

Question 4: Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?

- **Massachusetts** passed the STEP Act (Ch. 52 of the Acts of 2016) to limit first-time opioid prescription to seven days. It also requires practitioners to check the prescription monitoring program before prescribing opioids and mandates student prevention education training during concussion safety training for athletes. It increases prescriber education requirements, expands Good Samaritan protections by shielding individuals administering naloxone to a person during an opiate overdose from civil liability, and requires a substance use disorder evaluation for individuals presenting in the emergency room because of an apparent opiate overdose.

Massachusetts also allows people to decline in advance any treatment option that includes opioids by signing a simple directive.

- **Rhode Island**'s H5469 A /S656 law allows information contained in the state's prescription drug monitoring program to be disclosed to certified law enforcement drug diversion investigators in a qualified law enforcement agency certified by the Rhode Island Department of Health. This bill was introduced in 2016 at the request of the state's Attorney General in order to more proactively investigate instances of prescription drug abuse.

Question 5: How can Medicare and Medicaid better prevent, identify, and educate health professionals who have high prescribing patterns of opioids?

A number of states have limited education requirements addressing pain management or opioid prescribing practices in their statutes for physician Continuing Medical Education (CME) requirements. The number of hours are very limited and are typically completed over a multi-year period (e.g., 50 hours of CME every two years). Examples include:

- **Alaska:** If providers hold a Drug Enforcement Agency certificate, they must receive at least two hours (out of 50 required CME hours every two years) of pain management, opioid use, and addiction education.
- **California**: All physicians (except radiologists and pathologists) must complete 12 education units on pain management and appropriate care and treatment of terminally ill patients. This is a one-time requirement to obtain a license.
- **Kentucky**: Providers who can prescribe controlled substances must complete 4.5 hours of education (out of 60 total CME hours) every three years on addiction disorders and pain management in KASPER (the state's prescription drug monitoring program - PDMP).
- **West Virginia**: Requires three CME hours minimum of drug diversion and opioid prescribing practice training.

Question 6: What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as prescription drug monitoring programs?

State All Payer Claims Databases are valuable sources of adjudicated claims data that several states, including West Virginia, Minnesota and Utah, have used to identify opioid prescribing patterns and patient characteristics. Using actual paid claims provides reliable data about physician prescribing practices. However, absent federal support, many states do not yet have these in place and without federal intervention, data submission from self-insured businesses remains voluntary.

Prescription Drug Monitoring Programs (PDMPs) allow prescribers, licensing boards, and law enforcement agencies to detect and address prescription drug abuse and diversion, including prescribed opioids. Prescriber registration in a PDMP is discretionary in some states and mandated in others. Registration does not guarantee that prescribers will use PDMP data in their clinical practice. All 50 states, plus Washington, DC, and Guam, have operating PDMPs, although Missouri's is not yet statewide.[1] As of May 2016, 30 states had passed laws mandating that prescribers check their state's PDMP before prescribing an opioid, which has been found to reduce morbidity and mortality related to prescription drug misuse.[2] Beyond mandates, states are also exploring a variety of measures to increase PDMP usage in response to the opioid epidemic.
For example, South Carolina's Department of Health and Environmental Control and Rhode Island's Department of Health use direct outreach to prescribers through practice facilitation and academic detailing to promote safe opioid prescribing and effective use of the states' PDMPs to prevent opioid

misuse and abuse.[3] US Centers for Disease Control and Prevention grants are a common source of support for these state efforts.

Other data-sharing tools:

Washington state uses PRISM, a web-based predictive modeling and data integration tool that aligns patient and displays data across state programs, health plans, and care coordination organizations. It gives providers the capability to perform global patient look-up. PRISM is used to:

- Identify barriers to care;
- Access provider contact information for care coordination;
- Create child health summary reports;
- Provide a source of regularly-updated contact information from the medical, eligibility determination process;
- Monitor medication adherence;
- Identify potential drug-seeking behavior; and
- Identify psychotropic medication polypharmacy patterns associated with overdose risk.

Washington experienced a 37 percent decline in opioid overdose deaths between 2008 and 2013, a period when many states were seeing the opposite trend with alarming increases in deaths. Hospitalization rates for prescription opioid overdoses also declined 29 percent between 2011 and 2013. These decreases are in part attributed to the state's Interagency Guidelines on Prescribing Opioids for Pain, developed by the Agency Medical Directors' Group (AMDG). The guidelines were first released in 2007 and are currently in their third edition (2015). AMDG collaborates with a number of evidence-based policy programs in Washington, including the Washington Health Technology Assessment program that makes coverage recommendations designed to prevent the underuse, overuse, or misuse of medical technologies and procedures. Data sources include medical, behavioral health, long-term services, housing, and Medicare.

Connecticut uses distributed data networks — networks of data with no central repository — to analyze SUD data across silos without aggregation. Data is maintained behind the firewall of each data holder. The state uses Zato Health Interoperability Platform to share and analyze data.

Oregon has a robust hospital admissions, discharge, and transfer system, which allows doctors to know if a patient is pill shopping. It also serves as a companion program that many CCOs subscribe to that allows doctors and health systems to review hospital ADTs and upload pain medication contracts for patients so hospital and primary and behavioral health care are more coordinated.

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[1] As of August 24, 2017. Source: http://www.pdmpassist.org/pdf/PDMP_Program_Status_20170824.pdf
[2] Source: http://www.pdmpassist.org/pdf/COE_documents/Add_to_TTAC/COE%20briefing%20on%20mandates%203rd%20revision.pdf)
[3] Source: https://nashp.org/wp-content/uploads/2018/01/VCU-Brief-No-2.pdf