ACAP
Association for Community Affiliated Plans

Strategies to Increase MAT Prescribing

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CHAPTER 1

Executive Summary

Misuse and abuse of prescription medications in the United States is a serious public health problem. The opioid crisis continues to have significant impact on families, communities, and the healthcare system. From 2000 to 2016, there were more than half a million deaths from drug- and opioid-involved overdoses, with 115 Americans dying every day from an opioid overdose.[1]

This burden of opioid use disorders (OUD) and resulting crisis has disproportionally impacted low-income and disabled individuals and the programs and resources that support them, many of which are financed by Medicaid.[2] As the crisis continues to unfold, many ACAP Safety Net Health Plans are addressing these issues on several fronts. They have forged deep relationships with their communities—including patients, providers, policymakers and public health officials—by engaging in collaborative conversations around preventative measures and effective treatments and interventions.[3,4]

Effective strategies have emerged from these conversations, including processes for engaging primary care providers (PCPs) in prevention, detection and treatment of OUD through the deployment of Medication-Assisted Treatment (MAT) and the integration of physical and behavioral health. MAT combines behavioral therapy and the administration of three medications—methadone, buprenorphine, and naltrexone—to treat substance use disorder (SUD).[5] The evidence supports the effectiveness of MAT in treating opioid and alcohol use disorders.[6] However, despite its impact, only about 1 in 10 Americans who seek MAT can receive it, due in part to a shortage of buprenorphine prescribers and addiction specialists.[7]

Paper Methodology: Strategies to Increase MAT Prescribing

This paper provides a practical perspective on how health plans can support and engage PCPs to increase MAT prescribing. As primary payors for health care services, including prescription drugs in most states, health plans play a critical role in addressing the opioid crisis. Health plans can influence the behavior of providers and patients through tactics such as:

- Provider education;
- Organizational operations and care management;
- Member identification and stratification;
- Incentives and varying payment models; and
- Addressing stigma.

Partnerships between health plans and PCPs are essential because the PCP serves as a patient's key influencer on healthcare decisions. This paper identifies three levels of support that health plans can provide:

1. Increase awareness of safe opioid use through organization-wide initiatives;
2. Implement policies and programs to recruit PCPs and specialty providers to become MAT prescribers; and
3. Support and maintain these programs to retain MAT prescribers in their provider network.

This paper was developed through a literature review that evaluated content from peer-reviewed journal articles and industry publications. In addition, the authors interviewed seven ACAP-member health plans between September and December 2017 to ascertain their strategies, learnings, and outcomes around MAT. The health plans that participated were:

- Community Health Network of Connecticut
- Geisinger Health Plan (Pa.)
- Inland Empire Health Plan (Calif.)
- Partnership HealthPlan (Calif.)
- Passport Health Plan (Ky.)
- University of Pittsburgh Medical Center – UPMC for You (Pa.)
- Virginia Premier Health Plan

Notes

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CHAPTER 2

Introduction

Opioid use disorder (OUD) treatments have evolved since methadone was shown to be effective in the mid-1960s and the U.S. Food and Drug Administration (FDA) approved it for this use in late 1972.[8] In 2002, the FDA approved buprenorphine, a newer alternative to methadone treatment, as a Schedule III narcotic for use in treating opioid-dependent adults.[9] While methadone can only be dispensed in highly structured and regulated clinics, buprenorphine can be prescribed by practitioners, including PCPs, in an outpatient setting and managed by patients at home with follow-up appointment once a month or every three months.[10] Physicians receive federal waivers to become buprenorphine and buprenorphine/ naloxone (Suboxone®) prescribers after eight hours of training; nurse practitioners and physician assistants require 24 hours of training.[11] Patient panels receiving MAT are capped at 30, 100, or 275 per provider, depending on the provider's experience and practice setting.[12]

Published Studies on Effectiveness

Methadone and buprenorphine are considered effective, first-line treatments to manage OUD,[13] and substantial research supports the effectiveness of these treatments. In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored research to analyze treatment effectiveness across numerous research studies from 1995 through 2012.[14] The analysis examined research on methadone Maintenance Treatment (MMT) and buprenorphine or buprenorphine-naloxone maintenance treatment in two peer-reviewed articles.[15] Findings showed that when Methadone Maintenance Treatment and Buprenorphine/ Buprenorphine-Naloxone Maintenance Treatment are used at appropriate dosages, there are similar reductions in illicit opioid use across treatment modality. Comparing people who receive MMT with those in shorter-term programs (often called "detox") in which psychosocial services and aftercare were provided for 6 months, the group receiving MMT had a longer retention in treatment compared with the detoxification group (438.5 versus 174 days).[16]

According to the California Society of Addiction Medicine, methadone maintenance is associated with success rates ranging from 60 to 90 percent.[17] The longer an individual is under treatment for methadone, the more likely he or she will achieve stable long-term abstinence.[18] However, access to methadone is highly regulated, and methadone for addiction treatment can only be dispensed in an opioid treatment program, which is typically outside of a primary care site. Many studies have also demonstrated the effectiveness of buprenorphine in treating opioid addiction. The 2015 Prescription Opioid Addiction Treatment Study trials evaluated short- and long-term buprenorphine treatment. The study showed that patients who were tapered off buprenorphine at 12 weeks had an opioid abstinence rate of 9 percent, compared to an abstinence rate of 50 percent among patients continuing treatment. At 18 months, patients using buprenorphine were more than twice as likely to report abstinence compared to those who were not using buprenorphine (80% versus 37%), a difference that continued at 42 months (80% versus 51%).[19]

A 2014 study[20] analyzed the costs of care for persons with opioid dependence in commercial integrated health systems. This study found that patients treated with buprenorphine plus counseling had reduced use of general medical services and lower total health care costs compared to patients with little or no addiction treatment. Moreover, health care costs per person per year with buprenorphine treatment were estimated at $13,578, compared with an estimated $31,055 without addiction treatment.[21]

Other studies have shown that higher doses of buprenorphine/naloxone are associated with a longer time in treatment, less resource use, and lower total medical costs despite a higher pharmacy cost.[22] Moreover, studies show that buprenorphine seems to be superior to methadone across a number of metrics, including its better tolerability profile, lower risk of overdose and recreational use, and greater ease of use[23], making it a good option for use in outpatient primary care offices.[24] Reducing barriers and streamlining access to MAT has been shown to lower emergency department (ED) and hospitalization costs,[25] lower hepatitis C and HIV rates, and decrease mortality rates.

Effective SUD Care

Like other chronic diseases, effective SUD treatment requires considering a broad set of factors affecting patients. Because addiction is often associated with traumatic events, behavioral health services must be combined and coordinated with medication treatment in MAT to ultimately reduce the risk of relapse. Counseling services can help family and friends of an individual with SUD be part of a support network aimed at recovery. MAT illustrates how a whole-person care approach which considers an individual's physical health, behavioral health, and social determinants, can be successful in treating SUD.

The decision to start any medication treating a SUD and the duration of the treatment are highly personal and require close collaboration between a patient and their care team. Substance use disorders, like all chronic medical illnesses, require whole-person treatment throughout an individual's lifespan. Patient outcomes from substance abuse treatment are similar to that of chronic diseases[26] such as diabetes, asthma, and hypertension in that positive outcomes require consistent self-management.[27]

Identifying best practices for ACAP health plans to effectively leverage MAT to address SUD and OUD will be helpful for Medicaid health plans facing this crisis today and in the future. Moreover, health plans can leverage their role and relationship to influence the behavior of providers and patients alike to increase access, knowledge, and awareness of MAT.

Current Barriers to MAT

While MAT is acknowledged as an important and effective OUD intervention, it is underutilized, in part, due to a widespread prescriber shortage.[28] The shortage arises from barriers associated with becoming a MAT prescriber and the challenge of integrating MAT into an ongoing medical practice. According to the literature review and health plan interviews conducted during the development of this paper, barriers to increasing the number of MAT prescribers include:

1. *A lack of provider education* about addiction, MAT, and pharmaceutical options to treat OUD. Many PCPs typically have limited exposure in training on addiction and OUD and are insufficiently equipped with information about evidence-informed treatment options, such as MAT, to support their patients in successful recovery.
2. In addition, even when there are existing training options, *providers seeking to prescribe MAT are often burdened by the administrative requirements to access the training* for themselves or their staff.
3. *Operational and financial burdens*, including the amount of policy and procedural steps in place to become an MAT prescriber, adversely affected provider interest and willingness to provide MAT services.

There are additional barriers to integrating MAT into a practice and retaining MAT prescribers within a provider network, which include:

1. *Additional management burden of MAT practice*. MAT is a multi-faceted approach that requires close monitoring and coordination between physical health and behavioral health providers. The interdisciplinary nature of MAT is an added lift for providers and practice staff to manage. Coordinating referrals and follow ups for OUD patients can be complex. More frequent office visits and the more time-consuming induction-related MAT visits can also pose staffing challenges in provider practices.
2. *Maintaining processes and meeting standards* are ongoing challenges for MAT prescribers. Providers often struggle with member identification, stratification, and data sharing due to little uniformity between MAT providers nationally. As most providers do not have a consistent screening tool, it is difficult to identify patients exhibiting signs of OUD.
3. Some plans experience *barriers related to coordination across providers*, due to federal and state privacy and data sharing regulations. The regulatory environment can make referrals difficult and add complexity to treatment.

Stigma is a further barrier that prevents MAT integration into primary care practices, including both stigma related to the patient population and provider bias related to opioid addiction. Interviewees indicated that providers feel uncomfortable treating members of this complex patient population. Some providers, whose previous interactions with OUD patients was likely in an emergency department setting, are concerned about developing a negative reputation as an MAT prescriber and not having the appropriate infrastructure to manage the patient load. Though this stigma may be misplaced, it is a factor that can impede providers from becoming MAT prescribers.

Unfortunately, prescriber scarcity due to these barriers keeps patients from receiving evidence-based treatment that can improve health outcomes, reduce overall cost of care, and decrease morbidity associated with OUD. To implement MAT on a scale that will make a real impact on the opioid crisis, the barriers noted above need to be addressed.

Notes

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CHAPTER 3

Health Plan Strategies to Engage New MAT Prescribers and to Support and Retain Existing MAT Prescribers

To effectively meet the needs of the nation's communities, health plans must leverage their role and relationship to influence the behavior of providers and patients alike to increase access, knowledge, and awareness of MAT. The interviews conducted for this paper identified activities in which health plans can engage to expand MAT to meaningfully address the opioid crisis. These activities include two levels of support related to engaging new MAT providers, which include:

1. Increasing awareness of safe opioid use through organization-wide initiatives, such as broad provider awareness and educational opportunities; and

2. Implement policies and programs to recruit PCPs and specialty providers to become MAT prescribers, including by providing operational supports and financial incentives.

The third level of support relates to supporting and maintaining existing MAT providers, which includes a number of related, sub-strategies:

a) Supporting interdisciplinary operations;

b) Providing practice support;

c) Streamlining clinical operations, including care management; and

d) Addressing stigma and provider bias.

CHAPTER 4

Strategies to Engage New MAT Prescribers

As the lead of a member's care team and the patient's main point of contact with the health care system, PCPs are well-positioned to identify and address OUD and addiction issues. As described below, health plans can provide substantial support to PCPs, including supporting them to access the tools necessary to become MAT prescribers.

Implement Broad Provider Awareness and Educational Opportunities

Many health plans provide PCPs training and education on addiction, member screening and identification, and MAT prescribing to help support their efforts to treat patients with OUD and encourage them to become MAT prescribers. **Interviewees noted that when providers better understand addiction and the mechanism of recovery, they are more willing to treat patients living with OUD and serve as champions of MAT prescribing**.

For example, *Partnership HealthPlan* works to increase overall understanding about addiction and safe prescribing of opioids through its Managing Pain Safely program (MPS), an example of how a health plan's infrastructure and collaborative approach to opioid prescribing can be applied to the current epidemic. MPS, which launched in 2014, works to improve member outcomes by ensuring safe and appropriate prescribing of opioids by network providers. The program includes interventions for providers and members developed by six internal workgroups. Through MPS, the plan has revised internal policies around opioids, including formulary changes, and launched new interventions including increased provider outreach, quality improvement initiatives, and engagement in Project ECHO (Extension for Community Health Outcomes) to train PCPs on advanced skills in caring for patients with chronic pain. This collaborative facilitates remote training and support with case consultation to providers to broaden understanding of OUD and MAT. Internally, Partnership hosts regular webinars and online training modules as well as internal discussions and presentations to health plan staff. The initiative's results are notable: internal data from 2014 to 2015 show a 48 percent reduction in total opiate fills per 100 members per month, plan-wide.[29,30]

Notably, other interviewees reported that participation in Project ECHO, worked especially well for providers in rural settings who have few fellow prescribers with whom to connect. For example, *Passport Health Plan*, based in Kentucky, is involved in the Project ECHO collaborative for buprenorphine prescribing in partnership with their behavioral health partner, Beacon Health Options. Support delivered through Project ECHO helps Passport's network providers understand how to obtain a waiver to become an MAT prescriber, and Project ECHO offers a broader support network as providers become MAT prescribers. Further, *Inland Empire Health Plan* in Southern California has plans to leverage the Project ECHO curriculum and coordinate with a local community health association, Community Health Association Inland Southern Region, to roll out technical assistance around MAT.

University of Pittsburgh Medical Center (UPMC) works to prevent "addiction illiteracy" by facilitating educational sessions for students in several health profession schools, including the medical school. Early in their training, UPMC medical students are engaged in addiction and recovery medicine, attend seminars on addiction, and meet addiction care managers. Through these interactions, they learn the science of addiction, what it was like to experience an addiction by individuals in recovery, how to best manage OUD patients, and how effective screening and MAT can help patients recover. In addition, UPMC has provided extensive educational and training opportunities for medical and behavioral health providers, and other social services professionals by designing and implementing webinars, conferences, on-site presentations and other educational programs. This has focused on a wide range of challenges, including member engagement and retention, the use of MAT and naloxone, co-occurring psychiatric disorders, the impact of OUDs and other SUDs on families and strategies to facilitate their involvement in treatment and/or recovery

programs, and the importance of promoting recovery in community mutual support programs such as Narcotics Anonymous, Nar-Anon and others. UPMC has disseminated guidelines, treatment protocols and many other forms of information and resources to thousands of providers throughout the region.

This spectrum of activities has enhanced the understanding of OUD and the capacity to provide MAT among UPMC providers serving members of the *UPMC for You* Health Plan. These efforts have resulted in steady growth in the number of individuals entering all forms of MAT, including methadone, buprenorphine, and injectable naltrexone modalities. UPMC medical programs continue to increase the number of providers who prescribe buprenorphine and the number of clinics that offer MAT and/or additional services to aid recovery from OUDs. MAT clinics are offered for pregnant women in multiple locations, and patients in General Internal Medicine, multiple Primary and Family Care, Psychiatric and Addiction Medicine clinics.

Community Health Network of CT has offered a two-day conference over the last two years for providers around addiction, OUD, and MAT. The conference is aimed at improving the skill of PCPs at treating psychiatric conditions in the primary care setting and includes extensive coverage of SUD. Attendees can participate for free and are eligible for up to 16 hours of CME. The plan also offers a webinar and online toolkits for primary care providers in safe opioid prescribing which includes the CDC guidelines as well as providers in an emergency department setting. A tapering toolkit is also provided.

Within the provider section of the plan's website, providers are introduced to the process of becoming certified to prescribe buprenorphine and given an overview of the requirements. The plan's network management staff notifies providers of the availability of these tools and additional resources through office visits and promotional mailings as well as recruiting providers to obtain MAT certification.

Provide Operational Supports and Financial Incentives

As outlined above, another barrier to MAT prescribing takes the form of additional administrative requirements, especially those related to referrals and authorizations. **While interviewees reported that reducing administrative requirements wherever possible is essential, they also described strategies to leverage incentive programs or varying payment models to encourage providers to engage in MAT despite administrative burdens.**

For example, *UPMC* supports prescribers by providing performance-based payments that can be used to enhance treatment services, such as hiring a social worker or a nurse care manager. This payment is tied to multiple quality indicators, such as engagement in both medication and concurrent psychosocial treatment. Similarly, *Inland Empire Health Plan* plans to revise contracts to include a payment structure that would support time out of the office for training and provide payment to support participation. Parameters would be dependent on the number of patients inducted into MAT and the number of patients on maintenance therapy. *Partnership HealthPlan* increased PCP involvement by offering a financial incentive for potential providers who are buprenorphine certified, or providers willing to take outside referrals. Those who accept the incentive payment must have a minimum number of Partnership members and agree to specific monitoring activities.

Using a slightly different strategy, *Geisinger Health Plan* implemented a bundled payment for MAT prescribers. The set PMPM amount covers the initial visit, induction, stabilization, and maintenance phases, but does not include the payment for the drugs, which are reimbursed separately. In addition to its financial incentive to keep patients engaged in MAT on a long-term basis, the bundled payment reduces providers' administrative burden. In this arrangement, providers submit a weekly patient roster to the plan for verification and are paid monthly. However, providers are still required to submit individual encounters to the state. Approximately 15 providers currently receive the bundled payment. Early outcomes indicate a 25 percent reduction in inpatient cost of care, 25 percent reduction in ED cost of care, higher immunization rates, and a retention rate in MAT of 42 percent. Geisinger also identified an increase in overall drug costs and dental costs for these members receiving MAT due to increased utilization, indicating appropriate and consistent engagement with their PCP under the bundled payment arrangement.

Finally, *Passport* plans to leverage member incentives to engage patients in MAT. While in development at the time of publication, the incentive would likely be linked to a skill-building activity that will impact member life skills or job placement, instead of a cash incentive.

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CHAPTER 5

Strategies to Support and Retain Existing MAT Prescribers

In addition to recruiting new MAT providers, the ability for a health plan to support and retain the network MAT providers who are already operating is essential. Health plans use several strategies to accomplish this.

Supporting Interdisciplinary Operations

Geisinger Health Plan is fostering strong connections between PCPs, clinics, and behavioral health providers and their linkages to Centers of Excellence. They use a **"hub-and-spoke" model**, wherein the "hub" is the addiction specialist physician within the Center of Excellence supporting the spokes—the PCPs and support teams administering MAT in the community. This promotes knowledge sharing and communication across teams, critical to the interdisciplinary nature of MAT, and helps to break down silos that lead to gaps in care. This approach better supports patients living in rural or underserved areas and those providers working to improve their access.

In addition, the Geisinger MAT program facilitates the hiring of Certified Recovery Specialists to assist providers with assessments, screenings, and referrals. These Certified Recovery Specialists are individuals with a history of addiction currently in recovery who have completed a training and certification program to serve in a peer support role. Co-located within high-volume emergency departments, the Certified Recovery Specialists can help individuals with OUD better understand the path to recovery and the process of MAT induction. This peer-engagement strategy leverages non-clinical community-based individuals to continue to educate and raise awareness of MAT and support providers with MAT engagement during an ED visit.

UPMC has partnered with the Pennsylvania Department of Drug and Alcohol programs, which received a $5.7 million grant from SAMHSA to develop "hub-and-spoke" MAT networks in several rural regions. Today, UPMC is administering the grant and partnering with local counties and providers to expand the number of MAT clinics and quick access to care, and to enhance the quality of medication assisted treatment.

Providing Practice Support

Since 2016, *Partnership HealthPlan* has engaged an experienced MAT provider to visit practice sites and provide on-the-ground MAT implementation supports to prescribers. Similarly, *Inland Empire Health Plan* has hired a family medicine doctor with MAT expertise to pilot enhanced education efforts for a few of the Federally Qualified Health Centers in their network. Both efforts aim to develop a "champion" who can provide practical support as providers and practice staff implement both the clinical and administrative requirements related to MAT.

UPMC supports "on call" physicians who are available to answer questions from prescribing physicians 24 hours a day, 7 days a week. In addition, it has established a 24/7 care management service that is always available to identify treatment options for providers or members, including scheduling next day appointments for initiation of MAT treatment or information on other services needed such as residential rehabilitation, intensive outpatient care or other.

Geisinger Health Plan in Pennsylvania facilitates full-day continuing education training sessions for providers that cover OUD and MAT. The sessions also provide a venue for mentorship between current MAT prescribers.

Community Health Network of CT proactively offers education to certified prescribers within their network to ensure they have the confidence to regularly prescribe MAT. The plan found that in some cases, PCPs were becoming certified but still did not feel comfortable implementing MAT. In response, the plan currently reviews SAMHSA's state-specific list of MAT certified providers[31] and cross-references this with pharmacy data to understand who is currently prescribing MAT and identify providers that are certified but may need additional support to begin prescribing. Additional resources are provided through involvement in

Project ECHO and the Connecticut Behavioral Health Partnership, a local resource that supports providers referring for behavioral health services.[32]

Streamline Clinical Operations, Including Care Management

Health plans are more likely to successfully implement MAT programs when they **embrace a highly integrated approach that connects patient identification, care management, and ongoing maintenance treatment for OUD patients**. This is especially important as it relates to the behavioral health component of MAT and, as demonstrated by the examples below, can be supported by appropriate staffing and effective team communication.

UPMC works to improve integration and coordination across its insurance and provider organizations by conducting regular cross-sector meetings of a Steering Committee and assembling a Task Force focused on SUDs. The Task Force is responsible for assessing internal UPMC operations to identify gaps and challenges related to both patients with SUD/OUD and MAT prescribing, including monitoring referral pathways and coordination with behavioral health providers. The Task Force also has capabilities that allow them to initiate system-wide programs to improve MAT effectiveness. With the support of the Task Force, UPMC recently placed patient navigators in five hospitals to improve referral to care coordination and initiate MAT as soon as a patient with OUD enters the emergency department, promoting access and improving linkages to treatment for individuals with OUD.

Some plans have adjusted resources and broadened staffing models to better facilitate MAT. For example, *Community Health Network of Connecticut* recruits advanced practice registered nurses to join their provider network and become MAT prescribers. This can ease the burden on PCPs while ensuring appropriate screening and testing of patients. *Passport Health Plan* has added a new Behavioral Health Program Manager role to coordinate directly with PCPs prescribing MAT. In this role, the Program Manager serves as an internal point of contact to identify and prevent gaps in the MAT process.

Many plans have successfully structured care manager teams and roles to specifically serve patients with OUD who receive MAT. Care managers work as an essential coordinator of care teams, which is especially important for MAT prescribers and patients. For example, *Partnership HealthPlan* works to comprehensively approach the member condition and OUD as a long-term chronic illness. Members of the care team approach a patient with the goal of addressing not just the disease itself, but the social components that have affected the patient or served as barriers to care. With appropriate member consent, care coordinators work to assess member's needs beyond physical and behavioral health, including housing. Following the comprehensive assessment, care coordinators work to establish supports and keep the member's care team, including the MAT prescriber, informed. At the same time, some practices receive financial support from health plans to hire additional care managers with specific addiction experience. Whether they are at the plan or practice level, care managers that support patient engagement and help providers navigate the process of MAT can help to improve patient outcomes.

Many interviewees reported that identifying and stratifying members who are candidates for MAT is a challenge. In response, they are developing streamlined, systemic processes to more accurately capture their patient population and describe the prevalence of OUD. *Inland Empire Health Plan, Passport*, and *UPMC* are all working toward formalizing a consistent screening and identification process that does not rely solely on claims data, which can often be delayed, unreliable, and inaccurate. Health Plan Care Managers attempt to connect with patients with OUDs and other SUDs discharged from hospital Emergency Departments to facilitate follow-up services needed for the SUD, including patients who have co-existing psychiatric disorders. *Geisinger Health Plan* has an internal workgroup to address member identification, which pulls relevant ICD codes and cross-references behavioral health diagnosis codes to identify co-morbid conditions. Patients whose records contain both codes are candidates for targeted outreach and interventions. However, as with other plans' experience, this process relies on manual input and is not yet standardized.

Community Health Network of Connecticut has a process in place that leverages their existing risk stratification protocols to measure the burden of opioid use and identify outlier prescribers. Through this process, the plan monitors prescriptions of more than 100 MME per day and conducts provider outreach to facilitate additional case management, member MAT induction as appropriate, and provider education (e.g., Project ECHO).

MAT providers, patients, and payors would further benefit from a revision of 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, to facilitate more effective patient identification, streamline referrals, and harmonize 42 CFR Part 2 with HIPAA privacy laws. Revisions like these that better account for integrated programs which rely on data sharing can support more coordinated care while ensuring patient confidentiality.

Addressing Stigma and Provider Bias

While most plans acknowledge that stigma related to OUD patients exists, there have been few strategies in place to address and resolve it. An interviewee noted that there is a sense in the provider community that the stigma related to this patient population is similar to the stigma around HIV in the early days of the epidemic. Many interviewees felt that **stigma can be directly addressed by increasing provider education on addiction to promote acceptance**. Examples of some of these strategies are included below.

At *Inland Empire Health Plan*, a highly-engaged MAT prescriber is working to have all doctors under him become MAT-certified during residency. As described above, *UPMC* invests in early-career education for providers related to recovery and addiction, which serves as an effort to empower more providers to understand and treat OUD as a chronic disease. At *Geisinger Health Plan*, informal mentoring between MAT provider champions and newer MAT prescribers helps demonstrate how best to work with this specific patient population and how to address barriers in individual practices.

Geisinger Health Plan is also involved in community-wide efforts to raise awareness of OUD and the need to implement an integrated approach. Representatives from the plan's clinical staff participate in a cross-sector community collaborative that encourages safe prescribing practices as a harm reduction strategy. The collaborative also strategizes around provider education needs. Perhaps the most important aspect of this effort is the work to reduce stigma within the healthcare community. Increasing awareness and understanding of OUD, addiction, and treatment options helps to reduce bias, but many providers remain hesitant. To better understand the scope of the problem, Geisinger recently conducted an internal survey of physicians around addiction and OUD. The results of this survey, which will likely be released in spring 2018, will allow for the targeted development of provider education and resources to combat this barrier. Understanding OUD as a chronic condition that can be successfully treated in a primary care setting is a powerful way to reduce the stigma around it.

Moreover, *UPMC* has partnered with state and local governments, law enforcement, providers, members, families and other stakeholders to enhance regional planning efforts to address the opioid crisis. Understanding that health plans and providers alone cannot solve this situation, UPMC has taken a leading role in supporting development of regional prevention and treatment strategies. These tactics also include family engagement groups and extensive online activities to address stigma in the community by providing information, access to resources, and conveying a message of hope that recovery is possible for addicted individuals and their families. The plan recently sponsored a Facebook Live event focused on "Prescription Drug Misuse and Addiction" that drew over 17,000 viewers. In addition, several thousand individuals accessed articles on SUD issues on the website, which also included easy access to links to a broad range of UPMC programs and services, local, state and federal resources, mutual support programs, and resources specifically geared towards families affected by a SUD. Three additional Facebook Live events are planned in 2018 to continue to provide information about SUDs, treatment and recovery, and resources to members and their families, and to providers of medical, psychiatric or addiction care. All these events include written information and resources. UPMC is in the process of organizing "Substance Use Grand Rounds" that will address providers across the UPMC system including strategies to reduce stigma and increase the focus on SUDs among medical patients. It has also developed and distributed educational and treatment related materials and links to informational, treatment, and mutual support program resources for providers, individuals with opioid and other substance use disorders, and families.

Notes

31 Beacon Health Options. Retrieved from http://www.ctbhp.com/providers-welcome.html

32 CMS. (2017, September 22). Retrieved from http://www.dmas.virginia.gov/Content_atchs/bh/2017%20VA%20GAP.ARTS%20Amendment%20Approval%20Documents%20(09.25.17)%20STCs.pdf

CHAPTER 6

Case Study—Expanding Access to MAT Through Medicaid Waivers: Virginia Premier Health Plan

Virginia Premier Health Plan has been working collaboratively with the state Medicaid agency under an SUD 1115 waiver to implement comprehensive MAT throughout the state.[33] The state recognized a widespread opioid abuse problem and found coverage of SUD services to be limited. With a rapidly increasing number of deaths from drug overdose involving prescription opioids, there were not enough providers to meet the growing need. The goal of the waiver program was to ensure a comprehensive continuum of addiction and recovery treatment, including:

- Strategies to identify individuals with SUD/OUD;
- Disseminating evidence-based practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and MAT;
- Increasing use of quality and outcome measures and developing value-based payment models with Managed Care Organizations (MCOs);
- Developing innovative care coordination models to link individuals to the most appropriate provider and resource;
- Implementing safe prescribing programs;
- Increasing the MAT provider workforce through education and training; and
- Evaluation activities to understand the impact of the demonstration[34]

The state waiver, developed in partnership with stakeholders from across Virginia, offers patients a more coordinated program with an increased chance of success. To address the provider shortage, the waiver offers incentives for prescribers to become MAT prescribers. The waiver program also features a highly integrated approach to screening for OUD and implementing MAT to address many of the barriers that MAT prescribers experience in less-coordinated programs.

Central to the implementation of the waiver program is the concept of Office-Based Opioid Treatment (OBOT). These OBOTs rely on a preferred provider network and are similar to a medical home model. OBOT providers include PCPs and obstetricians for pregnant women, and OBOTs include one on-site licensed behavioral health provider for every 100 patients. Interdisciplinary care plans are developed for each patient and are updated monthly to reflect a patient's progress in the program. Several harm reduction tactics are employed, including monthly urine drug screens and weekly visits for initial treatment, which become monthly as patients stabilize. There are no prior authorization requirements for buprenorphine or buprenorphine/naloxone within OBOTs. As part of the waiver, participating providers receive reimbursement at increased rates and can bill for case management and peer support services.

To support MAT prescribers throughout the state, stakeholders designed OBOT collaboratives. Within the collaboratives, MAT prescribers, addiction specialists, and other members of the care team share knowledge and identify challenges or areas for improvement. These collaboratives encourage providers to become MAT prescribers while at the same time creating a community for providers interfacing with a complex patient population.

Virginia Premier has been a strong partner in the implementation of the state waiver. With an extensive background in care coordination and integrated care teams that include a pharmacy technician, the plan has been able to seamlessly adopt waiver processes; all members of the care team have knowledge of addiction and recovery. To support patient identification, they actively review the Prescription Drug Monitoring Program database. They have also developed a process to specifically identify the most at-risk groups, including pregnant women. To ensure they can meet the needs of this specialized population, they proactively seek out OBs to participate and can provide a professor from their partner, Virginia Commonwealth University, to consult on pregnant women receiving MAT when necessary.

Notes

33 Commonwealth of Virginia. (2016, August 05). Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-pa.pdfhttp://www.dmas.virginia.gov/Content_atchs/bh/2017%20VA%20GAP.ARTS%20Amendment%20Approval%20Documents%20(09.25.17)%20STCs.pdf

34 ibid.

CHAPTER 7

Conclusion

As communities address the opioid crisis, health plans are well-positioned to implement best practices to increase PCP engagement in MAT and positively influence patient outcomes. This must begin with increasing the understanding of addiction and recovery at all levels of health plan staff and raising providers' awareness of OUD as a chronic illness. As demonstrated by the plans interviewed for this paper, this education will lay the groundwork for the implementation of integrated care delivery to address OUD, such as MAT.

Numerous best practices currently being implemented by ACAP-member plans serve as a model for other health plans to support increased access to and availability of MAT. As described, this includes robust provider education related to MAT, such as supporting education and training through toolkits or subsidizing participation in training sessions. PCPs can be equipped to address perceived operational and administrative burdens with the mentorship of MAT champions and practice coaches. Engaged care managers can support PCPs and the integrated MAT care team with managing referrals and patient outreach. From a contracts perspective, adding payment incentives for MAT induction and maintenance to the PCP agreement may also encourage providers to become MAT prescribers. Plan and provider engagement at every level is fundamental to MAT success.

This support, combined with strong partnerships between health plans and providers, will elevate the awareness and understanding of opioid use and address stigma and bias related to this patient population. Effective use of MAT sets the stage for improved member outcomes, especially for those at highest risk. Improving access to MAT aligns with the goals of Safety Net Health Plans to improve the health of members, use evidence-based practices, and control costs.

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