Strategies to Reduce Prescription Drug Abuse

Lessons Learned from the ACAP SUD Collaborative

APRIL 2015

The work outlined in this report was supported by a grant from the Open Society Foundations.

Writing and editorial services were supplied by Ellen Bayer.

Dear Colleague:

It is with great pleasure that the Association for Community Affiliated Plans (ACAP) presents *Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative,* the product of the collective efforts of thirteen ACAP-member Safety Net Health Plans.

The issue of substance abuse in general—and the misuse and abuse of prescription opioid painkillers in particular—is a particularly pressing issue for Safety Net Health Plans. The CDC estimates that opioids were responsible for more than 14,800 overdose deaths in 2008, and more than 475,000 emergency department visits the following year. Beyond the human toll is the financial toll: the societal cost of opioid abuse is an estimated $53 billion to $72 billion per year. By way of comparison, the Federal government spent $62 billion—roughly the midpoint of the estimate—on disaster relief in 2011 and 2012 combined.

Given the scope of the issue, ACAP decided that having its member plans work together to tackle the issue of prescription drug abuse would foster a response that would be greater than the sum of plans working individually. Our plans met regularly to discuss the issue with subject matter experts, share challenges ranging from appropriate staffing levels to data analysis challenges, and compared progress along the way.

This document represents our collective progress to date. We hope that you find the account of the efforts of each of the 13 plans that participated throughout the course of the collaborative to be useful in informing your efforts to combat the misuse of prescription drugs, most notably opioid painkillers.

The work of this collaborative was made possible by a grant from the Open Society Foundations. We gratefully acknowledge not only their financial support of this project, but also the dedicated efforts of Kimá Joy Taylor, M.D., M.P.H., the Open Society Foundations' National Drug Addiction Treatment and Harm Reduction Program Director, who provided invaluable guidance and support across the duration of the project.

Sincerely,

Margaret A. Murray

Chief Executive Officer

April 2015

CHAPTER 1

Overview

The Epidemic of Prescription Drug Abuse

In the past 20 years, as the use of prescription painkillers has risen significantly in the United States, abuse of prescription drugs has become a major public health concern. The Centers for Disease Control and Prevention (CDC) estimates that 80 percent of misused and abused controlled substances originate as legal prescriptions.[1] According to the 2010 National Survey on Drug Abuse and Health, an estimated 2.4 million Americans—an average of 6,600 people per day—used prescription drugs nonmedically for the first time in the past year.[2]

Opioid painkillers, such as Oxycontin and Vicodin, are by far the most commonly abused class of prescription drugs. Other frequently abused prescription substances include stimulants for treating attention deficit hyperactivity disorder (such as Adderall, Concerta, and Ritalin) and central nervous system depressants to relieve anxiety (*e.g.*, Valium and Xanax).[3]

According to the 2010 National Survey on Drug Abuse and Health, an estimated 2.4 million Americans—an average of 6,600 people per day—used prescription drugs nonmedically for the first time in the past year.

Prescription drug overdoses now account for more than half of deaths from drug overdose, which recently surpassed motor vehicle accidents as the leading cause of death from unintentional injury.[4,5] Opioids accounted for nearly three-quarters of prescription drug overdoses[6] and nearly 60 percent of drug overdose deaths in 2010—far exceeding deaths from any other drug or class of drugs, legal or illicit.[7]

The Cost of Prescription Drug Abuse

The human and societal costs of prescription drug abuse extend far beyond the cost of overdose deaths. Prescription drug abuse places a tremendous burden on the nation's health, social service, public safety, and criminal justice systems. The CDC reports that for every death from prescription painkillers, there are 10 hospital admissions for abuse, 32 emergency room visits for misuse or abuse, 130 people who abuse or are dependent, and 825 people using the drugs for nonmedical reasons.[8] Rates of emergency room visits associated with prescription drug abuse increased 114 percent from 2004 to 2011.[9] Substance abuse treatment admission rates for opioid analgesic abuse increased six-fold from 1999-2010.[10]

Prescription drug misuse and abuse can lead to many adverse health consequences. It can be a transition to injection drug use (which often leads to infections such as hepatitis C and HIV) and can lead to falls and fractures among older adults. Prescription substance abuse among pregnant women is a leading cause of neonatal abstinence syndrome (NAS).[11] Prescription drug abuse often is associated with domestic violence, homelessness, unemployment, and illicit activity that poses a danger to individuals and a threat to public safety.[12] Cost estimates for opioid abuse alone have ranged from $53-$72 billion annually.[13]

Rates of Abuse in the Medicaid Population

Rates of prescription drug abuse are higher among people living in poverty, in rural communities, with behavioral health conditions, or who have a history of substance abuse; these demographic groups are disproportionately represented in the Medicaid population.[14] Medicaid recipients are prescribed painkillers at twice the rate of those not covered by Medicaid and have higher rates of emergency room visits and hospitalization for poisoning by opioids and related narcotics than people with all other forms of insurance and the uninsured.[15]

Prescription drug abuse is a major cost burden for State Medicaid programs. A 2009 report by the U.S. Government Accountability Office found that the practice of doctor-shopping—visiting multiple providers often to obtain prescription drugs for nonmedical use—among 65,000 Medicaid beneficiaries in five states cost the Medicaid program approximately $63 million in 2006 and 2007.[16] These costs did not include the medical costs *(e.g.,* for office visits) of obtaining the prescriptions.

An Historic Opportunity for Progress

The historic transformation underway in the Medicaid program creates significant new opportunities to address the epidemic of substance abuse. Pursuant to the Affordable Care Act (ACA), 28 states and Washington, D.C.[17] are expanding Medicaid to cover adults with incomes up to 133 percent of poverty, and coverage must include mental health and substance abuse services that meet the requirements of the Mental Health Parity and Addiction Equity Act.[18] Since the program's expansion took effect, more than 11 million people have gained health coverage, and total enrollment has reached 70 million.[19] The Medicaid expansion population is expected to have significant need for substance abuse treatment. Nearly 12 percent of adult Medicaid beneficiaries have a substance use disorder (SUD), and 15 percent of uninsured individuals who are newly eligible for Medicaid have the condition.[20] The federal government has identified early diagnosis and improved treatment for SUD in the Medicaid population as a high national priority.[21]

For every death from prescription painkillers, there are 10 hospital admissions for abuse, 32 emergency room visits for misuse or abuse, 130 people who abuse or are dependent, and 825 people using the drugs for nonmedical reasons.

The Role of Safety Net Health Plans

Managed care plans, which provide health insurance to the Medicaid population in 39 states,[22] cover an estimated 73 percent of Medicaid and Children's Health Insurance Plan (CHIP) beneficiaries nationwide.[23] The vast majority of states that are expanding Medicaid under the ACA contract with managed care organizations to provide health coverage, and most are using their existing managed care programs to serve the expansion population.[24] Medicaid health plans have a long track record of promoting early intervention and coordinated care to address the medical, behavioral health, and social service needs of beneficiaries with substance use disorder. As millions of new enrollees enter the program, Medicaid health plans are rising to the challenge by pursuing a variety of innovative approaches to prevent and reduce prescription drug abuse and improve beneficiaries' health and well-being.

The Reducing Prescription Drug Abuse Collaborative

In 2013, the Association for Community Affiliated Plans (ACAP) received a grant from The Foundation to Promote Open Society in collaboration with the Open Society Institute (OSI) to support the Reducing Prescription Drug Abuse Collaborative. In 2014, Safety Net Health Plans participating in the Collaborative designed and implemented evidence-based quality improvement projects to reduce prescription drug abuse in the Medicaid population. To address the high

rates of opioid misuse and abuse among beneficiaries, many of these programs targeted opioid utilization and incorporated strategies to promote safe and effective pain management. Thirteen plans participated in the Collaborative.

At the project's initial meeting, health plans received training on best practices, along with guidance and resources to develop action plans. Participants in the Collaborative subsequently launched action plans for projects tailored to their members' unique characteristics and needs. Throughout the year, participating plans held quarterly networking calls to discuss their projects' implementation challenges and emerging outcomes. Health plan staff submitted quarterly progress reports to ACAP and met in person to share their experiences and learn from each other. Additionally, ACAP held a series of Webinars to highlight important issues and lessons learned. All Collaborative participants plan to continue their projects after the initiative's official conclusion. Safety Net Health Plans' continued focus on these projects demonstrates their strong and ongoing commitment to address prescription drug abuse in the Medicaid population.

Chapter 2 of this report provides details on each project implemented by Collaborative participants. Chapter 3 provides a toolkit for health plans seeking effective ways to address SUD among Medicaid beneficiaries and highlights important lessons learned. Chapter 4 identifies key challenges to achieving lasting improvements in effective prevention and treatment of prescription drug misuse, and it provides recommendations for addressing these challenges. The final chapter identifies next steps for moving forward.

It is our hope that the lessons learned and best practices identified through this Collaborative will offer valuable guidance to leaders in the public and private sectors—including Safety Net Health Plan staff, state and federal policymakers, as well as Medicaid agency officials—who are committed to finding effective solutions to the complex problem of prescription drug abuse in the Medicaid population. Ultimately, we hope that the report will contribute to a long-term process of improving the quality of care and quality of life for Medicaid beneficiaries as the program's evolution continues in the years ahead.

1. Roberts, A.W., & Skinner, A.C. (May 2014). Assessing the present state and potential of Medicaid controlled substance lock-in programs. *Journal of Managed Care Specialty Pharmacy*. 20(5): 439-46c. Abstract. Available at: http://www.ncbi.nlm.nih.gov/pubmed/24761815.

2. National Institute on Drug Abuse (November 2014). How Many People Abuse Prescription Drugs? Available at: http://www.drugabuse.gov/publications/research-reports/prescription-drugs/trends-in-prescription-drug-abuse/how-many-people-abuse-prescription-drugs.

3. National Institute on Drug Abuse (December 2014). Drug Facts: Prescription and Over-the-Counter Medications. Available at: http://www.drugabuse.gov/publications/drugfacts/prescription-over-counter-medications.

4. Mercer (US) Inc. (October 2014). State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose: A Report for the National Association of Medicaid Directors. Phoenix, AZ: Author. Available at: http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_rx_abuse_report_october_2014.pdf.

5. U.S. Department of Health & Human Services (September 2013). Addressing Prescription Drug Abuse in the United States: Current Activities and Future Opportunities. Washington, DC: Author. Available at: http://www.cdc.gov/HomeandRecreationalSafety/pdf/HHS_Prescription_Drug_Abuse_Report_09.2013.pdf.

6. Centers for Disease Control and Prevention (July 2013). Policy Impact: Prescription Painkiller Overdoses. http://www.cdc.gov/homeandrecreationalsafety/rxbrief/.

7. U.S. Department of Health & Human Services (September 2013).

8. Centers for Disease Control and Prevention (July 2013).

9. U.S. Department of Health & Human Services (September 2013).

10. Ibid.

11. Ibid. Neonatal abstinence syndrome is a group of medical problems occurring in newborns who were exposed to addictive opiates in the mother's womb. Cited in: Medline Plus (January 31, 2014). Neonatal Abstinence Syndrome. Available at: http://www.nlm.nih.gov/medlineplus/ency/article/007313.htm.

12. Mercer (October 2014).

13. U. S. Department of Health & Human Services (September 2013).

14. Ibid.

15. Ibid.

16. United States Government Accountability Office (September 2009). Medicaid Fraud and Abuse Related to Controlled Substances in Selected States. GAO-09-957. Available at: http://www.gao.gov/new.items/d09957.pdf. The five states in the GAO study—CA, IL, NY, NC, and TX—accounted for more than 40 percent of all Medicaid prescription drug payments in fiscal years 2006 and 2007.

17. Henry J. Kaiser Family Foundation (January 27, 2015). Status of State Action on the Medicaid Expansion Decision. Available at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

18. Boozang, P., et al. (May 2014). Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care. Technical Assistance Brief. No. 2. Center for Medicare & Medicaid Services. Baltimore, MD: Medicaid Managed Care Information Resource Center. Available at: www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/cms-adult-substance-abuse-services-coverage.pdf.

19. U.S. Department of Health & Human Services. Office of the Assistant Secretary for Planning and Evaluation (March 20, 2015). ASPE Issue Brief. Medicaid Enrollment and the Affordable Care Act. Available at: http://www.aspe.hhs.gov/health/reports/2015/MedicaidEnrollment/ib_MedicaidEnrollment.pdf.

20. Centers for Medicare & Medicaid Services (October 29, 2014). CMCS Informational Bulletin: Delivery Opportunities for Individuals with Substance Use Disorder. Available at: http://medicaid.gov/federal-policy-guidance/downloads/cib-10-29-14.pdf.

21. Ibid.

22. Henry J. Kaiser Family Foundation. State Health Facts. Medicaid Managed Care Market Tracker. Available at: http://kff.org/data-collection/medicaid-managed-care-market-tracker/.

23. Avalere (October 23, 2014). Medicaid Managed Care Enrollment Set to Grow by 13.5 Million. Press Release. Available at:http://avalerehealthproduction.s3.amazonaws.com/uploads/pdfs/1414069964_20141023_Medicaid_Managed_Care_Press_Release_FINAL.pdf. Note: This figure excludes beneficiaries dually eligible for Medicare and Medicaid.

24. Boozang et al. (May 2014).

CHAPTER 2

Highlights of Collaborative Projects

This chapter describes projects implemented by the 13 Safety Net Health Plans participating in the ACAP Reducing Prescription Drug Abuse Collaborative. The projects focused on the following areas:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT);
- Outreach to Medicaid Health Care Providers or Beneficiaries;
- Specialized Support Services for Beneficiaries;
- Prescriber and/or Pharmacy Lock-In Programs; and
- Quality Improvement for Medication-Assisted Treatment (MAT) with Suboxone.

Information in this chapter is based on telephone interviews with health plan program staff conducted in the first quarter of 2015. The following section provides details on the planning, implementation, challenges, and status of each health plan's project.

Screening, Brief Intervention, and Referral to Treatment

Screening, brief intervention, and referral to treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent misuse and abuse of alcohol and illicit drugs.[25] When used in primary care, emergency rooms, trauma centers, and employee assistance programs (EAPs), SBIRT has shown potential to increase early identification of high-risk substance abuse.[26]

Texas Children's Health Plan – Training Physicians on Effective Outreach to Adolescents

Research to Define the Problem: Following the Six Sigma methodology to promote quality,[27] Texas Children's Health Plan conducted extensive research prior to implementing its Collaborative project, aimed at training primary care physicians (PCPs) to provide SBIRT for adolescent patients. The project team reviewed claims data and medical records, obtained input from providers in the field, and reviewed the literature to identify best practices.

Health plan staff analyzed claims in real time to create customized reports on the source of medications associated with adolescent emergency room (ER) admissions involving prescription drug poisoning. Through this process, health plan staff found that many patients had obtained prescriptions not from their PCPs, but rather from dentists, orthopedists, and specialized outpatient orthopedic centers. Furthermore, patients often had not used their health benefits to obtain the prescriptions, and a check of Texas Medicaid's Prescription Drug Monitoring Program showed that many had not obtained the substances from Texas pharmacies. The health plan concluded that adolescents often were obtaining prescription drugs illegally from friends and family members, a practice known as diversion.[28] Focus groups with providers confirmed these findings.

Training for Primary Care Doctors: Based on this research, Texas Children's Health Plan is offering a continuing medical education (CME) credit for primary care physicians. Five PCP sites with at least one adolescent ER visit for prescription drug poisoning are receiving in-person training on SBIRT, and five serve as control sites. At the program's outset, the trainer administers a pre-test to assess physicians' knowledge of prescription drug abuse. The trainer then presents on the misuse of opioids for non-cancer pain, as well as the most common sources of opioids for adolescents. Subsequently, physicians learn about screening

tools to identify teens at high risk of prescription drug abuse, including the CRAFFT assessment[29] and an opioid risk tool. Clinicians using the CRAFFT assessment rank teens from low to high risk on a scale of 1 to 5, with the highest scores indicating a need for treatment. To facilitate screening and referral, the trainer distributes CRAFFT pocket cards for physicians to keep and provides information on substance abuse treatment sites.

Next, participants consider two sample cases involving patients with different symptoms and risk scores. Doctors discuss strategies for addressing the patients' needs, engaging in safe opioid prescribing, and obtaining reimbursement for SUD screening. Additionally, they review five actual cases—identified prior to the training sessions—involving teen patients in the practices who had ER visits for drug poisoning but did not receive prior or follow-up treatment. Discussion focuses on warning signs that may have been missed, as well as effective use of screening tools in the future.

An open discussion and question-and-answer period follow the presentation. Participants discuss potential barriers to implementing SBIRT, and health plan staff offer suggestions for addressing them. For example, providers have asked where to send patients for further evaluation. Prior to concluding the session, the project team administers a post-test of physicians' knowledge. Each participant receives one CME credit.[30] To date, the health plan has awarded a total of 20 CME credits.

Because physicians play a central role in the initiative, the project team advises other health plans pursuing similar approaches to "have an internal champion," either a member of the health plan's leadership or a stakeholder in the community, who can serve an advisory committee to guide the program.

Current Status and Future Plans: In April 2015, Texas Children's Health Plan is assessing practice patterns of physicians in the intervention group to measure the impact of training on SUD treatment referrals. In the future, the health plan will evaluate the program's impact on ER visits, and it may expand the program to provide SBIRT training to dentists, orthopedists, and other high-volume opioid prescribers for adolescents. Texas Children's staff estimate that the program's full implementation, including an evaluation, will take three years.

L.A. Care Health Plan – Training on Motivational Interviewing

Outreach to Providers: L.A. Care Health Plan's Collaborative project provides training on motivational interviewing[31] to medical residents at two academic medical centers that deliver substance abuse treatment: Harbor UCLA and Olive View Medical Centers. L.A. Care Health Plan's behavioral health staff conducted two one-hour training sessions for residents, and the health plan's Web site includes a SBIRT tool.

Having a Physician Champion: The physician supervisor at the Harbor UCLA site—who is passionate about SBIRT's potential to effect positive change in beneficiaries' lives—has strongly supported the initiative. L.A. Care's Pharmacy Director noted that having a physician champion at the provider site was critical to the program's success. "It's helpful to find someone who cares as much as you do about making a change," she said.

Patient Outreach for Motivational Interviewing: To find patients who could benefit from the program, L.A. Care analyzes pharmacy claims and identifies people who have three or more opioid prescriptions, use three or more pharmacies, and/or have three or more prescribers. Health plan staff send these patients' files to the program director at Harbor UCLA and Olive View Medical Centers for review.

Once the director verifies that an individual's care patterns suggest potential misuse or overuse of opioids,[32] medical residents at Olive View conduct motivational interviewing at the patient's next scheduled visit. During the interviews, residents ask patients to identify important life goals and help them understand that seeking treatment and following care plans will enable them to reach those goals.

At Harbor UCLA, medical residents meet with patients during routine clinic visits to gather information about their chronic pain and to initiate SBIRT and motivational interviewing. Residents refer patients who demonstrate readiness to engage in further treatment to the HOPE (Helping Overcome Pain Effectively) Clinic.

The HOPE Clinic takes a holistic approach to treatment. An interdisciplinary team of providers—including a psychologist, medical resident, senior attending physician, and clinical pharmacist—meet with patients for as long as necessary, often for more than an hour. During these

appointments, clinicians educate patients about non-pharmaceutical adjunct therapies to manage pain. These include mindfulness exercises, acupressure, and brief psychological interventions. Clinicians use screening tools to further assess patients' potential for opioid misuse. Patients are asked to consider changes in their pain management regimens, and some are asked to decrease or discontinue opioid therapy. The clinic, which has been operating since October 2014, currently serves 20 patients.

In the future, L.A. Care may add social workers and case managers to the program to connect patients with SUD services and help them follow treatment plans.

Provider Payment for SBIRT: Although Medi-Cal reimbursement for SBIRT is limited to alcohol abuse treatment, medical residents participating in the program wanted to conduct motivational interviewing for patients with all types of SUD because they are interested in learning about best-practice models. Residents have been encouraged by patients' responses to the program, even in its initial stages. "It's exciting for them [the residents] that it [motivational interviewing] works," the project director said.

Program Challenges

Carve-Outs: Because substance abuse, serious mental illness, and SUD medications are carved out of Los Angeles County's Medicaid managed care program, L.A. Care's ability to track patients' use of SUD services is limited at best, and the health plan is unable to conduct an opioid replacement program.

IT System Challenges: System transitions and difficulties with interoperability made analysis of patient data challenging. IT staff dedicated to the project developed effective solutions to move the project forward.

Limited Access to Substance Abuse Treatment: In an effort to eliminate fraud and abuse that was prevalent among SUD treatment providers in the Medi-Cal program several years ago, the State of California now requires all providers to undergo recertification. The process has moved slowly and has created a barrier to substance abuse treatment for Medi-Cal patients. Currently there is a wait list for care.

L.A. Care's Pharmacy Director noted that having a physician champion at the provider site was critical to the program's success. "It's helpful to find someone who cares as much as you do about making a change," she said.

Progress to Date: Based on the success of motivational interviewing with members participating in the project, medical residents have begun to conduct motivational interviewing with all clinic patients during the first visit.

Passport Health Plan – Offering Web-Based Tools for Primary Care Providers

Web-Based Education: After the project it had originally planned was put on hold,[33] Passport Health Plan conferred with Texas Children's Health Plan and rolled out an SBIRT program that includes links to Web-based resources and training. The program currently is offered to primary care providers, including family medicine doctors, pediatricians, and internists, and it most likely will expand to include OB/GYNs and behavioral health providers who do not specialize in SUD.

To implement the program, Passport created a new Web page that features links to SBIRT resources, including Webinars, tools to help PCPs talk with patients about potential substance use disorders, Web sites for SUD providers, and Passport's toll-free number that physicians can call for help with consultation about behavioral health treatment. Passport requires PCPs to complete at least one SBIRT Webinar and maintain the certificate of completion on file.

Outreach to Physicians: Passport notified providers of the program electronically and followed up with written communication. During the planning and implementation process, project staff met several times with the health plan's Primary Care Work Group to obtain input and provide project updates. In response to PCPs' comments, Passport added a Webinar on conducting SBIRT for children.

When conducting regular visits to provider offices, the health plan's network provider specialists ask PCPs about barriers to implementing SBIRT and connect them with resources to help.

When conducting regular visits to provider offices, the health plan's network provider specialists ask PCPs about barriers to implementing SBIRT and connect them with resources to help. Additionally, they can arrange for member appointments with behavioral health specialists as needed.

Payment: As an incentive to physicians, Passport amended contracts to reimburse PCPs for SBIRT on a fee-for-service (FFS) basis in the Louisville area, where PCP payments are capitated. In the remainder of the state, where the health plan reimburses providers on a FFS basis, the health plan added codes for SBIRT services. Kentucky's Medicaid payment rate for SBIRT is based on 15-minute increments. Passport reimburses PCPs for an initial visit of up to 30 minutes and an extended visit of 31 minutes or more.

Efforts to Expand the Network of SUD Treatment Providers: Until 2013, community mental health centers were the exclusive providers of outpatient SUD treatment services for Kentucky Medicaid beneficiaries. Recently the State authorized outpatient behavioral health service organizations to provide the services, and Passport added these providers to its network. If proposed legislation to license and recognize alcohol and drug counselors for Medicaid coverage is enacted, the health plan also will expand its network to include this category of providers.

Next Steps: The program's full implementation is expected to take two to three years, and results are not yet available. Currently the health plan is obtaining feedback from PCPs, and it recently received the first claim for SBIRT. In the future, the health plan will analyze behavioral health claims to assess the program's impact on referrals for SUD treatment. Additionally, Passport may conduct in-person SBIRT training at medical and behavioral health conferences that are offering continuing education credits.

Outreach to Medicaid Health Care Providers or Beneficiaries

The process of identifying members who may benefit from SUD treatment and connecting them with qualified providers—not only to treat their addiction but also to address the underlying medical, psychosocial, and financial issues often associated with addiction—creates formidable challenges. Overcoming these challenges requires creative outreach to gain patients' trust and give health care providers the tools they need to engage patients and help them achieve positive outcomes. Three Collaborative participants focused on outreach to Medicaid beneficiaries or health care providers: Commonwealth Care Alliance, Gold Coast Health Plan, and Priority Partners Health Plan.

Commonwealth Care Alliance – Engaging with Members At Risk of Overdose and Complications

Bringing Members into Treatment: Commonwealth Care Alliance's (CCA's) project has provided outreach and care coordination for members at risk of overdose and medical complications from misuse or abuse of controlled substances. The project targets members who have been prescribed opioids and benzodiazepines and who have a history of substance abuse, use of detoxification facilities, two or more visits to the ER in one month, or use of multiple prescribers or pharmacies.

Obtaining Support from Primary Care Providers: Before reaching out to members, CCA staff held meetings to inform primary care providers, including nurse practitioners and physician assistants, about the initiative. Some providers expressed concern that outreach calls would generate negative responses. To allay their concerns, CCA staff explained that outreach professionals—who are behavioral health specialists, as well as licensed social workers and mental health counselors—would take a helpful, supportive approach and focus on helping members fulfill critical life needs before addressing substance abuse.

Linking Members with Support Services: CCA began member outreach efforts in October 2014. Because many members are in denial and do not want to acknowledge addiction, outreach staff first seek to build trust. They begin conversations not by mentioning use of controlled substances, but rather by asking people about challenges they may have and offering to help. When outreach professionals believe that members may be ready to address their addiction, they administer two assessments: the Current Opioid Misuse Measure[34] and the SOCRATES Tool.[35]

Based on results of these assessments, outreach team members begin to connect people with needed services. They can help members set up appointments with PCPs and specialists, including behavioral health and substance abuse providers. They can arrange transportation, meet members at appointments, help people complete applications for subsidized housing, access food and child care, and obtain other needed services. Outreach staff follow up with health care providers to ensure that patients are continuing treatment. Outreach also includes checking in with members at intervals based on individual needs, at minimum once a month. The project team has found that providing a high level of support helps build trust, enables members to address many issues that contribute to substance abuse, and keeps people engaged in the treatment process. As of March 2015, nearly 350 people were participating in the program.

Program Challenges

Timeliness of Data: The program relies on claims data from the previous three months to identify members who could benefit from support. To improve the timeliness of member outreach, in the future CCA may seek to obtain patient data directly from PCPs.

Early Progress: The program's full implementation is expected to take five years. Anecdotal reports suggest that since the program was implemented, the number of repeat hospitalizations for substance abuse has declined, and participating members appear more likely to obtain behavioral health and substance abuse services in care settings less restrictive than psychiatric hospitals.

The project team has found that providing a high level of support helps build trust, enables members to address many issues that contribute to substance abuse, and keeps people engaged in the treatment process.

Gold Coast Health Plan – Helping Members Navigate Health and Social Service Systems

Using Community Health Workers to Connect Members with SUD Treatment and Other Services: When a previous initiative to reduce the high rate of emergency room use among members found that many were using the ER to access chronic pain treatment, Gold Coast Health Plan implemented the Health Navigator program. The program is intended to reduce preventable ER use for chronic pain conditions by helping members access needed resources and care to address pain management in a timely manner.

Bilingual community health workers known as *promotoras* reach out to members by phone and offer to help with addressing chronic pain. They speak in a friendly, non-accusatory tone—in English or Spanish depending on members' language preferences—and seek to build rapport. During these conversations, health navigators often learn that members are in need of housing, food, transportation, and other resources. In some cases, members are not aware that they have a primary care physician. Health navigators help members make doctor appointments and access a wide range of support services. They follow up with PCPs to ensure that appointments are kept, and they provide their phone numbers for members to call for additional help as needed.

Health navigators are able to connect people in crisis with immediate help. In one case, a health navigator discovered that a member was homeless, in a crisis situation, and suffered from several behavioral health conditions. During the call, she connected the member with a nurse case manager, who began working with the member right away to resolve the crisis and arrange for supportive services.

...promotoras reach out to members by phone and offer to help with addressing chronic pain. They speak in a friendly, non-accusatory tone—in English or Spanish depending on members' language preferences—and seek to build rapport.

Navigators typically have one or two contacts with members; a small number require additional assistance. The navigator links members with extensive, ongoing needs to the health plan's case management program. One member built such a positive relationship with a health navigator that she continued to contact her for help with a variety of health issues and challenges long after the initial call. Currently two navigators serve approximately 300-400 members. To date, 45 patients have been referred to case management.

Outreach to PCPs: Beginning next year, the program will be modified to have health navigators reach out to PCPs to inform them when their patients use the ER for chronic pain treatment.

Program Challenges

Lack of Timely Data: The three-month lag in claims data makes timely member outreach difficult. Gold Coast staff are working with the health services department to obtain real-time data.

Transition to Medicaid Managed Care: Medicaid managed care is relatively new in Ventura County, and the health plan continues to educate members about the importance of having PCPs and using non-emergency settings for routine care.

Member Information: Because members' eligibility and contact information change frequently, Gold Coast faces challenges in keeping member records up-to-date. Health plan staff coordinate with PCP offices to maintain current contact information.

Early Impact on ER Use: Since the program's implementation, members' use of emergency rooms for chronic pain treatment has declined substantially. Health plan staff attribute the decline to the combined effects of the Health Navigator program, an increase in referrals to care management, and members' increased familiarity with the Medi-Cal managed care program and the role of PCPs.

Priority Partners – Working With Substance Abuse Treatment Providers to Improve Routine Care and Reduce ER Use

Reaching Out to Substance Abuse Clinics: Priority Partners' project seeks to coordinate with substance abuse clinics throughout the State of Maryland to promote ongoing primary, preventive, and chronic care and reduce preventable emergency room use among members who are clinic patients.

Coordinating on an Ongoing Basis: Substance abuse clinic staff are coordinating with Priority Partners to help patients access primary, preventive, and chronic care so that they can live healthier lives, adhere to SUD treatment plans, and avoid preventable ER use. In many cases, clinic staff are unaware of patients' use of ERs and other health services; this lack of knowledge hinders their ability to monitor drug-seeking behavior and keep patients on track with substance abuse treatment plans.

The Priority Partners project lead attends the facility's monthly provider meetings and reaches out to clinic staff by phone to present data on members' use of ERs, inpatient care, office visits, and clinic visits. Priority Partners staff also informs clinic staff about resources—such as its nurse call system, local urgent care clinics, and Minute Clinics—that can be helpful to patients. This information enables clinics to offer patients additional guidance and take a more holistic approach to treatment.

As of April 2015, the health plan is conducting a pilot program to embed an on-site community health professional in six participating clinics to help members obtain resources—such primary care, dental care, housing, and food—and connect with case managers for ongoing support. If the initiative is successful, Priority Partners will expand it to clinics throughout the state.

Program Challenges

The Substance Abuse Carve-Out and 42 CFR Part 2: Maryland's carve-out of substance abuse services from the Medicaid managed care program is the main barrier to the program's full implementation. Since the carve-out took effect on January 1,

2015, the health plan has been unable to identify members receiving SUD treatment. The combined effects of the carve-out and the restrictions imposed by 42 CFR Part 2 (for more information, see Chapter 4) have prevented information-sharing about these patients. Priority Partners is limited to working with clinics which with it has signed Qualified Service Order Agreements (QSOAs), which delegate care management authority and allow for information-sharing among the health plan and clinics. Until the agreements are executed, data cannot be shared among entities.

As of February 2015, the health plan had one QSOA with the John Hopkins Center for Substance Abuse Treatment and a working arrangement with a homeless shelter that operates a clinic. Based on the success of these arrangements, Priority Partners will seek to sign QSOAs with additional clinics in the near future.

Early Positive Signs: Clinic staff are participating enthusiastically in the project—which serves an estimated 1,500-2,000 members—and have demonstrated strong support for its goals. Preliminary data on the program's impact are expected within six months. Noting that it can take several years to achieve success, the project director said, "We look at this [process] as a marathon, not a sprint."

Specialized Support Services for Beneficiaries

Medicaid beneficiaries with substance use disorders often lack access to medical and behavioral health care, housing, food, transportation, and other critical resources. Recognizing these members' unique needs and the importance of addressing the full range of life challenges that may contribute to addiction, two Collaborative participants created programs to provide specialized support services: CareSource and Children's Community Health Plan.

CareSource – Providing Standalone and Wraparound Case Management Services

Building on Past Success: In 2014, CareSource implemented improvements to two previously successful endeavors: CARE4U, a case management program for members at high risk of overdose or complications from controlled substances, and the Coordinated Services Program (CSP).

"We look at this [process] as a marathon, not a sprint."

Members enrolled in the CARE4U case management program have been identified as using controlled substances most commonly obtained outside the health care system. The CSP uses many of the same case management techniques as CARE4U, but its members have been identified as obtaining prescription medications from multiple pharmacies and prescribers. The CSP therefore features a pharmacy lock-in initiative with a case management wraparound.

Using Advanced Informatics: To identify members who could benefit from either program, CareSource applies predictive modeling algorithms to analyze data on patients' diagnoses, prescribers, pharmacies, use of controlled substances, emergency room visits, and hospital admissions. Based on this analysis, the health plan develops individual patient risk scores. Nurse case managers regularly review records of patients found to be at high risk, and they determine whether members would benefit from enrolling in CARE4U or the CSP.

Pharmacy Lock-In: Members identified for the CSP receive letters stating that they must fill all prescriptions at a designated pharmacy and have medical services coordinated by their PCP. CareSource chooses network pharmacies for lock-in that have filled the majority of members' prescriptions in the past. Members have the right to a hearing to dispute lock-in decisions. Currently, 270 beneficiaries are enrolled in the Coordinated Services Program.

Meeting Members Where They Are: The enhanced case management featured in CARE4U and the CSP aims to "meet members where they are." Members with substance use disorders often lack housing, food, and transportation. Many do not visit primary care providers or behavioral health care providers regularly. Case managers address members' needs one at a time and connect them with community resources, social services, and health care professionals who can help. The program's case managers are trained in effective communication and listening strategies, and they use motivational interviewing to help members identify

their life goals and develop action plans to reach those goals. Through these interactions, nurses build the long-term, supportive relationships necessary for members to acknowledge their substance abuse and engage in treatment.

When members in the program are hospitalized or visit emergency rooms, nurses are informed immediately through alerts in the health plan's care management documentation system, and they follow up to identify the next steps needed for successful care transitions. Nurse case managers coordinate with hospital staff to help develop members' discharge plans.

Providing Ongoing Support: Once members are stabilized and engaged in SUD treatment, case managers conduct monthly or quarterly calls to discuss progress and provide additional support. Program participants can contact case managers at any time for help. Members typically remain in CARE4U for at least 12 months, and upon completing the program, they may transition to the health plan's medical or high-risk case management program for continued support. Even if members choose not to participate in CARE4U, case managers coordinate with their health care practitioners to connect them with behavioral health, substance abuse treatment, pain management, and social service providers. CSP enrollees typically remain in the program for 18 months, and enrollment can be extended by an additional 18 months as needed to achieve members' goals. Currently, CareSource has five full-time case managers to serve members in both CARE4U and the CSP.

Program Challenges

Carve-Outs: In Ohio, behavioral health services provided by community mental health centers (CMHCs) are carved out from the Medicaid managed care benefits package. Although the State Medicaid program provides health plans with historical data on members' use of services received in CMHCs, the carve-out complicates efforts to coordinate care. To bridge gaps in information-sharing, CareSource staff have built ongoing relationships with contacts at CMHCs.

Cash Payments: There are many members who avoid using their pharmacy benefits and instead pay cash for prescriptions to avoid lock-in and bypass CareSource's approval process. CareSource continues to seek effective ways to address the issue.

Children's Community Health Plan – Partnering with Community Organizations to Reduce Controlled Substance Abuse Among Pregnant Women

Joining Forces with the Wisconsin Association for Perinatal Care: To reduce the incidence of neonatal abstinence syndrome, Children's Community Health Plan (CCHP) is pursuing a long-term, community-based strategy. CCHP has joined forces with the Wisconsin Association of Perinatal Care—a statewide coalition including representatives of health care practitioners, community agencies, child welfare agencies, and the state's maternal and child health advisory committee—working to achieve the same goal. CCHP representatives now serve on the organization's Board and recently participated in statewide and regional task forces to call the community to action on the issue.

The association developed the "Newborn Withdrawal Project Educational Toolkit"[36] to help health care practitioners successfully address the issue of substance abuse with pregnant women. The toolkit includes background information for providers on NAS, an assessment tool, and informational materials for providers to offer at-risk pregnant women. CCHP is now exploring the most effective ways to distribute the toolkit to providers once it has developed an automated system to identify pregnant women with potential SUD issues.

Need to Obtain Timely, Complete Data: Originally, CCHP sought to reduce the incidence of neonatal abstinence syndrome by promoting early SUD treatment among pregnant women who may be abusing prescription drugs. However, the process of using claims data and enrollment files for timely identification of pregnant women who could potentially be misusing prescription drugs was challenging.

As an alternative, the health plan conducted a retrospective study of prescription drug claims for mothers whose babies were born with NAS. The study suggested that these mothers often avoid using their health benefits to access prescription drugs but instead pay cash, obtain the medications from friends or family members, or use street drugs. Because Wisconsin health plans are not permitted to access the state's Prescription Drug Monitoring Program (see Chapter 4), CCHP has been unable to obtain information about controlled substance prescriptions that members may have obtained without using their pharmacy benefits.

Prescriber and Pharmacy Lock-In Programs

Medicaid lock-in programs identify beneficiaries with claims suggesting possible misuse or abuse of prescription drugs—visits to multiple pharmacies, physicians, or emergency rooms to seek prescriptions—and limit them to a single pharmacy and/or prescriber for all medications. Medicaid health plans deny coverage for any prescriptions that these members attempt to obtain from other prescribers or pharmacies and guide patients to PCPs and pain management specialists to coordinate care and arrange for substance abuse treatment as needed.

Four Collaborative participants have implemented or enhanced prescriber or pharmacy lock-in initiatives: Affinity Health Plan; CalOptima; Horizon NJ Health Plan; and CareSource. The CareSource pharmacy lock-in also operates in conjunction with the Care4U case management program described in the previous section.

Affinity Health Plan – Using Prescriber and Pharmacy Lock-in to Reduce Overdose Risk

Finding Patients Who Can Benefit: Affinity Health Plan's pharmacy and prescriber lock-in program seeks to reduce opioid abuse among members with drug addiction and those who have experienced overdose. The health plan analyzes claims and identifies patients who could benefit from the program based on the types and doses of medications they are taking, as well as their use of multiple pharmacies, prescribers, and controlled substances. Affinity forwards selected patient records to a multidisciplinary committee that decides which patients to include. The committee includes a pharmacist, nurse, case manager, physician, and behavioral health specialist. Patients enrolled in the program receive written notice, and the New York State Medicaid program is notified of their lock-in status.

Leveraging Expertise of Qualified Pain Management Specialists: To implement its action plan, Affinity worked closely with a select group of pain management specialists. The health plan identified physicians with pain management expertise—physiatrists and anesthesiologists—who treat a high volume of Affinity members and follow best practices in pain management to treat patients enrolled in the initiative. Some members treated by these physicians as part of the initiative are locked in, and others voluntarily receive pain management services from one of the identified prescribers. Currently, six provider sites with a total of 10-15 prescribers and approximately 250 patients participate in the initiative.

A multidisciplinary committee decides which patients to include. The committee is comprised of a pharmacist, nurse, case manager, physician, and behavioral health specialist.

Providing Tools and Support for Members to Address Abuse: During initial visits with patients, the participating pain management specialists conduct risk assessments and pain screening. Members sign pain contracts[37] and must undergo random testing to check for use of drugs and doses beyond those prescribed. Patients are required to remain under a designated prescriber's care in order to obtain additional prescriptions. Affinity has created a variety of reports to monitor patients' progress. If an intervention group member continues to engage in drug-seeking behavior, Affinity staff reaches out to offer case management services for additional support.

Providing Tools and Resources for Pain Management Specialists: Affinity provides physicians in the intervention group a Pain Management Formulary, which serves as a quick reference on the health plan's covered agents and quantity limits. The health plan provides a Pain Management Toolkit with links to pain guidelines, resources, Continuing Medical Education, and risk assessment tools. Affinity shares additional information about pain management with physicians on an ongoing basis.

The program has a dedicated pharmacy technician who works closely with all participating prescribers so that challenges can be addressed

quickly. If a member does not follow the program's required procedures, prescribers can reach out to the technician, who connects patients with behavioral health or case management staff to identify and address underlying problems.

Program Challenges

Carve-Outs: Because New York State carves out prescription drug coverage for SSI recipients and Medicaid beneficiaries in methadone maintenance programs from the Medicaid managed care benefits package, Affinity has faced some barriers in coordinating services for these members.

Denial and Other Challenges in Engaging Members: Program staff have noted that lock-in procedures alone are not sufficient to reduce opioid misuse and abuse among beneficiaries. Members often are in denial and initially refuse to follow lock-in requirements or engage in treatment with pain management specialists. To overcome addiction, beneficiaries must recognize the problem, feel ready to address it, and commit to consistent changes in behavior. This process often takes many months. Therefore, health plan staff seeking to engage members in treatment must be prepared for a long process involving repeated engagement efforts. Health plan staff and health care providers are encouraged to assess readiness to address substance abuse during each member encounter and be prepared to initiate the treatment process as soon as the member is ready.

Member Turnover: Because Medicaid members in New York are allowed to change health plans every month, it can be difficult to engage with members on an ongoing basis to address addiction. However, in New York, when a member enrolled in a Medicaid lock-in changes health plans, the new plan is informed of the beneficiaries' lock-in status.

Challenges in Prescriber Recruiting: Affinity faced difficulties in recruiting pain management specialists for the program. Some practices were not receptive to outreach, and some raised concerns about reimbursement for office-based drug testing. Affinity reimburses for drug tests conducted in network laboratories or in CLIA-waived facilities.[38]

Limited Availability of Pain Management Prescribers: In some areas of the state, the number of pain management providers is not sufficient to meet the demand. Affinity is continuing efforts to expand its network of pain management specialists and has made progress in the Long Island and Suffolk regions.

Scope of the Problem. The number of beneficiaries struggling with addiction and prescription drug abuse presents challenges. Often addiction issues are addressed one patient at a time, *e.g.,* in conjunction with an overdose or suicide attempt. However, ultimately a population-based strategy that includes early identification and treatment would be preferable.

Early Signs of Progress: The program's pain management specialists increasingly report that they are able to retain patients who previously would have been discharged from care due to difficulties with adherence to pain contracts. Data analysis from the fourth quarter of 2014 found that among patients in the intervention group, costs for controlled substance prescriptions had declined by 18 percent. None of the intervention group members had received opioid prescriptions in combination with buprenorphine and benzodiazepines. From the first to the fourth quarter, the average morphine-equivalent dose[39] among patients in this group declined by 31 mg.

CalOptima – Combining the Benefits of Pharmacy and Prescriber Lock-In

Building on Past Success: Building on the success of a pharmacy lock-in initiative launched in 2004, CalOptima worked with one of its large health care networks, Monarch Health Care, to establish a prescriber lock-in for Monarch patients who appear to be engaging in drug-seeking behavior for opioids. Staff involved in the initiative include a lead pharmacist; a pharmacy technician; a medical director; and the director of pain management at Monarch Health Care. All prescribers designated for the lock-in are pain management specialists at Monarch.

Identifying and Linking Patients with Pain Management Specialists: CalOptima pharmacy staff periodically analyze claims data to identify patients who exhibit drug-seeking behavior and request to enroll them in the prescriber lock-in program operating at Monarch. CalOptima nurses then conduct patient outreach and connect patients with pain management specialists. When patients first meet with pain management specialists, they sign opioid pain management contracts to indicate consent for the lock-in and commitment to comply with the program's requirements.

The program currently has 70 enrolled members who are being treated by 11 pain management specialists within two prescriber groups.

Coordinating with Compliance and State Audit and Investigations Units: If patients refuse to visit the program's pain management specialists, program staff inform Cal-Optima's Compliance Department. After additional research, the department may forward information to the State Department of Health Care Services' Audits and Investigations unit as appropriate.

Program Challenges

Disenrollment: Because the prescriber lock-in program currently operates only within Monarch Health Care, members who change health networks also are disenrolled from the prescriber lock-in. Members also can be disenrolled if they violate pain management contracts and are removed from pain management groups or if they lose eligibility for MediCal. CalOptima staff continues to seek effective ways to address disenrollment.

Early Progress: An analysis of the program's impact among 87 program participants (including those enrolled and disenrolled) found a 50 percent reduction in the average number of opioid prescriptions per patient (from 3.6 to 1.8) and a 32 percent reduction in the average number of opioid prescriber groups (from 2.5 to 0.8) per patient.

Horizon NJ Health – Enhancing Pharmacy Lock-in With Case Management and Prescriber Support

Finding Patients Who Can Benefit: Horizon NJ Health's pharmacy lock-in program includes enhanced outreach and support for members, pharmacies, and prescribers to promote optimal outcomes. The health plan refers patients to the program based on analysis of medication profiles for members who use more than one prescribing office and more than one pharmacy to obtain controlled substances. The health plan forwards selected records to a multidisciplinary team—including the health plan's clinical pharmacists, medical directors, case managers and care managers, as well as case workers—who review each case to decide whether lock-in would be appropriate.

Reaching Out to Lock-in Pharmacies and PCPs: The health plan sends notification letters to enrolled members, their PCPs, and lock-in pharmacies. Member letters provide information about the lock-in and note that PCPs and pharmacies can serve as valuable resources. Letters to PCPs and lock-in pharmacies request support for coordinating members' care. Additionally, PCP letters emphasize member education, as well as the importance of evidence-based medication use, adherence to medication regimens, and the benefits of using a single pharmacy to fill prescriptions. Horizon NJ Health makes its clinical team available to answer questions from members, prescribers, and pharmacists.

Using Pharmacies as a Communication Hub: Because pharmacists may interact with patients more often than other health care providers, they can play an important role by conveying information about medication use and adherence to treatment plans. Community pharmacists notify Horizon NJ Health when their records show that patients are using multiple prescribing offices for controlled substance prescriptions. The health plan may send this information to case managers, who assess members' needs for additional support and may provide referrals to pain management specialists or other specialized care.

Because pharmacists may interact with patients more often than other health care providers, they can play an important role by conveying information about medication use and adherence to treatment plans.

If program enrollees continue to present lock-in pharmacies with multiple prescriptions in the same therapeutic class (*e.g.*, if they access prescriptions without using their health benefits, by paying cash to out-of-network providers), Horizon NJ Health's clinical pharmacist informs prescribers and documents interventions or care plans to address patients' ongoing needs. If necessary, the program's lead pharmacist may contact lock-in pharmacists to discuss clinical justifications for dispensing and document correspondence with prescribers.

Providing Actionable Information to Prescribers: When a member fills two or more prescriptions from two or more prescribers for controlled substances within the same therapeutic class, the health plan sends each prescriber a letter indicating the patient's diagnoses and recent prescription history, including medication names, dates of service, prescriber names and phone numbers, and the dispensing pharmacy's contact information. The letter asks physicians whether they had been aware of members' other prescriptions and prescribers and whether they would consider modifying patients' medication in light of the additional information. To improve coordination of care, prescribers are encouraged to discuss treatment plans with patients and each other. The health plan asks physicians to return the bottom portion of the letter, which includes an easy, check-box format to indicate plans for continued care. Prescribers have provided positive feedback on the correspondence.

Providing Case Management to Address the Full Range of Member Needs: Horizon NJ Health case managers may contact members to ask whether their pain is being managed effectively as well as arrange follow-up care and pain management appointments if needed. During these calls, case managers also evaluate patients' needs for critical resources such as housing, food, and transportation.

Program Challenges

Data Limitations: Horizon NJ Health does not have access to all data elements from members' prescription histories prior to enrollment in the health plan and its Pharmacy Case Management and Network Coordination of Care programs. Therefore, Horizon NJ Health was unable to perform an intiative-wide comparison of the number of controlled substance prescribers per member before and after the intervention.

Preliminary Findings: At the end of 2014, the program was serving 171 patients. Preliminary analyses of health care use and spending among program enrollees found reductions in the number of controlled substances per member, spending per controlled substance claim, and number of pharmacies used.

Quality Improvement for Medication-Assisted Treatment with Suboxone

Buprenorphine, sold under the brand name Suboxone, is a substitute opioid used to treat opioid addiction.[40] Suboxone has been used effectively in medication-assisted treatment (MAT) programs for opioid abuse. However, in some forms, it can create euphoria and cause dependence—though to a lesser extent than methadone—and thus has the potential for misuse and abuse. In addition, problems with questionable Suboxone prescribing, combined with prescriber demands for cash payments (see Chapter 4 for more information), have created challenges in some MAT programs. Two health plans implemented Collaborative projects focused on quality improvement for MAT programs using Suboxone: AmeriHealth Caritas and Neighborhood Health Plan.

AmeriHealth Caritas – Creating Quality Standards for Suboxone Prescribing

Addressing Problems in Suboxone Prescribing: AmeriHealth Caritas is addressing the lack of standards to promote safe, effective use of Suboxone for medication-assisted treatment. A crosswalk analysis of the health plan's provider network and members' prescription records showed that beneficiaries often were obtaining the medication from out-of-network providers, many of whom were managing more than the 100-patient limit established by the DEA for Suboxone prescribing (see Chapter 4). Moreover, site visits to high-volume Suboxone prescribers found that some were requiring cash payments—a practice that violates State and health plan rules. Project staff referred these cases to AmeriHealth Caritas's Special Investigations Unit and sent a reminder to all Suboxone prescribers in the network about the health plan's prohibition on requiring cash payments.

Developing a Network of Suboxone Prescribers Based on Best Practices: To address the existing problems and create the infrastructure needed for evidence-based MAT with Suboxone, AmeriHealth Caritas decided to create a preferred network of Suboxone prescribers who meet best-practice standards. Based on a site visit to a SUD treatment facility in Pittsburgh,

AmeriHealth Caritas has begun formulating these standards, which address quality of care, member visits for Suboxone treatment, and documentation. Because no formal credentialing process exists specifically for Suboxone providers, the health plan has begun developing an audit tool for provider offices to track compliance. The tool will be used for initial or renewal certification to participate in the preferred network. Items to be reviewed during the provider certification and recertification process include:

- XDEA number and absence of State and Federal disciplinary action;
- number of patient visits per hour to ensure that members receive appropriate attention;
- written policies and procedures for induction and maintenance of patients receiving Suboxone therapy (including number of authorized refills and procedures for reporting lost or stolen prescriptions);
- presence of comprehensive treatment agreements between members and providers; and
- process for referring members for behavioral health evaluation and ensuring that these visits occur.

Throughout 2015, AmeriHealth Caritas will continue to evaluate provider offices for participation in the preferred Suboxone network. The health plan will assess members' access to Suboxone preferred prescribers on an ongoing basis. Once sufficient access is achieved and the program has been fully implemented in 2016, the network will be limited to prescribers who meet the best-practice standards, and AmeriHealth Caritas will conduct periodic audits to ensure compliance. Suboxone prescribers who have not met the criteria and wish to participate in the network will need to implement corrective action plans to come into compliance. Otherwise, prescribers not meeting the criteria will become nonparticipating providers.

Offering Guidance and Information to Suboxone Prescribers: AmeriHealth Caritas will mail letters to all current and past Suboxone prescribers about plans for the new system. The health plan's medical director will be available to offer guidance to prescribers, and the network account executive will respond to any questions or concerns.

Learning from Data-Related Challenges: Like Children's Community Health Plan, AmeriHealth Caritas initially had planned a program to lower the incidence of neonatal abstinence syndrome by reducing opioid abuse among pregnant women. The health plan likewise was unable to use prescription claims to identify pregnant women using opioids, and project staff concluded that women were obtaining the medications through cash payments or diversion from friends or family members.

AmeriHealth Caritas decided to create a preferred network of Suboxone prescribers who meet best-practice standards. The health plan will develop a certification process for prescribers meeting these standards.

Neighborhood Health Plan – Improving Quality and Coordination of Care for Members and Improving Suboxone Prescribing

Developing the IT Infrastructure for Personalized Risk Assessment and Outreach: Since 2009, Neighborhood Health Plan has conducted a program to address members' abuse of controlled substances. The health plan's Collaborative project seeks to enhance the program by developing algorithms to identify members with substance use disorders who would benefit from care management and addiction services. When fully implemented, the initiative will create member profiles that include risk scores.

As part of the project, a multidisciplinary team comprised of medical and social service professionals, behavioral health care managers, and pharmacists will meet quarterly to review profiles of members identified as high-risk and determine the type of outreach best suited for each case. Depending on individual needs, a medical director, care manager, social care manager, or behavioral health care manager will conduct outreach by mail or phone to help members connect with behavioral health services for addiction. Recognizing that beneficiaries with substance use disorders often lack access to basic resources such as housing, food, and home

heating, program staff plan to coordinate with the health plan's Social Care Management Program to provide links to needed services and support. Members identified for the initiative also will be enrolled in a pharmacy lock-in program.

Addressing Inappropriate Suboxone Prescribing: At the same time that Neighborhood is building the IT infrastructure for individually tailored member outreach, health plan leadership has become concerned about questionable prescribing trends for Suboxone, which is among the top five drivers of its pharmacy costs. Many of the prescribers dispensing Suboxone to Neighborhood members refuse to participate in health plan networks and demand up-front, cash payments from patients.

When claims analysis indicates that providers are inappropriately prescribing controlled substances, including Suboxone, Neighborhood staff will follow up with clinical and chart reviews, limit referrals to these providers, and/or impose requirements to submit corrective action plans. As a last resort, the health plan can suspend referrals, report prescribers to the state, and/or remove them from the network.

Progress to Date: Neighborhood has succeeded in developing some clinical algorithms to identify patients at high risk of overdose and complications from abuse of Suboxone and other controlled substances. Additionally, the project team has been able to compile member and prescriber profiles. An interdisciplinary team is reviewing the profiles to develop interventions that could include outreach by phone or mail, as well as pharmacy lock-in.

Program Challenges

Neighborhood's IT Department is continuing work to implement the algorithms. Once the health plan has addressed the IT challenges associated with the process, the project will move forward.

25. SAMSHA-HRSA Center for Integrated Health Solutions. SBIRT: Screening, Brief Intervention, and Referral to Treatment. Available at: http://www.integration.samhsa.gov/clinical-practice/SBIRT.

26. U.S. Department of Health & Human Services. Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment (2013). Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment. Technical Assistance Publication (TAP) Series 33. HHS Publication No. (SMA) 13-4741. Available at: http://www.integration.samhsa.gov/sbirt/TAP33.pdf .

27. iSixSigma. Available at: http://www.isixsigma.com/new-to-six-sigma/getting-started/what-six-sigma.

28. Office of Inspector General. U.S. Department of Health & Human Services. Spotlight On...Drug Diversion. Available at: http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp.

29. The CRAFFT is a screening tool comprised of six questions to screen children under the age of 21 for high-risk alcohol and drug use. Recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents, it is intended to help practitioners assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted. Cited in Center for Adolescent Substance Abuse Research. The CRAFFT Screening Tool. Available at: http://www.ceasar-boston.org/CRAFFT/.

30. Approved for AMA PRA Category 1 Credit.

31. Motivational interviewing is used in chronic disease management to help people identify their motivations and goals and understand how making positive lifestyle changes will enable them to reach those goals. Motivational interviewing for substance abuse counseling has been described as a collaborative process to address ambivalence about substance abuse and change; focus on patients' motivations and values; and activate their ability to make beneficial changes. An empathic, supportive, yet directive approach to counseling creates the conditions for change to occur. Cited in Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol Series. No. 35. Rockville, MD: Author. Available at: http://www.ncbi.nlm.nih.gov/books/NBK64964/.

32. In some cases, patients have multiple prescribers due to the turnover among resident staff rather than due to drug-seeking behavior.

33. Initially, Passport Health Plan's Collaborative project was aimed at increasing referrals to a Kentucky program providing case management for pregnant women with substance use disorders. However, when the state decided to put the program's expansion on hold, Passport changed direction and instead implemented a program to promote SBIRT among primary care providers.

34. The Current Opioid Misuse Measure is a 17-item questionnaire to identify the potential for misuse of opioid prescriptions. Cited in Butler, S., et al. (November-December 2010). Cross validation of the Current Opioid Misuse Measure (COMM) to monitor chronic pain patients on opioid therapy. *Clinical Journal of Pain*. 26(9). 770-776. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2955853.

35. SOCRATES is a tool to assess individuals' readiness to change drinking behavior and help determine appropriate interventions for adults who abuse or are dependent on alcohol. Cited in Donovan, D.M. Assessment to Aid in the Treatment and Planning process. National Institute on Alcohol Abuse and Alcoholism. Available at: http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/planning.htm.

36. See http://www.perinatalweb.org/major-initiatives/perinatal-substance-use-and-abuse/resources.

37. Pain contracts include rules that patients must follow to take drugs safely. Rules are intended to discourage patients from taking excessive doses, mixing, sharing, or selling medications. Lock-in rules require patients to obtain prescriptions from a single prescriber and pharmacy and undergo drug testing. Cited in Andrews, M. (April 5, 2011). Some doctors ask patients to sign 'pain contracts' to get prescriptions. *Kaiser Health News*. Available at: http://kaiserhealthnews.org/news/michelle-andrews-on-pain-contracts-and-opioid-agreements/.

38. Pursuant to the Clinical Laboratory Improvement Amendments (CLIA), waived tests are simple lab exams and procedures with an insignificant risk of having erroneous results. The Food and Drug Administration determines criteria for CLIA-waived tests. Cited in: Centers for Medicare & Medicaid Services (March 2006). Clinical Laboratory Improvement Amendments. Brochure #6. Available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/howobtaincertificateofwaiver.pdf.

39. U.S. Department of Health & Human Services. Centers for Medicare & Medicaid Services (September 6, 2012). Supplemental Guidance Related to Improving Drug Utilization Controls in Part D. Available at: http://www.cms.gov/Medicare/PrescriptionDrugCoverage/PrescriptionDrugCovContra/Downloads/HPMSSupplementalGuidanceRelated-toImprovingDURcontrols.pdf. See Addendum C.

40. Sontag, D. (November 16, 2013). Addiction treatment with a dark side. *The New York Times*. Available at: http://www.nytimes.com/2013/11/17/health/in-demand-in-clinics-and-on-the-street-bupe-can-be-savior-or-menace.html?_r=0.

CHAPTER 3

Toolkit for Future Initiatives

As they worked to overcome a variety of implementation challenges, health plans participating in the Reducing Prescription Drug Abuse Collaborative have learned valuable lessons. Based on insights gained through their experiences, we created the following toolkit to guide future efforts to reduce prescription drug abuse among Medicaid beneficiaries. The toolkit includes actionable recommendations for approaching the following aspects of health plan initiatives:

- Program planning and management;
- Data analytics and reporting;
- Coordination with health care practitioners; and
- Development of patient-centered treatment strategies.

Program Planning and Management

1. Start with systematic research and planning.

Investing time up front in research is critical to creating an effective intervention. As part of the research process, reach out to key program stakeholders, such as members, substance use treatment providers, and other health care providers, to solicit input and feedback. Focus groups may be helpful, along with a comprehensive review of the literature to identify best practices. Research should include barrier analysis to identify potential obstacles and develop contingency plans.

2. Develop clear goals.

All collaborative initiatives were guided by a set of clear goals and specific action plans to reach those goals. As program staff encountered implementation challenges, they referred back to the initial goals and developed alternative strategies.

3. Be flexible and willing to change course.

Sometimes policy changes or data limitations—such as lack of data on controlled substance prescriptions obtained through cash payments or diversion—make it impossible to achieve even the most worthy goals. If it becomes clear that even the best efforts will be insufficient to reach the project's original objectives, be flexible enough to take a step back and develop a new plan.

4. Educate health plan leadership and key staff in other departments about the need to address prescription drug abuse and involve them in planning and implementation.

To marshal the human, IT, and financial resources needed for successful programs, it is critical to gain commitments not only from the CEO, but from the entire leadership team. Moreover, health plans have found it useful to involve multiple departments, including pharmacy, behavioral health, care management, as well as member and provider services in program planning and implementation.

5. Devote sufficient human resources to projects and consider hiring a project manager.

Resource constraints, staff changes at provider sites, and competing health plan priorities sometimes led to delays in Collaborative projects, and in some cases, projects were put on hold for

part of the year. A number of participating health plans are considering changes such as adding dedicated staff or a project manager who could address implementation challenges in a timely manner, coordinate project activities among multiple departments, and maintain momentum in an environment of competing priorities.

6. Build interventions around evidence-based practices.

Use of evidence-based tools, such as SBIRT—the focus of several Collaborative initiatives — increases the potential for programs' success.

7. Develop a sound evaluation plan that includes valid measures to assess progress.

Collaborative initiatives included clear measures to assess progress and measure the impact of project activities. Participating health plans are measuring effects such as: the impact of provider training on ER visits and referrals to SUD treatment; number of repeat hospitalizations for SUD; use of ERs for chronic pain treatment; number of opioid prescriptions and prescribers per patient; number of pharmacies used; and spending per controlled substance claim.

8. Approach program implementation "as a marathon, not a sprint."

Collaborative participants have noted that efforts to address prescription drug abuse among Medicaid members require long-term, multi-year commitments. To effectively address the multiple challenges involved—including a rapidly changing policy environment, policy barriers, IT issues, resource limitations and psychosocial issues involved in addiction—health plans can anticipate a time frame of up to three to five years to fully plan, implement, and evaluate comprehensive projects.

9. Identify important community partners and don't reinvent the wheel.

Many local, state, and national organizations are engaged in activities to address prescription drug abuse, and many have developed high-quality education materials and programming. Reaching out to other stakeholders to develop partnerships at the local and regional levels can be an effective strategy to advance project goals. Community stakeholders may be willing to share or co-brand educational materials and join forces for additional interventions.

10. Invest in efforts to expand the availability of high-quality substance abuse treatment providers.

In many states, a shortage of qualified substance abuse treatment providers hinders efforts to improve care. Several Collaborative projects included efforts to build provider capacity and expand networks of qualified, high-quality substance abuse treatment practitioners. In some states, legislative and regulatory changes may be needed to increase provider capacity.

Data Analytics and Reporting

1. Invest in data resources and infrastructure for planning, implementation, and evaluation and be prepared to find workarounds.

Effective data analytics, information exchange, and data reporting are essential to projects' success. Yet these processes are complex and challenging. Even with careful planning, data-related problems often occur. Health plans should devote sufficient staffing and resources to address data problems effectively and provide staff with the flexibility to overcome data-related obstacles.

2. Automate as many IT procedures as possible.

Several health plans reported delays associated with manual processes used to implement lock-in and outreach programs. Automating processes to the greatest extent possible helps promote accuracy and timeliness.

Coordination with Health Care Practitioners

1. Identify a physician champion to build provider support and maintain momentum for implementation.

Collaborative participants reported that having strong support from a physician leader, either at a provider site or within the health plan, who is passionate about the program's goal can be critical to launching projects successfully. Additionally, a physician champion can intervene to resolve implementation challenges and move projects forward.

2. Meet with health care practitioners at key points during project planning and implementation to obtain buy-in and feedback.

Seeking physicians' input prior to implementing programs can be important not only to obtain their support but also to identify clinical and other issues that should be addressed in program design. In addition, obtaining physician feedback on an ongoing basis can help health plan staff address implementation challenges and improve program effectiveness.

3. Consider using a multidisciplinary team to provide expertise on key elements of program design.

Because the problem of prescription drug abuse is multi-faceted, there is no single solution. To design an effective, multidimensional strategy, it can be helpful to create a multidisciplinary team—including medical, behavioral health, pharmacy, care management, and social service professionals, both within and outside of the health plan. Use of multidisciplinary teams can help ensure that project activities reflect a diversity of perspectives and facilitate collaboration among colleagues to achieve project goals. Several Collaborative health plans have implemented projects with a multidisciplinary approach.

4. Provide clear, succinct communication to physician offices and offer actionable information and tools.

Direct communication with primary care providers, pain management specialists, and psychiatrists participating in prescriber lock-in programs generated a positive response. Physicians said that they appreciated the information about patients' other prescribers, and many followed up with communication and care coordination activities.

5. Leverage pharmacists' ability to connect with patients on a regular basis.

Pharmacies can serve as important communication hubs. Because patients often visit pharmacies at least once a month to fill prescriptions, pharmacists can be a helpful point of contact to deliver program messages and direct members to health care providers who can deliver or arrange for effective treatment. It is important to communicate clearly with pharmacists and provide them with the tools and support they need to play this role.

Development of Patient-Centered Treatment Strategies

1. Design outreach strategies that effectively address denial and provide support to help patients meet a broad range of medical and psychosocial needs.

Collaborative health plans have recognized that denial is a significant barrier to effective treatment for substance use disorders. Therefore, they designed outreach strategies that take a non-threatening approach to engagement and "meet people where they are."

Outreach staff should be trained in effective ways to engage members with addiction. Offering to help people with major life challenges—such as lack of access to housing, food, transportation, and regular medical care—is an important first step. Using validated tools to assess people's readiness to change and tailoring outreach based on responses has been effective. Motivational interviewing to identify members' life goals and develop action plans to reach those goals

also has been used successfully. The process of acknowledging addiction and committing to long-term behavioral and lifestyle changes is long and difficult. Therefore, health plans should be prepared to make multiple contacts with members to effect long-term change.

2. Combine restrictions such as prescriber and pharmacy lock-in with enhanced support to help beneficiaries meet their basic needs.

Beneficiaries with unmet needs for essential resources may unable or unwilling to engage in substance abuse treatment. They may continue to change health plans or take other actions to avoid the lock-in.

Enhanced lock-in programs could include: interdisciplinary team meetings to review cases and refer beneficiaries for treatment and behavioral health assessment; specialized care management, education and counseling; use of health advocates and community outreach staff to link people with needed services; effective referral and assessment procedures; use of patient contracts to facilitate appropriate pain management; as well as data-sharing among health plans, PCPs, prescribers, and pharmacies to promote effective care coordination.

3. Use treatment models that integrate medical, behavioral health, and social services.

The mind-body connection is now a widely recognized, well-established tenet of effective health care[41] that is particularly relevant to substance abuse treatment. Substance abuse treatment models should be designed to foster ongoing communication and care coordination among patients' medical and behavioral health teams, including coordination among mental health and substance abuse treatment staff, as well as care management professionals.

4. Establish care systems to connect people in crisis with immediate help.

Early intervention always is preferable to treatment in crisis; however, in many cases, Medicaid beneficiaries with substance use disorders are not ready to change until they are experiencing a crisis such as an overdose episode or suicide attempt. Outreach to members in crisis should include immediate, real-time assistance to resolve the situation and connect people to evidence-based treatment. To be effective, outreach and care management staff should be well-informed of all community resources and have the capability to connect people right away to qualified professionals who can initiate treatment.

41. NIH Medline Plus (Winter 2008). Emotions and Health. 3(1). Available at: http://www.nlm.nih.gov/medlineplus/magazine/issues/winter08/aticles/winter08pg4.html.

CHAPTER 4:

Challenges and Recommendations

While implementing the Reducing Prescription Drug Abuse Collaborative, we have identified several challenges to achieving long-term improvements. In this chapter, we discuss these challenges and recommend strategies to address them. To address the first three challenges, we recommend regulatory changes to enable the information-sharing needed for effective care coordination and to address addiction among beneficiaries dually eligible for Medicare and Medicaid. To address the remaining issues, we recommend cooperative efforts by public- and private-sector leaders to develop tools for improving key aspects of care delivery and measuring the quality of SUD treatment.

Regulatory Changes to Promote Care Coordination

Issue: Information-Sharing

The Substance Abuse Confidentiality Regulations pursuant to HIPAA—42 CFR Part 2—restrict disclosure and use of patient records that identify individuals as having a current or past substance use disorder or as participants in any federally assisted alcohol or drug abuse treatment program. With limited exceptions, the regulations require patients' written consent for disclosures of this information even for the purposes of treatment, payment, or health care operations.[42]

While ACAP member health plans strongly value and protect patient privacy—particularly as it relates to the sensitive issue of substance abuse treatment—these rules have made it extremely difficult, and in some cases impossible, for health plans and health care providers to share information necessary for coordinating and improving the care of patients with SUD. At a time when delivery system innovations are promoting integration and care coordination among providers of medical, mental health, and substance abuse treatment services, regulatory change is needed to balance the imperatives of patient confidentiality with efforts to promote high-quality, effective care.

Recommendation:

ACAP recommends amending 42 CFR Part 2 to enable information-sharing for quality improvement and care coordination. The amended rule should provide clear guidance to payors and providers on the scope of permissible disclosures to achieve this goal.

Issue: Monitoring of Controlled Substances

Prescription Drug Monitoring Programs (PDMPs) are electronic databases that track patients, prescribers, and prescriptions associated with all controlled substances dispensed in a state.[43] Currently 49 states operate PDMPs.[44] These databases enable providers, professional licensing boards, and law enforcement officials to identify individuals involved in suspected abuse and illegal diversion of controlled substances,[45] and they can help identify patients who would benefit from early intervention and treatment.[46]

In many states, health plans are not permitted to access PDMP data. Health plans' pharmacy databases do not include information about controlled substance prescriptions not reimbursed through members' pharmacy benefits, such as those covered by State Medicaid programs under prescription drug carve-out arrangements or those purchased with cash. Without complete data on members' prescriptions for controlled substances, Medicaid health plans are unable to identify many people who could benefit from SUD treatment and counseling.

Recommendation:

ACAP recommends permitting Medicaid health plans to access state PDMP data for their membership in order to identify a larger proportion of patients in need of prescription drug abuse intervention and to initiate timely, effective outreach.

Issue: Pharmacy and Prescriber Lock-In Programs

Forty-six states use Medicaid lock-in programs to reduce prescription drug abuse among beneficiaries.[47]

Lock-in programs identify beneficiaries with questionable patterns of prescription, especially opioids (*i.e.*, visits to multiple pharmacies, physicians, or emergency rooms) and limit them to a single pharmacy and/or prescriber for all medications. Any prescriptions that beneficiaries seek outside of the designated pharmacies or prescribers are denied. Practitioners designated for prescriber lock-in programs typically are pain management specialists or primary care physicians. In some cases, lock-in programs include support services for beneficiaries to help with needs such as housing, transportation, or food, as well as information for prescribers to facilitate care coordination.

Several factors have limited the effectiveness of lock-in programs:

1. In some State Medicaid managed care programs, when beneficiaries enrolled in lock-in programs change health plans, Medicaid agencies do not inform the new health plan of patients' lock-in status. As a result, drug-seeking behavior resumes—at least until the beneficiary is again identified for lock-in.
2. Because lock-in programs are not allowed under Medicare Part D, individuals who are dually eligible for Medicare and Medicaid and who exhibit drug-seeking behavior cannot be limited to designated pharmacies or prescribers.

Recommendations:

1. When beneficiaries enrolled in a pharmacy or prescriber lock-in program change health plans, State Medicaid agencies should inform the new health plan on a timely basis of the individual's lock-in status.
2. Health plans serving dual eligibles should have the option to use pharmacy and prescriber lock-in programs that include appropriate beneficiary protections, safeguards, and due-process rights.

Tools to Improve Key Aspects of Care Delivery and Measure Quality

Issue: Suboxone Prescribing for Opioid Addiction

In conjunction with the growing epidemic of opioid use, sales of Suboxone have grown dramatically in recent years. Because it can create euphoria and cause dependence, Suboxone has the potential for misuse and abuse.[48]

Individuals with SUD can obtain Suboxone from prescribers authorized by the Drug Enforcement Agency to treat a limited number of patients with the drug.[49] Because of the limit on patient panels, the number of authorized Suboxone prescribers often is insufficient to meet the demand. As a result, some questionable providers have attempted to fill the gap.[50]

Suboxone misuse and abuse present major challenges for State Medicaid programs and Safety Net Health Plans.[51] Medicaid health plans continue to seek ways to promote legal, safe, and evidence-based use of Suboxone to treat addiction. However, beneficiaries with SUD often obtain the drug from prescribers who refuse to participate in health plan networks and demand up-front, cash payment. Furthermore, in State Medicaid programs that carve out Suboxone treatment from the managed care pharmacy benefits package, health plans are unable to coordinate Suboxone treatment to promote evidence-based care.

Recommendation:

As a first step to addressing the public health and safety concerns associated with the current system of Suboxone prescribing, public- and private-sector leaders should commit to working together to develop new safeguards to promote appropriate, evidence-based treatment, particularly with respect to cash prescribing.

Issue: Quality Measures for SUD Treatment:

Though the Reducing Prescription Drug Abuse Collaborative and other initiatives, Safety Net Health Plans are seeking to improve the quality of substance abuse treatment. In conjunction with its accreditation and performance measurement programs for Medicaid health plans, the National Committee for Quality Assurance measures the percent of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations for AOD diagnoses within 30 days of the initial visit.[52] The Pharmacy Quality Alliance currently is addressing the issue of the overprescription of opioids and is in the process of field-testing potential measures.

Recommendation:

Public- and private-sector stakeholders, including health plan leadership, should engage in a collaborative process to develop valid, reliable, and actionable measures of appropriate opioid prescribing. ACAP's internal development of a quality measure to address the concurrent use of Suboxone and other opioids represents an initial first step to address one issue. However, additional, broad-based efforts are needed to develop a standard, comprehensive set of measures.

42. Awad, S . (August 15, 2013). Confused by Confidentiality? A Primer on 42 CFR Part 2. *ASAM Magazine*. Available at: http://www.asam.org/magazine/read/article/2013/08/15/confused-by-confidentiality-a-primer-on-42-cfr-part-2.

43. Katz, N. et al. (2013). Prescription opioid abuse: Challenges and opportunities for payers. *American Journal of Managed Care*. 19(4). 295-302. Available at: http://www.ajmc.com/publications/issue/2013/2013-1-vol19-n4/Prescription-Opioid-Abuse-Challenges-and-Opportunities-for-Payers/.

44. PDMP TTAC. Prescription Drug Monitoring Training and Technical Assistance Center. Brandeis University. The Heller School for Social Policy and Management. Prescription Drug Monitoring Frequently Asked Questions (FAQ). Available at: http://www.pdmpassist.org/content/prescription-drug-monitoring-information-architecture-pmix.

45. Ibid.

46. Centers for Disease Control and Prevention (July 2013). Policy Impact: Prescription Painkiller Overdoses.

47. Roberts & Skinner (May 2014). Assessing the present state and potential of Medicaid controlled substance lock-in programs.

48. Sontag, D. (November 16, 2013). Addiction treatment with a dark side.

49. The Drug Abuse Treatment Act of 2000 (DATA 2000), as amended in 2006, states that individual physicians may have a maximum of 30 patients on opioid therapy at any one time for the first year. One year after the date of submitting the initial notification, physicians may submit a second notification of the need and intent to treat up to 100 patients. Cited in SAMSHA. Substance Abuse and Mental Health Services Administration. Buprenorphine. Frequently Asked Questions About Buprenorphine and the Drug Addiction Treatment Act of 2000 (DATA 2000). Available at: http://buprenorphine.samhsa.gov/faq.html.

50. A study by *The New York Times* found that at least 1,350 of nearly 13,000 Suboxone-prescribing doctors had been sanctioned for offenses such as excessive narcotics prescribing, insurance fraud, sexual misconduct, and practicing medicine while impaired. Some had been suspended or arrested. Cited in Sontag, D. (November 16, 2013).

51. A *New York Times* survey found that the drug cost State Medicaid agencies at least $857 million over a three-year period through 2012. Additionally, *The New York Times* found that Suboxone prescribers were far more likely than other doctors to have received state disciplinary sanctions. Disciplinary rates were even higher for Suboxone prescribers who were certified to treat the maximum patient load. Cited in Sontag, D. (November 16, 2013).

CHAPTER 5

Concluding Thoughts

Setting the Stage for Progress

Medicaid transformation creates an unprecedented opportunity to improve the health and well-being of low-income, underserved populations. Medicaid expansion and delivery system innovations—such as patient-centered medical homes and care coordination initiatives for dual eligibles[53]—have tremendous potential to boost the quality of care for millions of Americans with unmet health care needs.

Recent research findings suggest that Medicaid expansion already has increased early diagnosis and treatment of chronic illness: In states that had expanded Medicaid as of January 2014, early diagnosis of diabetes rose by 23 percent, compared with 0.4 percent in the states that had not expanded the program.[54] Researchers noted a similar trend of early diagnosis for patients with HIV in Medicaid expansion states and suggested that the results offer promise for diagnosis and treatment of other chronic conditions.[55] These findings have important implications for efforts to address addiction[56] in the Medicaid population.

Building on the Work of Safety Net Health Plans and the Reducing Prescription Drug Abuse Collaborative

Safety Net Health Plans are on the front lines of national efforts to address prescription drug abuse among beneficiaries. Over the years, many Medicaid health plans have worked with health care providers to develop the infrastructure and expertise needed for early intervention and effective treatment of substance use disorders and other behavioral health conditions.[57]

In the past year, ACAP member health plans participating in the Reducing Prescription Drug Abuse Collaborative learned important lessons about best practices in programs aimed at reducing prescription drug abuse in the Medicaid population. By sharing their findings in this toolkit, we hope to inform the next generation of programs seeking to confront prescription drug abuse. Safety Net Health plans stand ready to partner with colleagues throughout the health care system—including community health centers and other safety-net providers, state and federal Medicaid officials, and leadership of community-based organizations throughout the country—in broad-based, multidimensional efforts to find and implement effective solutions.

Achieving this goal will require a spirit of innovation and a long-term commitment. Effective strategies will involve creative efforts to address denial and meet beneficiaries where they are; expand the availability of effective, evidence-based services; and coordinate medical, behavioral health, substance abuse, and social services at the local, state, and federal levels. Safety Net Health Plans welcome the challenge and look forward to taking the next steps.

52. U.S. Department of Health & Human Services. Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=47233.

53. Smith, V., et al. (October 14, 2014). Medicaid and Delivery System Reform. Medicaid in an Era of Health and Delivery System Reforms: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015. Washington, DC: Henry J. Kaiser Family Foundation. Available at: http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/.

54. Kaufman, H., et al. (March 22, 2015). Surge in newly identified diabetes among Medicaid patients in 2014 within Medicaid expansion states. *Diabetes Care*. Published online ahead of print. Available at: Available at: http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334.full.pdf.

55. Ibid.

56. National Institute on Drug Abuse. Addiction is a Chronic Disease. Available at: http://archives.drugabuse.gov/about/welcome/aboutdrugabuse/chronicdisease/.

57. Mercer (October 2014). State Medicaid Interventions for Preventing Prescription Drug Abuse: A Report for the National Association of Medicaid Directors.

NOTES

NOTES

ACAP

Association for Community
Affiliated Plans

1015 15th Street NW, Suite 950
Washington, D.C. 20005
202.204.7508

www.communityplans.net