



Spotlight on Pennsylvania

Leading-Edge Practices and Next Steps
in Ending the Opioid Epidemic

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manatt



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The American Medical Association is the powerful ally and unifying voice for America's physicians, the patients they serve, and the promise of a healthier nation. The AMA attacks the dysfunction in health care by removing obstacles and burdens that interfere with patient care. It reimagines medical education, training, and lifelong learning for the digital age to help physicians grow at every stage of their careers, and it improves the health of the nation by confronting the increasing chronic disease burden.

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Roadmap to Ending Pennsylvania's Opioid Epidemic

The American Medical Association (AMA) and Manatt Health are undertaking an in-depth analysis of four states' responses to the opioid epidemic to identify best practices and next steps where further action is needed. In this spotlight analysis of Pennsylvania's response to the epidemic, we analyze the Commonwealth's efforts in three areas: substance use disorder treatment, pain management, and harm reduction. Highlights include:

Where the Commonwealth Is Succeeding

- Comprehensive support for MAT.** Pennsylvania has adopted multiple measures to increase access to medication-assisted treatment (MAT) for substance use disorders (SUDs), considered essential for evidence-based treatment. These include eliminating prior authorization requirements for MAT and establishing 45 Centers of Excellence across the state to expand access to MAT, including mental and behavioral health care services.
- Enforcement of parity laws.** The Pennsylvania Insurance Department (PID) is actively reviewing benefit packages, prior authorization policies, and cost-sharing obligations to enforce mental health and parity laws. The PID found significant parity violations in a market conduct exam and is in the process of completing exams on all leading insurers.
- Medically based oversight for Medicaid patients.** The Commonwealth also has combined medical oversight of patients on opioid therapy with expanded access to non-opioid pain management strategies in Medicaid, including coverage of non-opioid prescription medications as well as alternative therapies, such as physical therapy, occupational therapy, and behavioral health services.
- Comprehensive naloxone access.** A statewide standing order and stakeholder support for increased naloxone access has helped save lives from overdose.

"The leadership shown by the governor and his administration to reach this agreement should act as a call for all states to demonstrate that they support patient's access to care."

Patrice A. Harris, MD, MA,
AMA President-elect, Chair,
AMA Opioid Task Force,
commenting on insurers
agreeing to end prior
authorization for MAT,
October 12, 2018

Where the Commonwealth Can Build on its Accomplishments

1. **Continuum of care for patients with SUDs.** Continue building out state infrastructure and ensure health insurers and Medicaid identify and remove barriers to adequate networks and workforce shortages. Infrastructure improvements include further development of hub-and-spoke arrangements, including leveraging federal funding to turn grant programs into sustained practices.
2. **Pain care.** Identify and learn from best practices to provide comprehensive, multimodal pain care, and work closely with stakeholders to review and reform benefit design and formulary requirements to ensure patients have access to non-opioid alternatives.
3. **Naloxone access.** Build on the Commonwealth's naloxone access successes through statewide education efforts with physicians and other key stakeholders.
4. **Evaluation.** Build on efforts underway at the Department of Health to evaluate the policies, programs, and other efforts in the Commonwealth to determine what is truly working to improve patient care and reduce opioid-related harms, including understanding relationships between current policies and clinical outcomes to further successful efforts while amending those that may be having unintended consequences.

"If even one person is delayed access to the treatment they need, it is one person too many."

Governor Tom Wolf,
March 2, 2018

Exhibit 1. AMA Priorities for Addressing the Opioid Epidemic

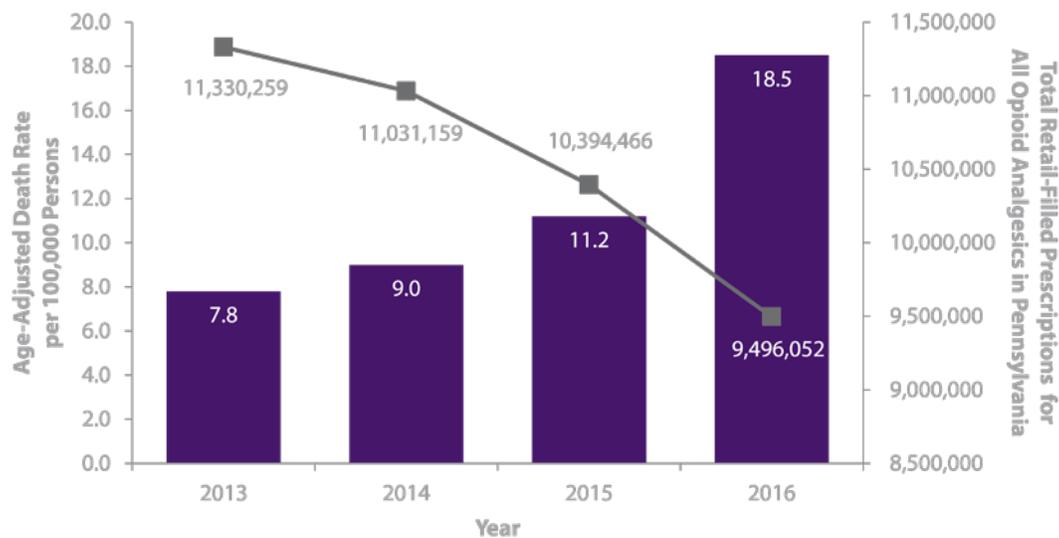
The AMA has developed a comprehensive set of recommendations aimed at ending the opioid epidemic. This spotlight analysis addresses multiple AMA priorities:

- **Increase access to high-quality, evidence-based treatment for OUD, including enforcing state and federal mental health and substance use disorder parity laws**
- **Support comprehensive, multidisciplinary, multimodal pain care, including non-opioid alternatives**
- **Reduce harm with naloxone and other efforts to help save lives from overdose and link patients to treatment**

I. Introduction

Pennsylvania has been hit hard by the opioid epidemic with prescription opioid-related overdose growing in the early 2000s and more recently, high volumes of heroin and fentanyl coursing through the Commonwealth given its strategic location as a major transportation hub. The challenges faced by the Commonwealth make for an ideal case study of how strong leadership can make a difference—even if the fight is not over yet. In January 2018, Governor Tom Wolf issued and has continued to renew a 90-day opioid disaster declaration and has mobilized an inter-agency task force to treat patients and reduce harm. There has been a 28 percent reduction in opioid prescriptions since 2013, but the loss of life and emotional toll of the epidemic continue to climb.¹ Indeed, Pennsylvania's death rate took a sharp increase from 2015 to 2017 despite the state's actions (Exhibit 1). This is consistent with national trends that demonstrate it will take much more than cutting opioid prescriptions to solve an epidemic that requires a concerted federal and state partnership to bring the epidemic under control. Pennsylvania has long had a disproportionate share of opioid deaths and is not alone in finding that the epidemic continues to evolve. Even as the rate at which physicians are prescribing opioids is declining, heroin and illicit fentanyl—a synthetic opioid 50 to 100 times more potent than heroin—have rushed in and driven up death rates.

Exhibit 2. Opioid-Related Overdose Deaths in Pennsylvania



Source: National Institute of Drug Abuse, Pennsylvania Opioid Summary, Revised February 2018, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/pennsylvania-opioid-summary>; IQVIA, State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013–2017.

This spotlight analysis primarily highlights the work of two agencies—the state Medicaid agency (housed in the Department of Human Services) and the Pennsylvania Insurance Department—that are at the forefront of the fight. These two agencies address coverage issues that determine what care is accessible and affordable to the 27 percent of Pennsylvanians covered by Medicaid and CHIP and 24 percent with fully insured individual or group insurance coverage.² There are, however, many other agencies, including the Department of Health (DOH) and Department of Drug and Alcohol Programs (DDAP), involved in the broad interagency initiatives of the Wolf administration, and the work of all those agencies merits the same close scrutiny we have given the PID and Medicaid in order to have a full picture of the Commonwealth’s efforts.



II. Increasing Access to High-Quality, Evidence-Based Care for SUDs

With an estimated 19.4 million cases of SUDs nationwide,³ including 900,000 cases in Pennsylvania,⁴ there is an urgent need to make treatment more widely available, starting with MAT.⁵ Despite strong evidence that MAT is the most effective treatment option for many individuals with SUDs, barriers to MAT persist, including stigma that keeps some patients and providers from utilizing MAT, inadequate provider networks, high cost sharing, and prior authorization requirements that can impede access for patients whose willingness to seek treatment can quickly fade if they face a delay.⁶

Pennsylvania has taken some notable steps to increase access to MAT in a variety of treatment settings as detailed below.

Enforcing Mental Health and Substance Use Disorder Parity and Equity

SUD treatment is an essential health benefit (EHB) under the Affordable Care Act (ACA), which applies to individual and small group (1–50 employees) coverage. A long-standing Pennsylvania law, Act 106, also requires individual and group insurers to cover inpatient and outpatient services for SUDs, with specific benefit levels set out in the law.⁷ The PID has a useful guide on its web page that provides details on these benefits, including helpful tips for consumers on these services.⁸

The PID guide also points out that minimum required benefit levels for group insurance plans have been largely superseded by the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements so that insurers are required to cover medically supervised withdrawal services, residential services, and outpatient/partial hospitalization services for SUDs to the same extent they are covered for physical health services.^{9,10}

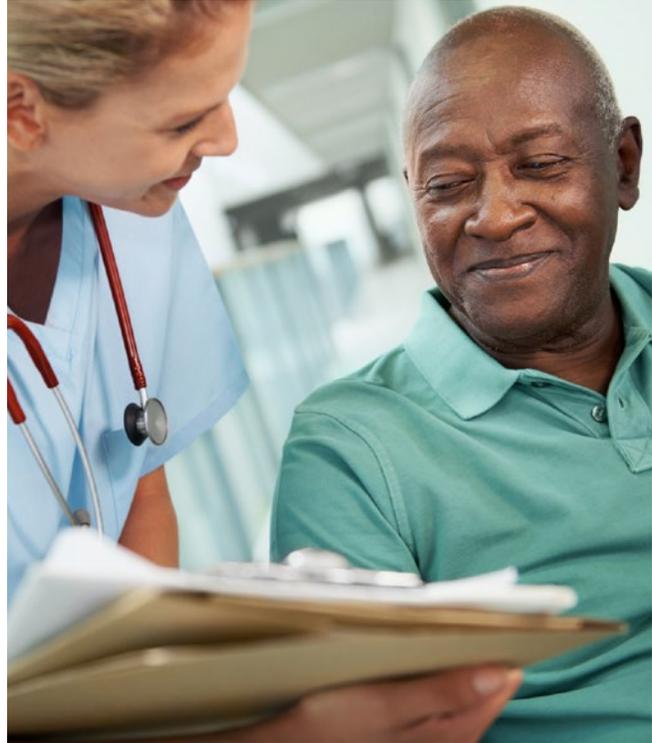
While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, mental health parity is still a work in progress across all public coverage programs and commercial insurance. There often are thorny issues in determining exactly what parity means in relation to specific services.



Exhibit 3. Parity Enforcement

While the ACA and MHPAEA requirements establish a strong standard for coverage of SUD treatment, mental health parity is still a work in progress across all public coverage programs and commercial insurance.

Strong market conduct examination procedures, such as those being undertaken by the PID, can help ensure compliance with state and federal parity requirements.



The PID is leading the way for Pennsylvania in digging into the tough issues through market conduct examinations of the Commonwealth's largest commercial health insurers, developing new templates and tools to uncover parity violations and to make parity standards as transparent as possible. A recently published market conduct examination detailed one insurer's multiple parity violations with respect to SUD medical and pharmacy claims. This included findings that the health insurer imposed treatment limitations not in parity with medical/surgical benefits, including "limiting the scope and duration of treatment" of mental health and SUD claims "more stringently than medical/surgical benefits." The first exam recommendation is that "the company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity compliance requirements of [federal and state law]."¹¹ The next step in the typical market conduct exam process is for the company to agree on a corrective action plan and, in some cases, pay a civil penalty. Re-examinations are also a common tool to ensure corrective action has been taken. As the PID moves forward to complete its market conduct examinations of the remaining leading insurers, it will be refining its analytical tools and examination procedures that will be very helpful to other states committed to strong evaluation and enforcement actions to make sure insurers are meeting their legal obligations.

Enhancing Network Adequacy Oversight

One reason for parity violations could be that insurers lack adequate provider networks to meet the needs of SUD patients. The PID currently relies on the DOH to assess network adequacy, as does Medicaid. This approach fosters interagency coordination, and an important topic for future research will be to assess the strengths and weaknesses of this model, which is not uncommon across other states, especially for health maintenance organizations (HMOs). One challenge inherent in this model is that commercial networks can be different than Medicaid networks. For example, Centene, which started as a Medicaid managed care organization (MCO) in multiple states and now is the largest insurer in the ACA-compliant individual market with 1.5 million members nationally, has been fined and required to expand its ACA networks in other states.¹² With Centene set to enter the Pennsylvania ACA market in 2019, we encourage Pennsylvania to carefully consider how best to assess network adequacy as part of “front end” rate and form reviews and in “back end” compliance audits or market conduct examinations.

For example, federal regulations provide that a physician may treat up to 30, 100, or 275 patients with buprenorphine, in-office, for the treatment of SUDs. To help determine the total number of potential SUD patients who could be cared for in a network, Pennsylvania could require health insurance companies to identify how many physicians are currently able to provide buprenorphine (a form of MAT), and how many patients they can treat. The Commonwealth could even go a step further and require health plans to affirm how many of those MAT providers are actively seeing patients with SUD. This type of quantitative analysis is not only possible, but it is essential to determine the workforce capacity in a health insurance network. Identifying network gaps will not automatically solve them, but it will engage insurers in doing their part to identify what is needed and take appropriate action to fill those gaps.

We encourage Pennsylvania to continue improving its ability to carefully review the adequacy of SUD treatment capacity in each insurer’s products.

Recommendation: Continue refining the tools used in market conduct examinations to produce in-depth analyses of insurers’ compliance with network adequacy and mental health and SUD parity legal obligations, with appropriate enforcement actions, including re-examinations, to ensure compliance with examination findings.

Partnering With the Medical Community to Better Understand Network Barriers

To help identify barriers to SUD care faced by physicians and patients—as well as understand issues related to workforce capacity—the state could partner with the AMA and the Pennsylvania Medical Society to conduct a survey of physicians. This survey could provide a ground-level view of the specific barriers to care facing patients and physicians and serve as a foundation for future efforts to guide actions that would result in increased access to MAT services.

The Commonwealth could require insurers to confirm how many MAT providers are actively seeing patients with SUDs to measure network adequacy.

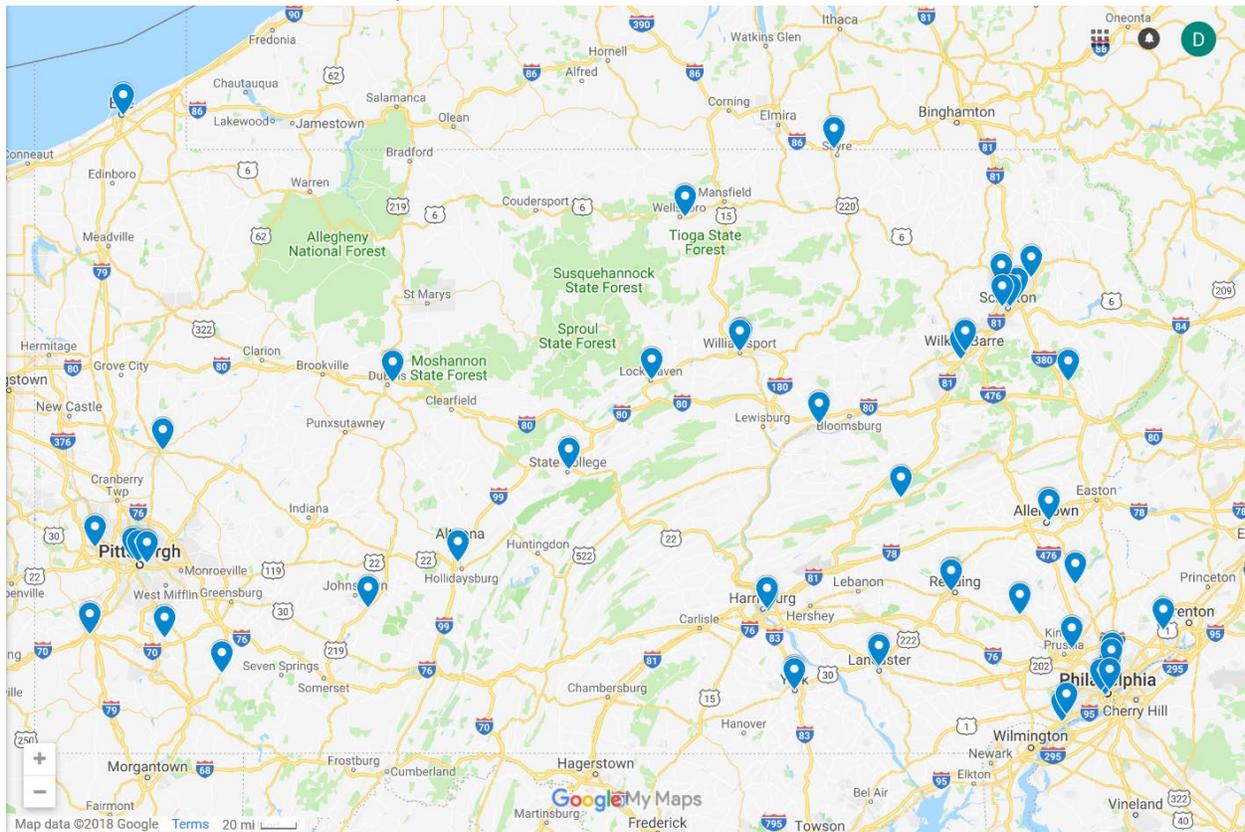
Recommendation: Work with the medical and health care community at-large to better understand barriers to providing care, including the role that stigma plays.



Establishing a Hub-and-Spoke Model Built Around Centers of Excellence

Pennsylvania used state behavioral health and Medicaid funding in 2015 to launch 45 Centers of Excellence (COEs) designed to reduce gaps in services and better support frontline providers (see Exhibit 5) in serving Medicaid beneficiaries and, increasingly, commercial and uninsured patients.¹³ The COEs provide integrated behavioral and primary care services, including MAT, to beneficiaries with OUD, emphasizing a whole-person approach to care. Using a hub-and-spoke model, each center includes a designated health center (i.e., the “hub”) charged with providing MAT and care coordination via a team of health care providers, certified recovery peer specialists and navigators.¹⁴ The hub also offers support to primary care physicians (PCPs) and other community-based providers treating people with OUD (i.e., the “spokes”).

Exhibit 4. Locations of Pennsylvania’s 45 Centers of Excellence



Source: Pennsylvania Department of Human Services, Centers of Excellence Map, <http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence>.

The hub-and-spoke model continues to gain popularity nationwide as a means to encourage physicians to offer MAT, which they can more readily do with backup and support from experts. In more recent months, Pennsylvania has used some of its federal opioid grant funding to expand its capacity to serve commercial patients, particularly in rural and western parts of the Commonwealth. Another priority is to supplement the health care spokes with spokes that provide recovery support services, such as access to housing, transportation, and training services.

Recommendation: Continue to build out the hub-and-spoke infrastructure, including additional funding and other mechanisms necessary to enhance access to SUD care in Medicaid.

Exhibit 5. Hub-and-Spoke Model¹⁵

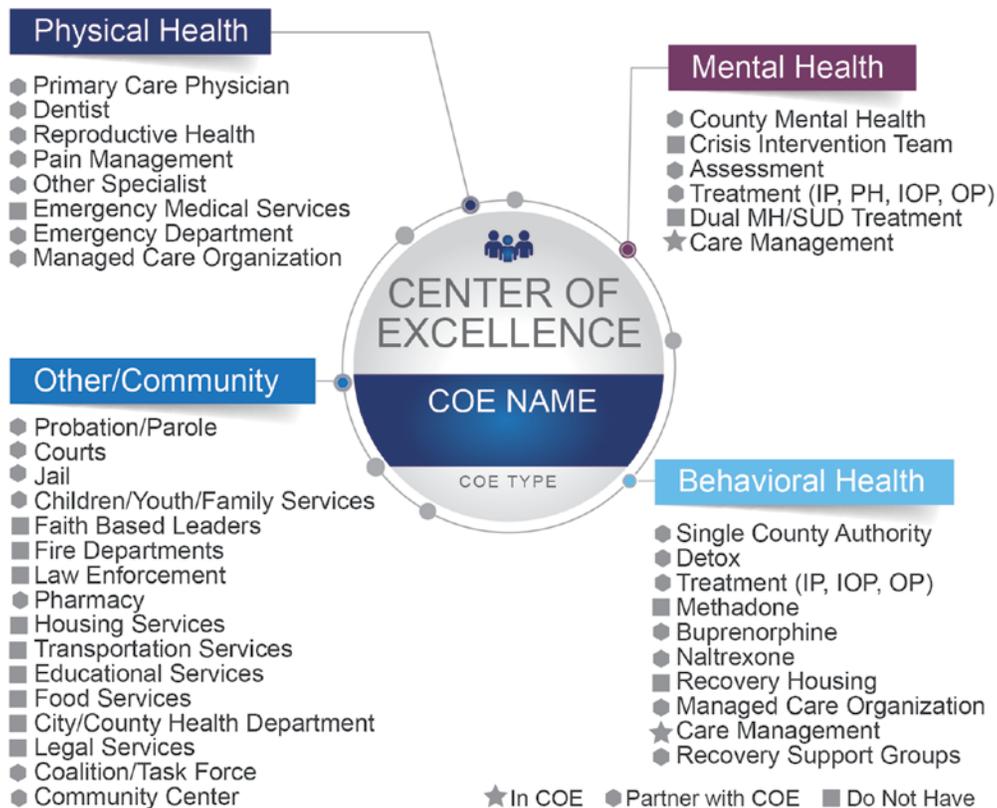


Exhibit 6. Early Findings on the Impact of Centers of Excellence

In 2017, the 45 COEs in Pennsylvania were able to engage 71 percent of the beneficiaries that they saw in treatment, and 62 percent remained in treatment for at least 30 days. Comparatively, in 2014, Medicaid data indicates that only 48 percent of individuals with SUDs received treatment, and only 33 percent of them were engaged in care beyond 30 days.¹⁶



Eliminating Financial and Paperwork Barriers to MAT

A key component of Pennsylvania's strategy is to expand Medicaid and insurance coverage of MAT and other SUD care and eliminate paperwork and financial barriers to such treatment. Medicaid, in part, and innovative insurers were the first to eliminate prior authorization, but cost sharing has remained an issue in the commercial market due to the fact that some MAT medications are not covered as well as the fact that mental, behavioral, and other necessary medical care services to help with treatment are potentially subject to high deductibles and benefit limitations. Because Medicaid has little or no cost sharing, elimination of prior authorization clears the way for streamlined access to MAT and necessary medical and behavioral support. However, Medicaid officials report ongoing issues with stigma among some patients, providers, and treatment programs and also a shortage of providers.

Pennsylvania took another big step forward when four state agencies held a summit in the fall of 2017 that brought together the Commonwealth's

"We must all confront the intangible and often devastating effects of stigma... The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment."

Patrice A. Harris, MD, MA,
AMA President-elect, Chair,
AMA Opioid Task Force

largest insurers, many of which offer products in both the commercial insurance market and the Medicaid managed care program. The summit focused on aligning insurer practices across Medicaid and the commercial market in two critical areas: reducing opioid prescribing and expanding access to MAT. Insurers were asked to extend specific policies to the commercial market that already were being implemented in Medicaid.

On October 12, 2018, Pennsylvania announced that all major commercial insurers are eliminating the requirement for prior authorization for MAT and covering it at the lowest patient cost-sharing tier on the pharmacy benefit. This agreement between the Commonwealth and the seven largest payers could serve as a national model for other states that we will be watching closely as the agreement is implemented. The agreement also addressed standardizing prior authorization for opioid prescriptions when opioids remain the appropriate medication as discussed in the section on pain management.

Exhibit 7. Commercial Insurers Agree to Limit Barriers to MAT Access

No Prior Authorization	Limited Cost-Sharing
<ul style="list-style-type: none"> ■ At least one buprenorphine/naloxone combination product ■ Injectable and oral Naltrexone ■ Methadone as MAT ■ At least one form of nasal naloxone without quantity limits 	<ul style="list-style-type: none"> ■ Coverage at the lowest patient cost tier on the plan's pharmacy benefit (to extent that cost-sharing is required)

In summary, Pennsylvania has put building blocks in place to expand treatment, but there are still capacity and parity issues to be addressed in both Medicaid and commercial insurance products.

Expanding the Workforce and Encouraging More Providers to Offer MAT

As in other states, Pennsylvania has a substantial number of SUD treatment facilities that do not offer MAT—slightly more than half of SUD treatment facilities in the state offer any form of MAT, and only one in 20 offer all three forms.¹⁷ Additionally, in 2018, there were more than 650 physicians newly waived to provide buprenorphine in-office for the treatment of opioid use disorder (OUD).¹⁸ Since 2002, there have been more than 4,400 waived physicians, but it is unclear whether these practitioners are actively providing buprenorphine to treat OUD and to

how many individuals. Often the resistance to MAT reflects the misconception that it is simply substituting one addictive substance for another, and that a true recovery requires someone to go “cold turkey.” Pennsylvania has used its COEs to address stigma issues by promoting the research basis for MAT; identifying strategies for reducing problems associated with MAT (e.g., risk of diversion of Suboxone); and taking other actions to destigmatize MAT. One promising policy initiative is the city of Philadelphia’s recent decision to require recovery houses to offer access to MAT as a condition of receiving funding.¹⁹ Pennsylvania also encourages primary care physicians, emergency medicine physicians, and other practitioners to become waived to treat patients with an OUD and link them to community-based resources from the emergency department or wherever they happen to present for OUD treatment. We encourage the Commonwealth to continue pursuing the full range of approaches to expanding the workforce of MAT prescribers and ensuring evidence-based medical care for treating OUD.

Recommendation: Continue to identify and remove barriers causing workforce shortages, remove stigma, and enhance incentives for the delivery of evidence-based medical care, including MAT.

Pennsylvania recently received approval from the federal government for a waiver of the “Institutions for Mental Disease (IMD) exclusion,” a federal ban on using Medicaid funds to offer mental health and SUD residential treatment services for more than 15 days in a month in facilities with more than 16 beds. Under the waiver, Pennsylvania can use Medicaid funds to finance stays delivered in IMDs for more than 15 days in a month, filling an existing gap in treatment options for Medicaid beneficiaries who require an extended residential stay. As part of the waiver, Pennsylvania must ensure that Medicaid beneficiaries have access to a full continuum of care for SUD services, as well as establish a robust evaluation of its waiver initiative.

Recommendation: Build upon the removal of prior authorization and the IMD waiver to advance efforts for identifying patients in need of SUD treatment, and linking them to high-quality, evidence-based medical care.

Engaging People in Treatment Through Active Outreach

The Commonwealth has adopted a number of policies to identify people who could benefit from treatment and connect them to providers.

Emergency Departments Can Facilitate Warm Handoffs

Emergency departments (EDs) see patients who have overdosed or who may be seeking prescription opioids in response to an addiction. Pennsylvania's Department of Drug and Alcohol Programs (DDAP) and DOH have been leaders in responding to the opioid epidemic, including improving ED services. These agencies have partnered with the Pennsylvania chapter of the College of Emergency Physicians to release guidelines for ED doctors to implement "warm handoffs." Instead of simply providing patients with a handout that lists resources, the protocols call for a more substantive connection. This includes the ED staff contacting a drug and alcohol assessor who meets with the individual in the ED and directly refers the individual to specialty SUD treatment.²⁰ Indeed, the ED can play an even broader role in helping link patients to treatment if there is a sufficient workforce of waived physicians to prescribe buprenorphine, as well as support personnel to identify addiction medicine physicians and other health care professionals in the local area who are in a patient's insurance network and accepting new patients.

Law Enforcement Can Help Connect People to Treatment

The Commonwealth's attorney general has adopted several initiatives, including partnering with local law enforcement agencies to allow anyone seeking addiction treatment to enter their local, partnering police station to be linked to care without the risk of arrest.²¹

Screening Can Identify Those Who Need Treatment

Pennsylvania is working to strengthen screening and referral to treatment for SUDs by leveraging Substance Abuse and Mental Health Services Administration (SAMHSA) grants to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) training in seven counties.²² By identifying people with an OUD or at risk for addiction, providers can help steer patients to treatment early on.

Recommendation: Expand efforts in emergency departments and with law enforcement to link efforts to coordinate patients' access to high-quality medical care; partner with the medical and health care community to share screening resources throughout the Commonwealth.

Best Practices and Next Steps for Increasing Access to High-Quality, Evidence-Based Care for SUDs

Best Practices	Next Steps
<ul style="list-style-type: none"> ■ Eliminating prior authorizations for MAT. Brokered an agreement with commercial insurers and Medicaid managed care plans to eliminate prior authorization for MAT and offer it on the lowest cost-sharing tier. ■ Expanding OUD treatment capacity. Established 45 “COEs” to expand access to MAT and provide support to local providers via a “hub and spoke” model for Medicaid beneficiaries. ■ Promoting “warm handoffs.” Developed guidelines that can be used by all emergency departments to actively connect to services people with or at risk of developing an SUD. ■ Securing authority to provide IMD services to Medicaid beneficiaries. Obtaining an IMD waiver to expand residential treatment capacity as part of a full continuum of care. ■ Initial action to enforce mental health and SUD parity. Proactively conducted market conduct examinations of the largest commercial insurers to identify and address violations of mental health and SUD parity. 	<ul style="list-style-type: none"> ■ Further expand SUD providers offering MAT and reduce stigma. Encourage or even require as a condition of receiving funding, as the city of Philadelphia has done, SUD providers to provide or facilitate access to MAT. ■ Assess barriers among physicians to providing SUD services. Partner with the AMA and the Pennsylvania Medical Society on outreach to physicians to identify barriers to providing SUD services, including the role that stigma plays. ■ Expand mental health and SUD parity enforcement. Build on existing market conduct exams to identify systematic gaps and enforce mental health and SUD parity requirements for all insurance coverage. ■ Strengthen network adequacy standards. Strengthen network adequacy oversight and enforcement in Medicaid and commercial insurance for SUD providers, particularly to help ensure a sufficient number of providers who deliver MAT and mental health care.

III. Providing Comprehensive Care to Patients With Pain

Even as physicians and patients work to reduce opioid-related misuse, millions of Americans still have chronic pain and require help. In 2016, the latest year for which data are available, the CDC estimates that “20.4% (50.0 million) of U.S. adults had chronic pain and 8.0% of U.S. adults (19.6 million) had high-impact chronic pain.”²³ Pennsylvania has sought to expand access to alternative pain management strategies, particularly in Medicaid, and to recognize that people already physically dependent on or in need of opioid analgesics may require special care.²⁴

Exhibit 8. Does It Work and Can We Afford It? The Cost and Effectiveness of Non-opioid Pain Relief

Alternative pain management strategies work just as well for many people as opioids and can be less expensive.²⁵ While some non-opioid treatments are expensive, this is not uniformly the case. As the Centers for Disease Control and Prevention (CDC) explains, “Although there are perceptions that opioid therapy for chronic pain is less expensive than more time-intensive nonpharmacologic management approaches, many pain treatments, including acetaminophen, NSAIDs, tricyclic antidepressants, and massage therapy, are associated with lower mean and median annual costs compared with opioid therapy, while COX-2 inhibitors, SNRIs, anticonvulsants, topical analgesics, physical therapy, and CBT are also associated with lower median annual costs compared with opioid therapy.”²⁶

Expanding Coverage of Alternative Pain Management Strategies

Pennsylvania’s Medicaid program uses in-house clinical staff to review the Medicaid coverage policies of each MCO in the state, including with respect to whether they cover alternative pain treatments. These include over-the-counter medications such as ibuprofen and acetaminophen; prescription medications that do not include opioids; local anesthetics such as lidocaine patches or steroid injections; and physical therapy, occupational therapy, cognitive behavioral therapy, and other physical and mental health services.

Notably, Pennsylvania Medicaid personnel look beyond the simple question of whether a benefit is covered. They also evaluate whether an MCO’s utilization management strategies

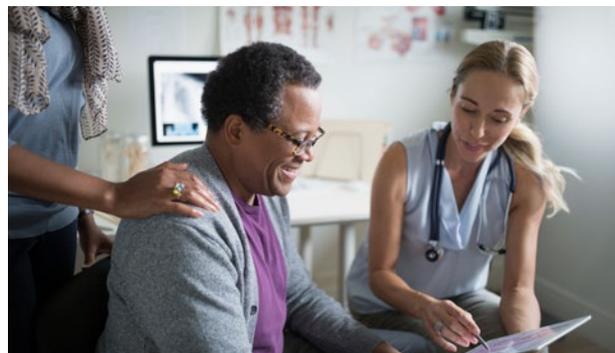
are dampening access to alternative pain management strategies. As a result of this practice, along with Pennsylvania's basic Medicaid benefit requirements, all Medicaid MCOs in the state, as well as the state's fee-for-service program, cover physical therapy, occupational therapy, cognitive behavioral therapy, and a number of the other services listed in Exhibit 9.

Exhibit 9. Examples of Treatment Options for Acute and Chronic Pain

Opioids	Non-opioid Pharmaceuticals	Non-opioid Topical and Injectable Treatments	Alternative Treatments
Vicodin	NSAIDS (Diclofenac, Meloxicam, etc.)	Sympathetic Nerve Blocks	Acupuncture
Oxycodone	Acetaminophen	Lidocaine Patches	Massage
Tramadol	Anti-Epileptics (Lyrica and Neurontin)	Transcutaneous Electrical Nerve Stimulation (TENS) Unit	Mindfulness Meditation
Percocet	Anti-Depressants (Amitriptyline and Cymbalta)	Steroid Injections	Yoga

Individualized Approaches to Long-term Opioid Use and Pain Management

Even as it promotes non-opioid pain treatments, the Pennsylvania Medicaid program recognizes that some beneficiaries with chronic pain require opioids. Others can be tapered, but only over time and with a careful plan that does not abruptly terminate their access to legally prescribed opioids. Accordingly, each MCO must have a state-approved plan in place for tapering the use of opioids by these latter patients, including by conducting a thorough assessment of the basis for their pain, offering alternative pain management options, and



providing intensive care management. To support physicians in tapering, Medicaid deploys in-house physicians and other health care professionals who can help coordinate how to proceed with complex patients. While prescribing policies are generally beyond the purview of this spotlight, the Pennsylvania Medicaid program includes a standardized prior authorization process for current opioid users that is the catalyst for identifying patients requiring tapering and then partnering with their prescriber to accomplish the taper. This standardized prior authorization process was also part of the commercial insurer agreement discussed in the SUD treatment section.

Recommendation: State officials should consider a detailed review of clinical outcomes for pain care, including opioid dependence, patient function, availability of non-opioid alternatives, and key utilization factors (e.g., hospitalization, overdose) to help guide further evolution of state's program.

Extending Medicaid Best Practices to Commercial Coverage

Pennsylvania's efforts demonstrate important new strategies for pain management.²⁷ Medicaid has made major strides in spreading best practices from its fee-for-service program to MCOs, and the Commonwealth is actively encouraging all commercial insurers to adopt similar alternative pain management strategies across business lines, recognizing that the regulatory framework for commercial insurance is different than for Medicaid. Many of the same insurers serve both Medicaid and commercial populations and are ideally positioned to apply the lessons learned about the importance of a balanced approach to tapering patients off opioids, as well as ensuring that there are affordable non-opioid medications and alternative therapies to replace opioids.

It is imperative that pain management specialists and emergency room physicians not face the dilemma of having no affordable option to offer patients in pain other than opioids.



Many insurers already have limited the dose and quantity of opioid prescriptions for acute pain; as these restrictions become more rigorous, it is imperative that the pain management specialists, ED physicians, and other medical personnel not face the dilemma of having no affordable or accessible option to offer patients in pain other than opioids in cases when that is not the best option. Moreover, there should be particular care paid to patients who are stable and functional on long-term opioid therapy to ensure that the Commonwealth's and payers' policies to reduce opioid prescribing do not have unintended consequences.

Recommendation: Evaluate insurer and state policies to enhance access to non-opioid pain care while simultaneously encouraging reductions in opioid prescribing. Such evaluation should focus on patient outcomes and opioid-related harms, including whether patients are turning to nonmedical forms of pain relief.

Ensuring Prescription Drug Formularies Meet Two Tests

Formulary review is the primary regulatory tool available to the PID for ensuring adequate pain medications are available and affordable to patients. Formularies are an important tool for insurers to manage their pharmacy benefit in the face of escalating drug prices, but formularies should also meet two basic consumer access tests: non-opioid alternatives should be available on the formulary, and use of formulary tiers, prior authorization, and other utilization management tools, if used, should be used sparingly to make access affordable and timely. Exhibit 11 describes common utilization management techniques that may serve as barriers to obtaining non-opioid pain management. Formularies that are overly restrictive may constitute benefit design discrimination, which is prohibited by the ACA. We encourage the PID to work with payers to ensure that formularies are posted online and regularly updated so that patients can clearly see whether their health insurance plan covers non-opioid alternatives.

Recommendation: Require commercial insurers to post their formularies online, with clear designation of commonly used non-opioid pain alternatives, including nonpharmacologic options. Ensure that formularies do not violate benefit design discrimination standards by, for example, limiting the availability of non-opioid alternatives on low-cost-sharing tiers or applying unreasonable prior authorization and step therapy requirements that will delay, deny or deter access to them.

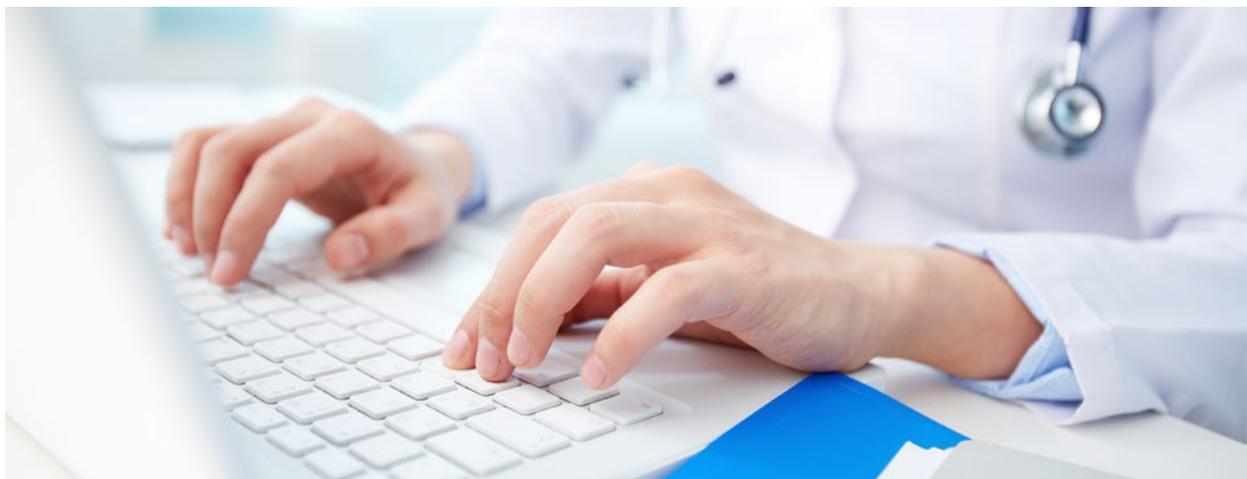
Exhibit 10. Coverage of Non-opioid Alternatives

While legislators shine a light on opioid prescribing patterns, the PID has the data, collected through rate and form review, to shine an equally bright light on whether the most common non-opioid pharmaceuticals for treating pain are covered and on their cost-sharing and utilization management requirements.



Exhibit 11. Common Utilization Management Techniques

Tiering	Insurers divide drugs into coverage tiers, typically with cheaper generic drugs or lower-cost brand-name drugs on lower tiers and more expensive drugs placed on higher tiers. Drugs on the higher cost-sharing tiers can have prohibitive out-of-pocket costs.
Prior Authorization	Requires insurer approval before a drug listed on the formulary will be covered for the specific patient.
Step Therapy	Requires a patient to try a drug that is typically on a lower cost-sharing tier before covering a higher-cost drug.



Partnering With the Medical Community to Better Understand Barriers to Pain Management

To help identify barriers to pain management faced by physicians and patients, Pennsylvania could partner with the AMA and the Pennsylvania Medical Society to identify a ground-level view of how initiatives to date are working to ensure patient access to pain care, including barriers to non-opioid alternatives by specific payers, and to guide further initiatives as necessary. This effort would include analysis of payment and benefit design that could enhance access to comprehensive pain care services—for example, ensuring that behavioral health and medical care services could be provided on the same day. In addition, this would include analysis of whether certain services are available in terms of time and distance standards.

Recommendation: Conduct a thorough review of how patients access comprehensive pain care services, including formulary and benefit design and provider experiences. This will require Pennsylvania to work closely with the medical and health professional community as well as with insurers and employers.

Best Practices and Next Steps for Providing Comprehensive Care to Patients With Pain

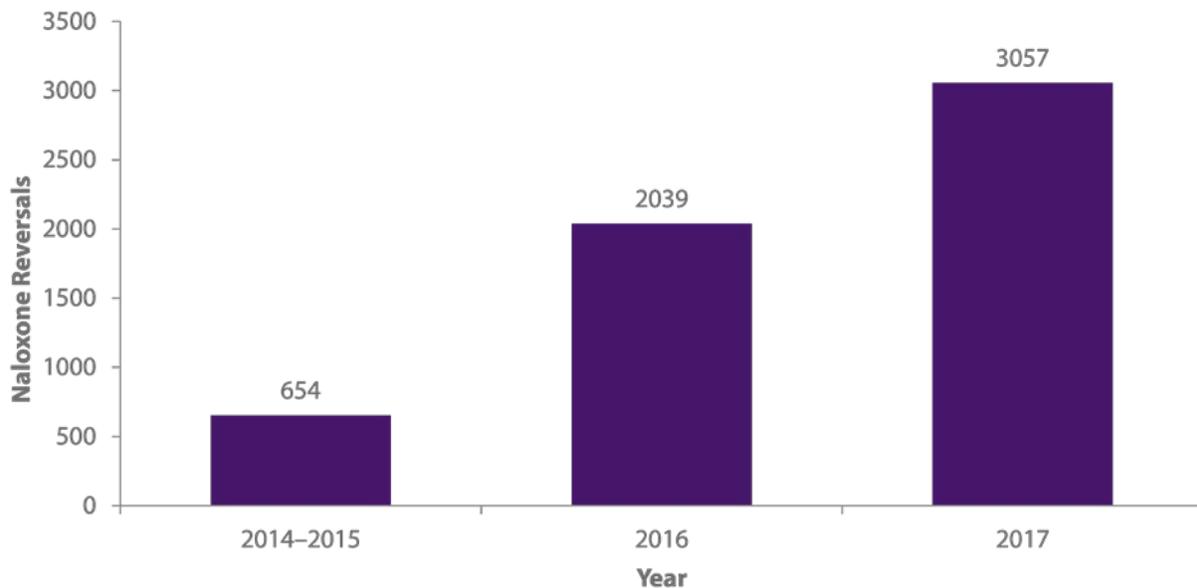
Key Best Practices	Key Next Steps
<ul style="list-style-type: none"> ■ Facilitating access to alternative pain management. In Medicaid, deployed in-house staff to review managed care plans' benefit packages and formularies to ensure coverage of alternative pain management strategies. ■ Supporting tapering. Required Medicaid managed care plans and commercial insurers to use a standardized prior authorization process to determine when tapering of opioids is necessary, with patient specific tapering—rather than abrupt termination—among current opioid users; in-house pharmacy and medical staff provide direct assistance to providers on tapering and alternative pain management. 	<ul style="list-style-type: none"> ■ Expand coverage of alternative pain management. Work with commercial insurers to offer a full array of alternative pain management options, including non-opioid medications, behavioral health, and other alternative services. Ensure that these options are readily available and affordable by eliminating or easing prior authorization requirements and reducing cost sharing. ■ Identify strategies to increase use of alternative pain management among providers. Partner with the AMA and Pennsylvania Medical Society to identify barriers to non-opioid medications and services.

IV. Enhancing Access to Naloxone

Pennsylvania has taken a number of steps to promote access to naloxone, a prescription medication that can reverse an overdose of opioids. These include a standing order by Physician General Dr. Rachel Levine to make naloxone available to both SUD patients and third parties, and promoting co-prescribing of naloxone with opioid prescriptions, which is a high priority for the AMA and the Pennsylvania Medical Society. Pennsylvania also has adopted a Good Samaritan law to protect third parties who help treat overdose victims with naloxone, and used federal grants to distribute naloxone to emergency departments and other community sites.²⁸

The insurer summit agreement requires Medicaid MCOs and commercial insurers to cover nasal naloxone without quantity limits, but challenges remain, including pharmacies that may not stock naloxone and resistance in the law enforcement community and elsewhere to using naloxone. We encourage the Commonwealth, under the leadership of DOH, to continue partnering with the medical community to break down these barriers.

Exhibit 12. Statewide Naloxone Reversals



Source: PA Department of Drug and Alcohol Programs, Successful Naloxone Reversals by Law Enforcement Years 2014–June 2018, Updated September 14, 2018, <https://data.pa.gov/Opioid-Related/Successful-Naloxone-Reversals-by-Law-Enforcement-Y/e9n3-x87d>.



Best Practices and Next Steps for Enhancing Access to Naloxone

Best Practices	Next Steps
<ul style="list-style-type: none"> ■ Standing order. Issued standing order for naloxone prescriptions. ■ Eliminating quantity limits. Eliminated restrictions on the number of naloxone prescriptions that a consumer can fill in both Medicaid and commercial products. ■ Promoting co-prescribing. Required Medicaid managed care plans to work with providers to prescribe naloxone when they prescribe opioids. 	<ul style="list-style-type: none"> ■ Addressing stocking issues. Conduct active review, such as through audits or “secret shopper” surveys, of the extent to which Pennsylvania residents can fill naloxone prescriptions at their local pharmacy. ■ Promote co-prescribing in the commercial market. The AMA and Pennsylvania Medical Society are eager to work with the Commonwealth to continue to educate physicians about co-prescribing naloxone to patients at risk of overdose.

V. Evaluation

Pennsylvania clearly is moving aggressively to address the opioid epidemic, deploying a range of strategies across prevention, treatment, and harm reduction. Many of the strategies are rooted in a solid evidence base, such as efforts to expand use of MAT. The reality, however, is that much more work remains, making it critical to evaluate on an ongoing basis which state policies are working as intended, how the policies work together, their impact(s) on patients, and what additional action may be required, including reevaluating policies that may be having unintended consequences.



The Commonwealth has made a number of efforts to gather and report data on the size and scope of the epidemic. For example, it has established a state-level dashboard that provides information at the state and county levels on newborns on Medicaid born with neonatal abstinence syndrome, the number of successful naloxone reversals (see Exhibit 11), individuals covered by Medicaid expansion with OUD, individuals covered by Medicaid receiving MAT, and individuals covered by Medicaid with an OUD. The Commonwealth, however, does not track commercial insurance on the same measures, potentially due to the greater difficulty in obtaining data for commercially insured populations.²⁹

As the state's evolving efforts to respond to the opioid epidemic continue, Pennsylvania will have the opportunity to build on its nascent efforts to establish systematic strategies for evaluating the effectiveness of its interventions from public health initiatives on naloxone to expanded coverage of alternative pain management strategies in Medicaid to PID's market conduct exams on mental health and SUD parity. Such evaluations could prove useful to Pennsylvania, as well as other states looking to Pennsylvania as a source of ideas and innovative approaches, particularly with respect to its efforts to improve access to alternative pain management strategies and eliminate prior authorization and other barriers to MAT.

Best Practices and Next Steps for Evaluation

Best Practices	Next Steps
<ul style="list-style-type: none"> Dashboard. Established a dashboard that provides county-level and statewide Medicaid information on key opioid metrics, such as newborns on Medicaid born with neonatal abstinence syndrome and the number of successful naloxone reversals. 	<ul style="list-style-type: none"> Systemic review of the effectiveness of policy interventions. Work with foundations, local universities or internal state resources to systematically evaluate which state policies are working as intended, how the policies work together, their impact(s) on patients, and what additional action(s) may be required, including reevaluating policies that may be having unintended consequences. Expand data in dashboard beyond Medicaid. Currently, the dashboard does not include data from commercial insurers; adding such data, if feasible to collect, could provide a more comprehensive portrait of the epidemic.



Endnotes

- ¹ IQVIA, State and National Totals of Retail Filled Prescriptions: All Opioid Analgesics, 2013–2017.
- ² Pennsylvania Insurance Department, ‘Health Insurance,’ <https://www.insurance.pa.gov/Coverage/Pages/Health-Insurance.aspx>.
- ³ Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health, <https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report>.
- ⁴ Pennsylvania Drug and Alcohol Annual Plan and Report, 2014–2015, <https://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2015-2016%20DDAP%20State%20Plan%20and%202013-2014%20Report.pdf>.
- ⁵ The Substance Abuse and Mental Health Services Administration defines MAT as the use of medications in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of SUDs. SAMHSA: Medication Assisted Treatment, <https://www.samhsa.gov/medication-assisted-treatment>.
- ⁶ PubMed.gov, Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence, July 8, 2009, <http://www.ncbi.nlm.nih.gov/pubmed/19588333>; JAMA Network, Injectable, Sustained-Release Naltrexone for the Treatment of Opioid Dependence: A Randomized, Placebo-Controlled Trial, February 2006, <http://archpsyc.jamanetwork.com/article.aspx?articleid=209312>; PubMed.gov, Office-Based Treatment of Opiate Addiction With a Sublingual-Tablet Formulation of Buprenorphine and Naloxone, Sept. 4, 2003, <http://www.ncbi.nlm.nih.gov/pubmed/12954743>.
- ⁷ Large groups are more complicated since most of them are self-insured and not subject to ACA or Pennsylvania benefit mandates.
- ⁸ Pennsylvania Insurance Department, Know Your Rights: I Have Individual Health Insurance, <https://www.insurance.pa.gov/Coverage/Pages/IndividualHealthMHSUD.aspx>.
- ⁹ The Mental Health Parity and Addiction Equity Act of 2008 is federal legislation that bars group health plans and health insurers that provide mental health and SUD benefits from imposing less favorable limitations than those for medical and surgical benefits. The Center for Consumer Information & Insurance Oversight: The Mental Health Parity and Addiction Equity Act (MHPAEA) Factsheet, https://www.cms.gov/ccio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.
- ¹⁰ Pennsylvania Insurance Department, Know Your Rights: My Small Employer Provides My Health Insurance, <https://www.insurance.pa.gov/Coverage/Pages/SmallGroupMHSUD.aspx>.
- ¹¹ Pennsylvania Insurance Department: Market Conduct Examination Report of First Priority Life Insurance Company and HMO of North Eastern Pennsylvania, INC. d/b/a First Priority Health Insurance Company. See pp. 102–104 available at <https://www.insurance.pa.gov/Regulations/Regulatory%20Actions/Documents/Current%20Market%20Conduct/First%20Priority%20Life%20Insurance%20Co.%2018.pdf>.

- ¹² Morse, Susan. "Centene Fined Again for Failing to Meet ACA Provider Standards," HealthCare Finance, March 27, 2018, <https://www.healthcarefinancenews.com/news/centene-fined-again-failing-meet-aca-provider-standards>.
- ¹³ Pennsylvania SUD Demonstration Amendment Application, March 9, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-former-foster-care-youth-diff-state-pa2.pdf>.
- ¹⁴ To be certified as a COE, a provider must agree to offer or facilitate access to MAT. COEs provide MAT using buprenorphine or naltrexone. Medicaid requires its physical health MCOs contract with all COEs in their regions, and collaborate with the COEs to coordinate care, collect quality measures and develop a regional and statewide learning network. Payments to the COEs have been excluded from the MCO capitation rates, but Medicaid plans to integrate them into the capitation rates as part of a long-term funding plan for the COEs. Source: HealthChoices Agreement Exhibits Effective Jan. 1, 2017, http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040150.pdf.
- ¹⁵ Vermont Department of Health, http://www.leg.state.vt.us/jfo/healthcare/Health%20Reform%20Oversight%20Committee/2016_10_25/Status%20of%20Opioid%20Treatment%20Efforts%20-%20Chen.pdf.
- ¹⁶ Governor Wolf Announces Year-One Successes of Centers of Excellence, Feb. 28, 2018. Retrieved from: <https://www.governor.pa.gov/governor-wolf-announces-year-one-successes-centers-excellence/>.
- ¹⁷ Opioid & Health Indicators Dataset, AMFAR, http://opioid.amfar.org/indicator/AMAT_fac.
- ¹⁸ Number of DATA-Waived Practitioners Newly Certified Per Year, https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=PA.
- ¹⁹ Recovery homes or sober living homes are privately operated residences for a small number of recovering addicts who support each other through therapy and Narcotic Anonymous or Alcoholics Anonymous meetings. Feldman, Nina, Many 'Recovery Houses' Won't Let Residents Use Medicine To Quit Opioids, <https://www.npr.org/sections/health-shots/2018/09/12/644685850/many-recovery-houses-wont-let-residents-use-medicine-to-quit-opioids>.
- ²⁰ DDAP, Emergency Department Warm-Handoff Schematic, Feb. 28, 2018, <https://www.ddap.pa.gov/SiteAssets/Pages/Warm-Hand-Off/WarmHandoff%20Schematic.pdf>.
- ²¹ Office of Attorney General, Attorney General Shapiro Announces Treatment Outreach Initiative, May 8, 2018, <https://www.attorneygeneral.gov/taking-action/press-releases/attorney-general-shapiro-announces-treatment-outreach-initiative>.
- ²² SAMHSA describes SBIRT as an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs that targets individuals with SUD prior to need for extensive or specialized treatment. SBIRT: <https://www.integration.samhsa.gov/clinical-practice/sbirt#why?>
- ²³ CDC: Morbidity and Mortality Weekly Report, Sept. 14, 2018, <https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6736a2-H.pdf>.

- ²⁴ Pennsylvania also continues to expand its regulation of prescriptions for legal opioids. Prior authorization is required for all long-acting opioids, and for new prescriptions of short-acting opioids after three days for children and five days for adults. Effective September 2018, prior authorization is required for daily dosages of or greater than 90 morphine milligram equivalents (MME) and will be required for dosages of or greater than 50 MME by July 2019.
- ²⁵ Nahin RL, Boineau R, Khalsa PS, Stussman BJ, Weber WJ. Evidence-based evaluation of complementary health approaches for pain management in the United States. *Mayo Clinic Proceedings*. 2016;91(9):1292–1306.
- ²⁶ CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm.
- ²⁷ Geinsinger, a Medicaid and commercial insurer in the state and a national leader in pain management, implemented a bundled payment for Medicaid that allows providers to use their clinical judgment to approve alternative services, such as acupuncture, to treat pain.
- ²⁸ Governor Tom Wolf, Governor Wolf Announces Naloxone Standing Order to Combat Heroin Epidemic (+FAQs), Oct. 28, 2015, <https://www.governor.pa.gov/naloxone-standing-order/>; Pennsylvania General Assembly, Act 139, Sept. 30, 2014, <http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2014&sessInd=0&act=139>.
- ²⁹ Pennsylvania recently received a \$1 million grant from the Aetna Foundation to enhance its Opioid Data Dashboard and build models to predict future trends.