Virginia Department of Medical Assistance Services (DMAS) Response to Senate Finance Committee

Medicare/Medicaid Policy Ideas Addressing the Opioid Crisis

February 16, 2018

Virginia Medicaid Highlights

Virginia implemented the Addiction and Recovery Treatment Services (ARTS) program on April 1, 2017 to increase access to evidence-based treatment for Medicaid and CHIP members with opioid or other substance use disorders. The Virginia Medicaid agency, known as the Department of Medical Assistance Services (DMAS), contracted with Virginia Commonwealth University (VCU) School of Medicine to conduct an independent evaluation of the ARTS program. The VCU report is attached as a reference. The major findings from the first 5 months of ARTS include:

- **Substantial increases in the number of practitioners and facilities providing addiction treatment** services to Medicaid enrolled members, including residential treatment facilities, opioid treatment programs, office-based opioid treatment providers, and buprenorphine waivered practitioners. The number of outpatient practitioners billing for ARTS services for Medicaid members with opioid or other substance use disorders more than doubled.
- **Treatment rates for members with opioid or other substance use disorders increased by more than 50 percent.** Treatment rates are higher for those with an opioid use disorder diagnosis (51 percent) than for those with alcohol use disorders (28 percent).
- The number of **emergency department visits related to opioid use disorders decreased by 39 percent** during the first 5 months of ARTS while the number of members with a visit related to opioid use disorder decreased by 21 percent.

Decrease in Prescriptions for Opioid Pain Medications

Virginia Medicaid took a number of actions to limit opioid prescribing for pain management through implementing guidelines from the U.S. Centers for Disease Control and Prevention Opioid Prescribing Guideline and the Virginia Board of Medicine regulations for prescribing opioids for both pain management and treatment of addiction. These actions include implementing strict prior authorization requirements and quantity limits for new opioid prescriptions beginning on December 1, 2016, which was expanded to all members in Medicaid health plans beginning in July 1, 2017. To encourage more substitution of non-opioid pain medications for opioids, the non-opioid pain medications were added to Medicaid formularies and do not require prior authorization. Highlights of the outcomes are below:

- During the first 5 months of ARTS, the **total number of prescriptions for opioid pain medications decreased by 28 percent** compared to a similar time period in 2016.
- **Total spending on opioid prescriptions and days supplied decreased by 34 percent** during the first 5 months of ARTS.
- The number of **non-opioid pain medications increased slightly** (2 percent).

1. ***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?***

   Between March and June 2016, the National Academy for State Health Policy (NASHP) conducted a survey of all 51 Medicaid agencies to determine the extent to which states have implemented specific programs or policies to encourage or require non-opioid therapies for acute or chronic non-cancer pain (https://nashp.org/wp-content/uploads/2016/09/Pain-Brief.pdf).

   Opioids are clinically indicated for some types of pain but there is a lack of evidence supporting their long-term use to treat non-cancer pain. The evidence base for non-pharmaceutical therapies such as acupuncture and chiropractic manipulation is mixed but promising.

   Most Medicaid agencies cover services that can be used to treat pain instead of opioids, but less than half have taken steps to specifically encourage or require their use. Medicaid agencies are faced with important policy considerations, including budget constraints that make covering additional services difficult and provider and beneficiary educational needs to raise awareness on when these services may be appropriate. The evidence base for or against non-pharmacological alternatives will become more robust as more Medicaid agencies implement programs encouraging the use of these services.

   Barriers to non-pharmaceutical therapies for chronic pain are not unique to Medicare and Medicaid and include, but are not limited to, awareness and knowledge of treatment options at the patient and provider level, patient perceptions of providers of non-pharmacological pain treatment modalities, and lack of support from healthcare systems. In recent studies, one of the most prevalent findings as a barrier is lack of patient motivation to use these modalities.

   Patient and provider education, combined with the deployment of the most current American Medical Association (AMA) pain management and CDC Opioid Prescribing Guideline can facilitate the movement toward non-pharmacological therapies.

   Virginia Medicaid is very interested in adding coverage of non-pharmaceutical therapies including acupuncture, chiropractic manipulation, yoga, Tai Chai (Qijong), medical massage, mindfulness stress reduction, and music therapy that the evidence indicates are effective in treating chronic pain without the risks of addiction. However, the agency would need authority and additional funding from the state legislature to add these non-pharmaceutical therapies as Medicaid covered services.

   CMS should help address these barriers by encouraging state Medicaid agencies to add non-pharmaceutical therapies to covered services in their State Plans. State legislatures should provide funding to add coverage of non-pharmaceutical therapies to covered Medicaid services. Medicaid agencies should include language in Managed Care contracts encouraging health plans to cover the evidence-based non-pharmaceutical treatments.

   HHS, SAMHSA, and HRSA could increase the utilization of non-pharmaceutical therapies by providing funding opportunities to support health systems, Federally Qualified Health Centers, and other providers in piloting comprehensive, integrated pain management programs with interdisciplinary teams of physicians, physical therapists, and behavioral health clinicians providing a comprehensive array of evidence-based non-pharmaceutical therapies.

2. ***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?***

Increase Access to Non-opioid Pain Relievers

CMS could increase patient access and minimize barriers to non-opioid pain relievers adding non-opioid pain relievers without prior authorization requirements (e.g. Lidocaine patches, capsaicin, and similar products) to the Medicare formularies. CMS could also encourage state Medicaid agencies to remove the prior authorization requirements for the non-opioid pain relievers on their Fee-for-Service formularies and contacted health plans' formularies. Virginia Medicaid expanded coverage of non-opioid pain relievers and requires managed care health plans to cover the same non-opioid pain relievers without any additional utilization management criteria. Virginia Medicaid has seen in 2% increase in utilization of non-opioid pain relievers since expanding coverage.

Implement CDC Guideline for Prescribing Opioids for Chronic Pain

Virginia Medicaid's Fee-for-Service program adopted the CDC Opioid Prescribing Guideline in July 2016 and required Virginia's Managed Care health plans to implement the Guideline by July 2017. This included a uniform prior authorization for short-acting and long-acting opioids that incorporated the CDC Guideline including checks of the Prescription Drug Program and urine drug screens. After the implementation of the CDC Guideline, the number of opioids prescribed for Medicaid members significantly decreased as demonstrated by the following results:

- During the first 5 months of ARTS and implementation of the CDC Opioid Guideline, the **total number of prescriptions for opioid pain medications decreased by 28 percent** compared to a similar time period in 2016.
- **Total days supplied of opioid prescriptions decreased by 34 percent**.
- **Total spending on paid claims for opioid prescriptions decreased by 34 percent**.

On February 1, 2018, Medicare announced in its annual request to bid for insurers participating in the Medicare program that it is planning to tighten oversight of opioid drugs prescribed to millions of elderly and disabled beneficiaries. Under the proposal, Medicare beneficiaries will have to consult their doctor and receive approval from their drug plan if a new prescription puts them above recommended cumulative dose levels for morphine-like painkillers. Pharmacists could still dispense a 7-day supply of medication. Medicare will also limit initial prescriptions of opioid drugs to a 7-day supply. This proposed change will take effect January 1, 2019. Medicare can build on this promising initiative by requiring all Medicare insurers to implement the CDC Opioid Prescribing Guideline.

CMS could also encourage state Medicaid agencies to implement the CDC Guideline in their Fee-for-Service formulary and require their contracted health plans to implement the CDC Guideline.

3. ***What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?***

Increase Reimbursement for Evidence-Based Medication Assisted Treatment

Virginia Medicaid implemented the Office-Based Opioid Treatment (OBOT) model as an integral component of the ARTS program. This model supports interdisciplinary teams of co-located

buprenorphine waivered practitioners, behavioral health clinicians, and care coordinators providing evidence- based Medication Assisted Treatment including medication, counseling, and high touch care coordination to individuals with opioid use disorder. Providers offering this model of care receive higher reimbursement rates for opioid counseling, a monthly payment for care coordination, and reimbursement for peer recovery support services. Virginia Medicaid has recognized over 78 Preferred OBOT Providers including public behavioral health providers, Federally-Qualified Health Centers, health systems, and private psychiatry and primary care practices. Virginia Medicaid is requiring all of the Medicaid health plans to pay the same enhanced rates for opioid counseling, care coordination, and peer recovery support services to the Preferred OBOT Providers.

Virginia Medicaid also developed quality metrics to measure the performance of Preferred OBOT Providers. These quality metrics will be used to transition the monthly substance use care coordination payment to a value-based payment that will reward Preferred OBOTs that achieve better outcomes with higher care coordination payments. This financial incentive will encourage Preferred OBOTs to continue to improve their outcomes.

Virginia Medicaid developed the same enhanced payment model with higher reimbursement rates for counseling and the new monthly care coordination payment for Opioid Treatment Programs (OTPs) that offer methadone and buprenorphine to treat opioid use disorder. As a result, the number of Opioid Treatment Programs participating in Virginia Medicaid increased from two prior to the ARTS program to 29 OTPs that are contracted with DMAS and the Medicaid health plans.

CMS could encourage other state Medicaid agencies and Medicare insurers to increase reimbursement rates to support Office-Based Opioid Treatment and Opioid Treatment Programs with co-located behavioral health clinicians and buprenorphine-waivered practitioners that provide the most effective, evidence-based treatment to individuals with opioid use disorder.

CMS could also add coverage of methadone for treatment of opioid use disorder to Medicare formularies and encourage all state Medicaid programs to add coverage of methadone to their formularies.

<u>Increase Screening, Brief Intervention, and Referral to Treatment (SBIRT)</u>

Virginia Medicaid is allowing providers to bill for the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) assessment by a variety of licensed professionals to increase identification of opioid and substance use disorders. These licensed professionals include physicians, pharmacists, nurse practitioners, physician assistants, psychologists, social workers, and counselors. Virginia Medicaid is allowing a variety of staff with training (such as Registered Nurses) to provide the SBIRT screening and bill under Medicaid enrolled providers. SBIRT can also be billed in a variety of settings including Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Community Services Boards, Health Systems, Emergency Departments, Pharmacies, Physician Offices, and Outpatient Clinics.

CMS could encourage state Medicaid agencies and Medicare insurers to allow for variety of staff with training to implement and bill for SBIRT in a variety of settings.

Provide Training and Support to Clinicians Treating Addiction

Virginia Medicaid and the Virginia Department of Health provided one-day Addiction Disease Management trainings to over 150 physicians and physician extenders and over 600 licensed behavioral health clinicians to increase the workforce providing treatment to individuals with opioid use disorder. This resulted in a significant increase in the number of physicians, nurse practitioners, and physician assistants obtaining buprenorphine waiver to treat opioid use disorder. The number of outpatient practitioners providing treatment to Medicaid members with opioid use disorder doubled in the first 5 months of the ARTS program and after these trainings. The Virginia Department of Health is launching a Project ECHO program to provide on-going training and support to buprenorphine waivered practitioners with case conferences to discuss treatment of individuals with opioid use disorder. Virginia Medicaid is also leveraging this program to create an ongoing Learning Collaborative to support the Office-Based Opioid Treatment providers.

HHS can offer funding opportunities to support state agencies in organizing training and support to increase the number of buprenorphine-waivered practitioners and licensed behavioral health clinicians treating opioid use disorder.

4. **What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?**

Substance use disorder may not be the presenting issue in a family. Initially, it may be hidden, only to become apparent during therapy. If any suspicion of substance abuse emerges, the counselor or therapist should evaluate the degree to which substance abuse has a bearing on other issues in the family and requires direct attention.

When someone in the family other than the person with presenting symptoms is involved with alcohol or illicit drugs, issues of blame, responsibility, and causation will arise. With the practitioner's help, the family needs to refrain from blaming, and reveal and repair family interactions that create the conditions for substance abuse to continue.

In any form of family therapy for substance abuse treatment, consideration should be given to the range of social problems connected to substance abuse. Problems such as criminal activity, joblessness, domestic violence, and child abuse or neglect may also be present in families experiencing substance abuse. To address these issues, treatment providers need to collaborate with professionals in other fields. This is also known as concurrent treatment.

Whenever family therapy and substance abuse treatment take place concurrently, communication between clinicians is vital. In addition to family therapy and substance abuse treatment, multifamily group therapy, individual therapy, and psychological consultation might be necessary. With these different approaches, coordination, communication, collaboration, and exchange of the necessary releases of confidential information are required

Source: https://www.ncbi.nlm.nih.gov/books/NBK64258/.