CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Innovation Accelerator Program (IAP)

Substance Use Disorders

Targeted Learning Opportunities (TLO)

TLO 9: Combating the Opioid Crisis with a Multifaceted Approach

IAP Medicaid Innovation Accelerator Program

Logistics

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- Moderated Q&A will be held periodically throughout the webinar
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Speakers (1 of 7)

- John O'Brien, MA
- Senior Policy Advisor, Disabled and Elderly Health Programs Group, Centers for Medicaid and Medicare

Speakers (2 of 7)

- John Coster, PhD, MPS
- Director, Division of Pharmacy, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services

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Speakers (3 of 7)

- Charissa Fotinos, MD, MS
- Deputy Chief Medical Officer, WA State Health Care Authority

Washington State Health Care Authority

Speakers (4 of 7)

- Lisa Millet, MHS
- Injury & Violence Prevention Manager, Public Health Division, Oregon Health Authority

Speakers (5 of 7)

- Robert Kent, JD
- Chief Counsel, Office of Counsel and Internal Controls, Office of Alcoholism & Substance Abuse Services (OASAS)

NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Speakers (6 of 7)

- James Becker, MD
- Medical Director, WV Bureau of Medical Services, WV Department of Health and Human Resources

Speakers (7 of 7)

- Rahul Gupta, MD, MPH, FACP
- State Health Commissioner, Bureau for Public Health, WV Department of Health and Human Resources

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Moderator

- Catherine Fullerton, MD, MPH
- Senior Research Leader, Truven Health Analytics

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Agenda

- Introduction from CMS
- State Experience: Washington
- State Experience: Oregon
- ***Break for Discussion***
- State Experience: New York
- State Experience: West Virginia
- ***Break for Discussion***
- Wrap Up & Sharing of Resources

Purpose and Learning Objectives

- Participants will learn about innovative state Medicaid policies that aim to reduce prescription drug abuse and prevent opioid overdoses
- Participants will learn how Medicaid programs have collaborated with PDMP to combat the opioid crises

Introduction

John O'Brien, MA

Senior Policy Advisor, Center for Medicaid and CHIP Services

John Coster, PhD, MPS

Director, Division of Pharmacy, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services

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Why Focus on Prescription Opioids

US prescription opioid deaths quadrupled between 1999 - 2013

CDC identified addiction to prescription opioids as the **strongest risk factor** for heroin addiction

Medicaid enrollees are prescribed prescription opioids at **twice the rate** of non-Medicaid patients

Medicaid enrollees are at **higher risk of prescription opioid overdose** than non-Medicaid patients

One state found that Medicaid enrollees made up **45% of all prescription overdose deaths** between 2004-2007

Why Focus on Methadone for Pain

Methadone accounts for a disproportionate share of opioid pain medication overdoses and deaths

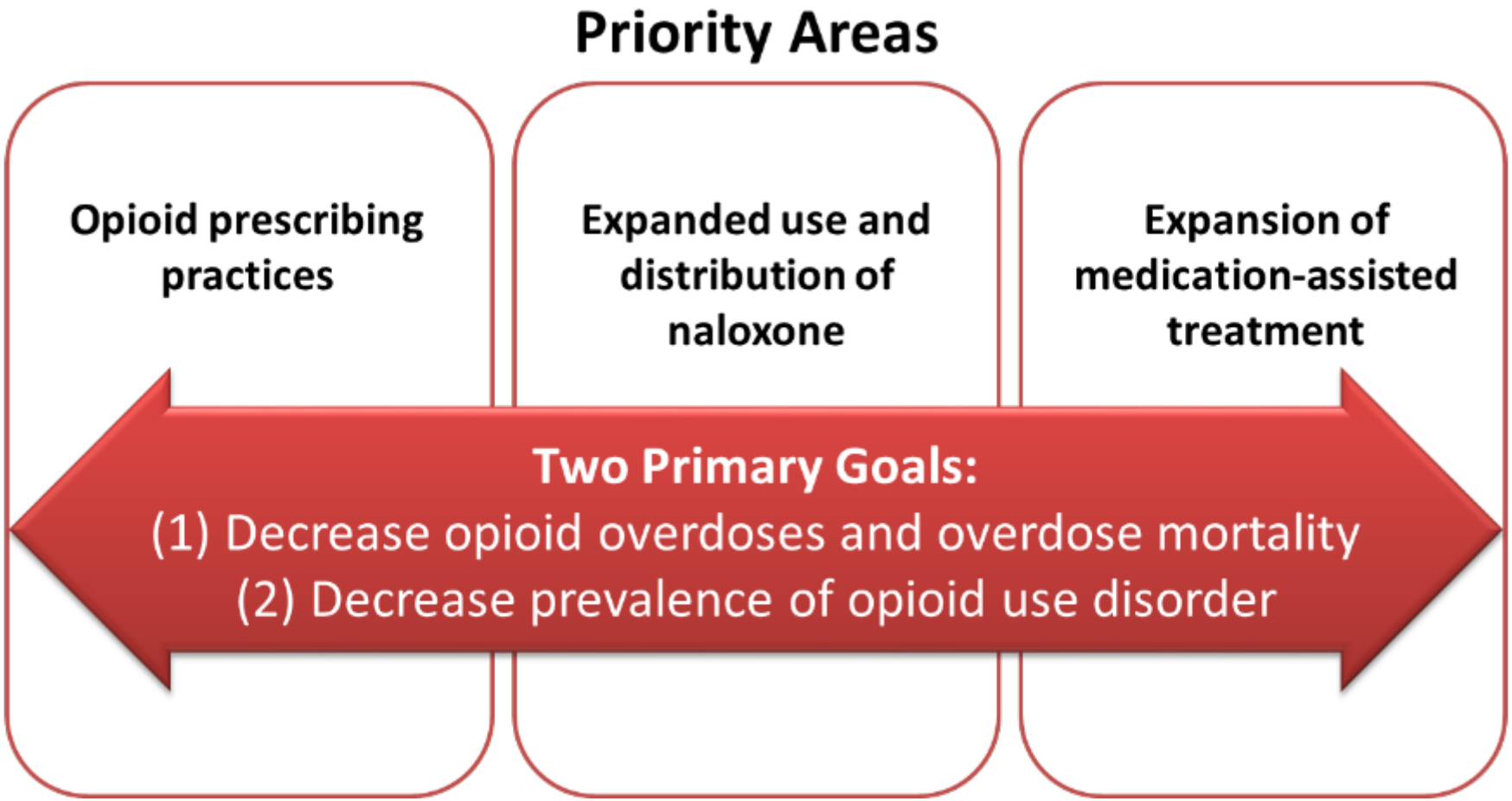
Between 2002 – 2008, methadone represented **less than 5%** of analgesic prescriptions

Methadone also represented **30% of opioid-related deaths** during that same period

In one state, the overdose rate of Medicaid enrollees was **10 times higher** for methadone than other prescription opioids

Overdoses involving methadone were **twice as fatal** compared to other prescription opioids

Secretary's Initiative on Opioid Abuse: Launched March 2015



Presidential Memorandum: Issued October 2015

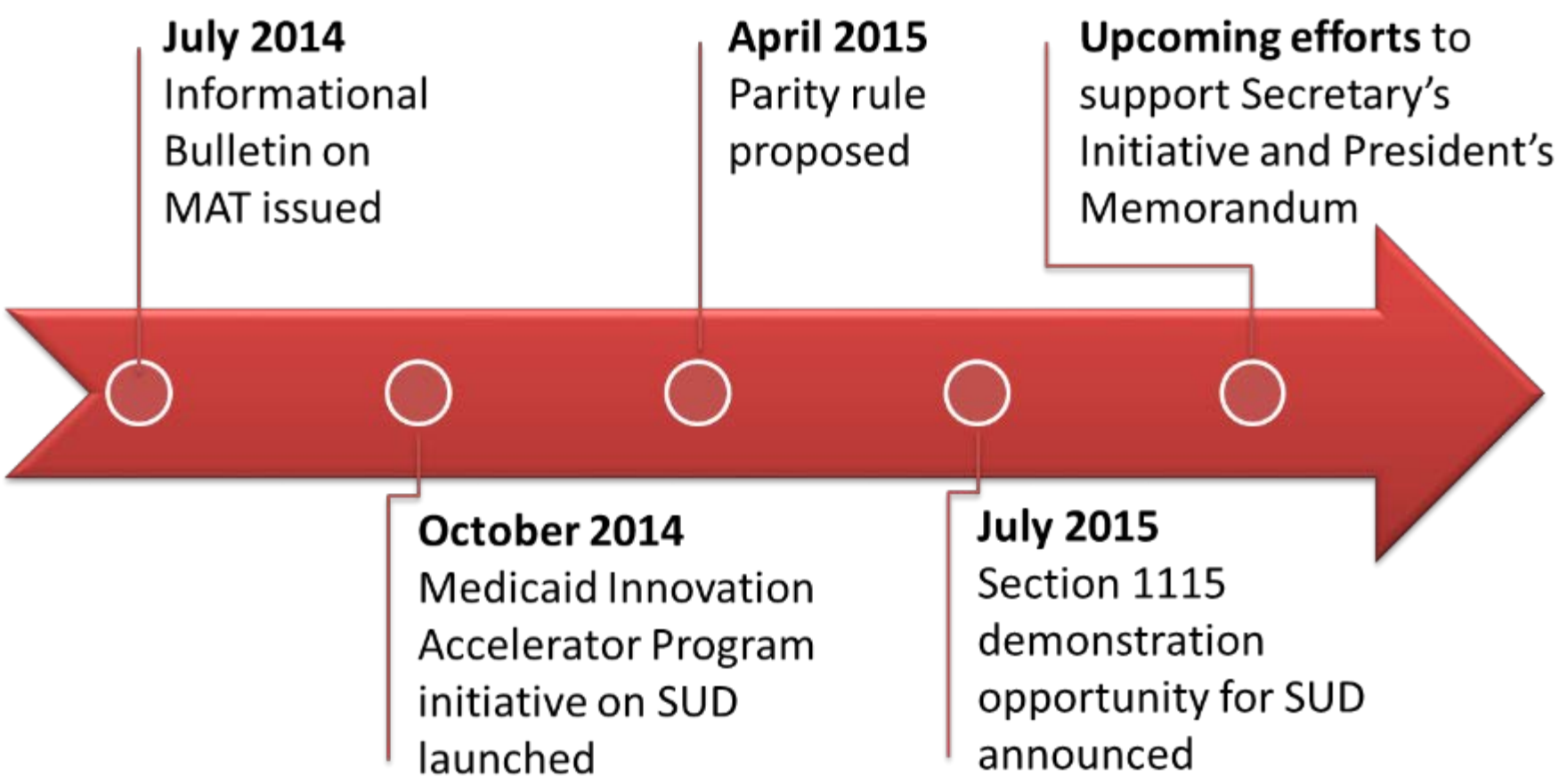
Goals

- Reduce prescription opioid and heroin deaths
- Promote appropriate and effective pain medication prescribing
- Improve access to treatment

Actions

- Train federal prescribers
- Identify barriers to accessing MAT in federal health programs
- Review the use of methadone as a preferred or first-line pain reliever

CMS Initiatives on Opioid Use Disorder



MAT Coverage: A Snapshot

MAT is evidence-based treatment for a chronic disease

FDA-approved medications for opioid dependence

- Buprenorphine
- Methadone
- Naltrexone

Prior Authorization

- 48 states have prior authorization for buprenorphine
- Prior authorization for antipsychotics leads to higher rates of hospitalization and higher total Medicaid expenditures

Very low utilization of extended-release injectable naltrexone

Expanding Coverage to MAT

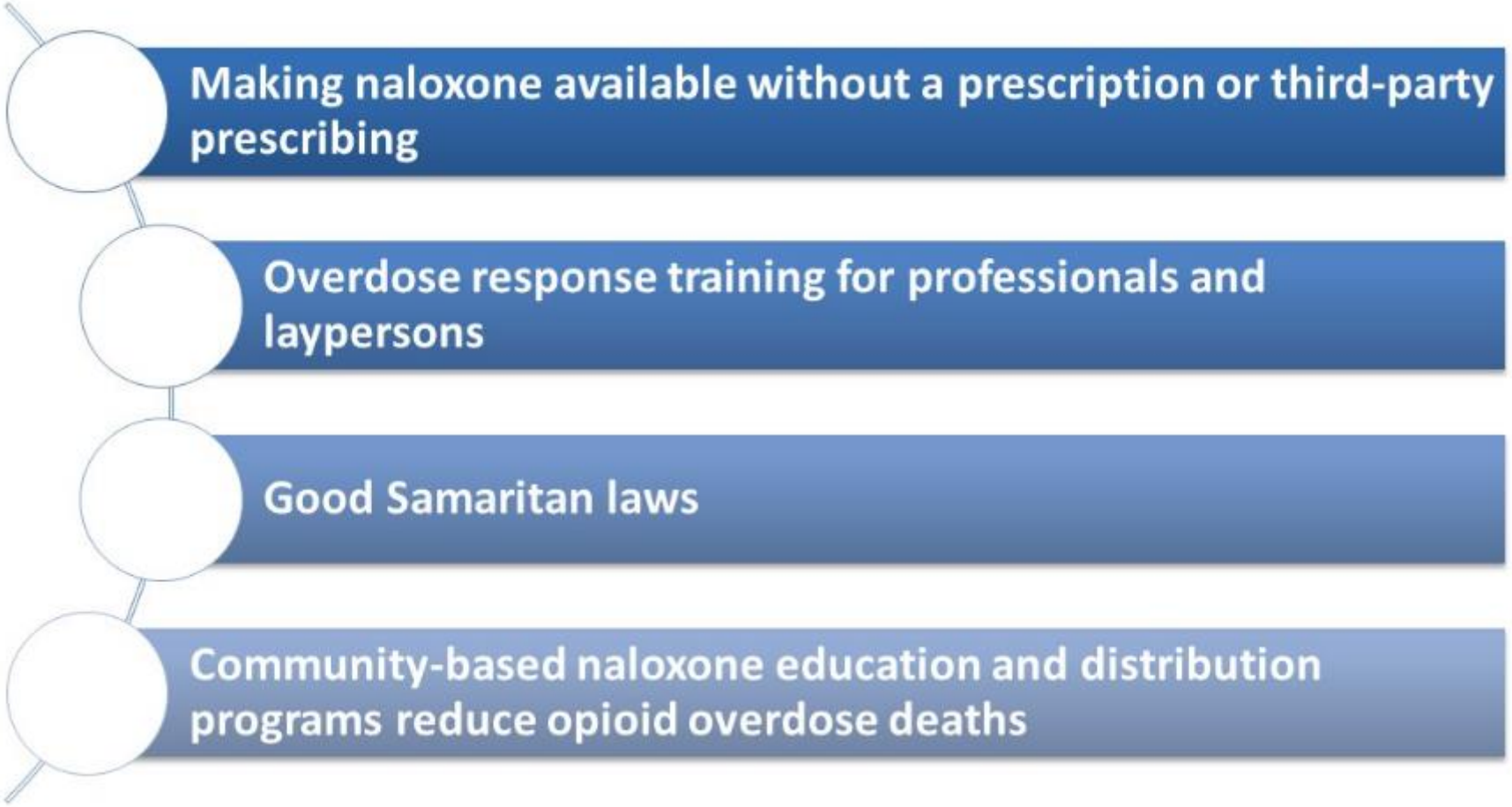
- Review limitations for barriers to access
- Medical, psychological and rehabilitative services in conjunction with medication management
- Data analytics on
  - Penetration rates (diagnosed and receiving SUD treatment, including MAT)
  - Network adequacy and MAT provider availability
  - Inactive authorized prescribers
  - Concurrent behavioral therapies delivery rates

Medicaid Pharmacy Benefit Management Strategies

- Preferred Drug List placement
- Preferred drug criteria
- Step therapy
- Prior authorization
- Quantity limits
- Provider education and prescribing guidelines
- Drug Utilization Review
- Patient Review and Restriction Programs
- Prescription Drug Monitoring Program
  - Mandated prescriber use shows reductions in controlled substance prescribing and multiple provider episodes (75% in New York)

Medicaid Strategies for Expanded Use of Naloxone

State Strategies for Expanded Use of Naloxone



Polling Question – Introduction

- Has your state implemented any of the following strategies to combat the opioid epidemic?
  - Provider Education
  - Pharmacy Benefit Management Restrictions
  - Drug Utilization Reviews
  - Use of PDMP
  - Increasing Access to Naloxone
  - Expanding access to Opioid Use Disorder Treatment

Washington State Health Care Authority

State Experience: Washington

Charissa Fotinos, MD, MSc
Deputy Chief Medical Officer,
WA State Health Care Authority

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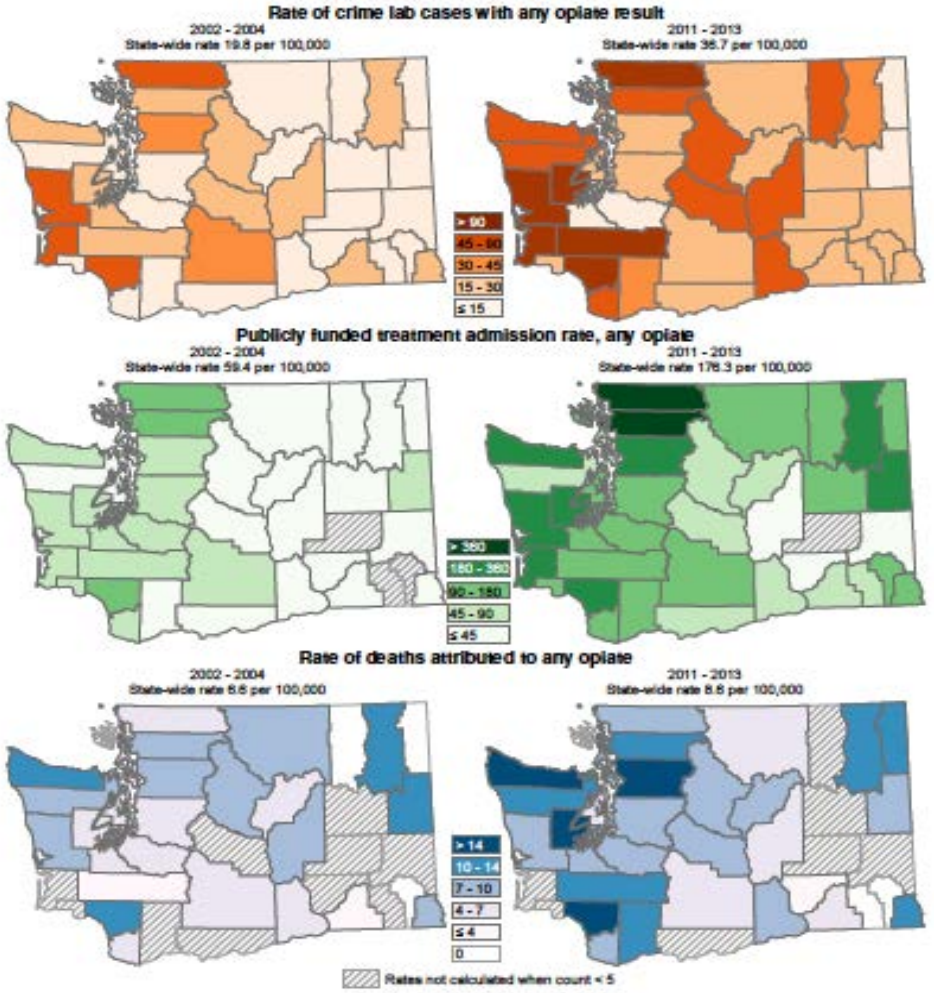
Agenda – Washington

- Opioid Use in Washington
- Cross Agency Collaboration
- Provider Education
- Prescription Drug Monitoring Program
- Pharmacy Benefit Management
- Increasing Access to MAT
- Overdose Prevention

Opioids in Washington

Opioids in Washingto

- Rate of crime
- Publically funded treatment
- Opiate-related deaths



Cross Agency Collaboration

Collaborative Efforts

- AMDG Guidelines
- Chronic Pain Rules
- Prescription Monitoring Program
- Policy
- Statewide Plan
- Medication Assisted Treatment

Provider Education: Pain Management

- Older policy
  - Required state medical, nursing, dental, osteopathic, podiatric boards/commissions to develop rules around management of chronic, non-cancer pain
- Repealed permissive pain rules & mandated new rules addressing:
  - Opioid dosing criteria
  - Guidance on when to see pain specialty consultation
  - Guidance on tracking clinical progress via assessment tools
  - Guidance on tracking adherent use of opioids

Updating Medical Director Guidelines

	2010 Guidelines	2015 Guidelines
Primary Focus	Mostly on chronic, non-cancer pain	Expands focus to include opioid use in acute, subacute & perioperative pain phases & in special populations
Main Sections	• Initiating, transitioning & maintaining patients on chronic opioid analgesic therapy (COAT) w/ principles on safe prescribing • Optimizing treatment for patients on > 120mg/day MED • Brief sections on getting consultations, aberrant behaviors, tapering, discontinuing COAT	• Recommendations for all pain phases: clinically meaningful improvement in function; dosing threshold; non-opioid options • New section on reducing or discontinuing COAT • New section on recognition & treatment of opioid use disorder • New section on opioid use disorder in special populations: pregnancy, NAS, children, adolescents, older adults, cancer survivors • Expanded sections on tapering & opioid use disorder

Prescription Drug Monitoring Program

- Data Sharing with Medicaid
  - WA State Department of Health is authorizes under RCW 70.225 to provide prescription data from PDMP to the Health Care Authority (HCA) for Medicaid recipients
  - Monthly updates based on matching records to a recipient file that HCA provides

Prescription Drug Monitoring Program: Patient Review & Coordination Program

Prescription Drug Monitoring Program: What did we look at?

- **High (120mg+) MED dose**
- Opiates combined with benzodiazepine &/or muscle relaxants
- Previous opioid-related adverse event with current prescription
- **Pill volume for chronic, non-cancer pain**
- Clients paying cash
  - Clients cross reference
  - ID pharmacies

Interventions

Intervention	Data	Action
Pharmacy	• FFS & MCO clients that do not have a rejected claim on file for same prescription • FFS who have a rejected claim for the same prescription before the cash purchase	• 1783 incidents of cash pay were targeted • Top 13 pharmacies were notified
Prescriber	• Diagnosis of opioid adverse events • At least 1 ep. of poisoning • At least 1 Rx>120 mg morphine equiv. dose • ED poisoning ep., AND • Received at least 1 opioid Rx in last quarter of 2014	• 88 Medicaid prescribers were identified to receive a letter of concern
MCO	• High risk previous overdose clients (see previous specifications) • Cash pay clients • PRC client's PMP record	• All contracted Medicaid managed care organizations received PMP data

Pharmacy Benefit Management

- Changes to Methadone Access
  - Has been on the Medicaid Preferred Drug List & did not require prior authorization
  - As of October 2015, methadone requires prior authorization approved by WA State Pharmacy & Therapeutics Committee
    - Must have tried and failed 2 other long-acting opioids
    - Maximum starting dose restrictions
  - Future removal from Medicaid Preferred Drug List is likely

Increasing Access to MAT: Changes to Medicaid Guidelines

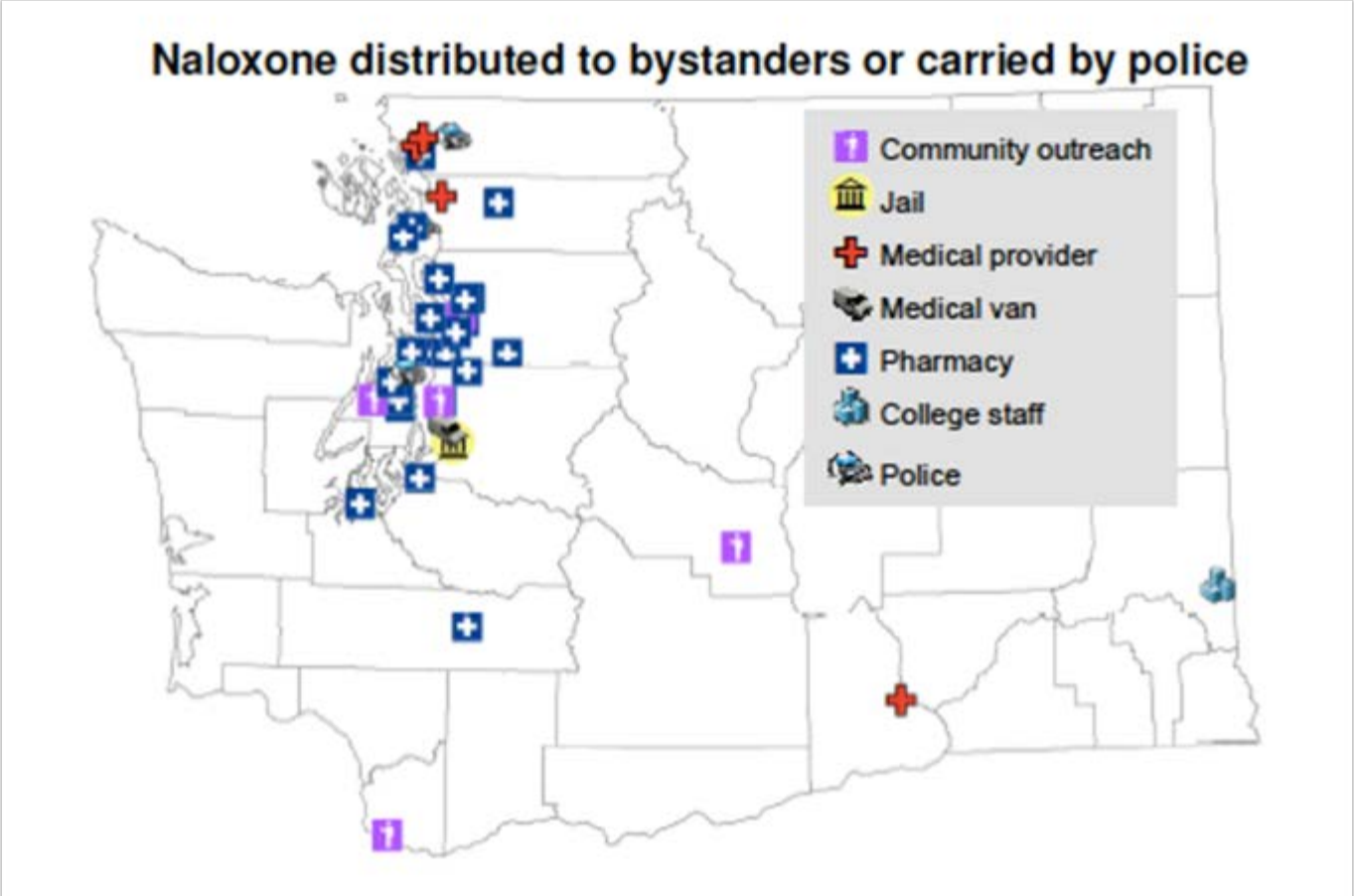
Buprenorphine monotherapy	• Covered only for pregnant women who meet DSM-IV criteria for opioid dependence or DSM-V criteria for moderate/severe opioid use disorder
Buprenorphine/ Naloxone	• Covered for all non-pregnant individuals age 16 or older who meet DSM-IV criteria for opioid dependence or DSM-V criteria for moderate/severe opioid use disorder
Treatment Facilities	• Treatment in a DSHS approved facility is encouraged, but not required for initiating MAT with buprenorphine

Overdose Prevention

- May 2015, ESHB 1671 Passed
  - Allows health care practitioners to prescribe, administer, distribute opioid OD reversal medication directly or via a collaborative drug agreement or standing order to anyone who might witness an overdose. Adds to prior legislation.
  - Liability Protection
    - Persons possessing & administering these drugs are protected if acting in good faith & with reasonable care
    - Prescribers protected if issued as part of legitimate medical purpose & as part of usual professional practice
  - Increasing Access to Help
    - Persons administering drug must encourage person with OD to seek care
    - Persons seeking care for someone with OD, person experiencing OD are protected from possession charges

Overdose Prevention, continued

Naloxone Distribution as of April 2015



State Experience: Oregon

Removing the Preferred Status of Methadone for Pain in Oregon's Pharmacy Program

Lisa Millet, MHS

Injury & Violence Prevention Manager,

Public Health Division, Oregon Health Authority

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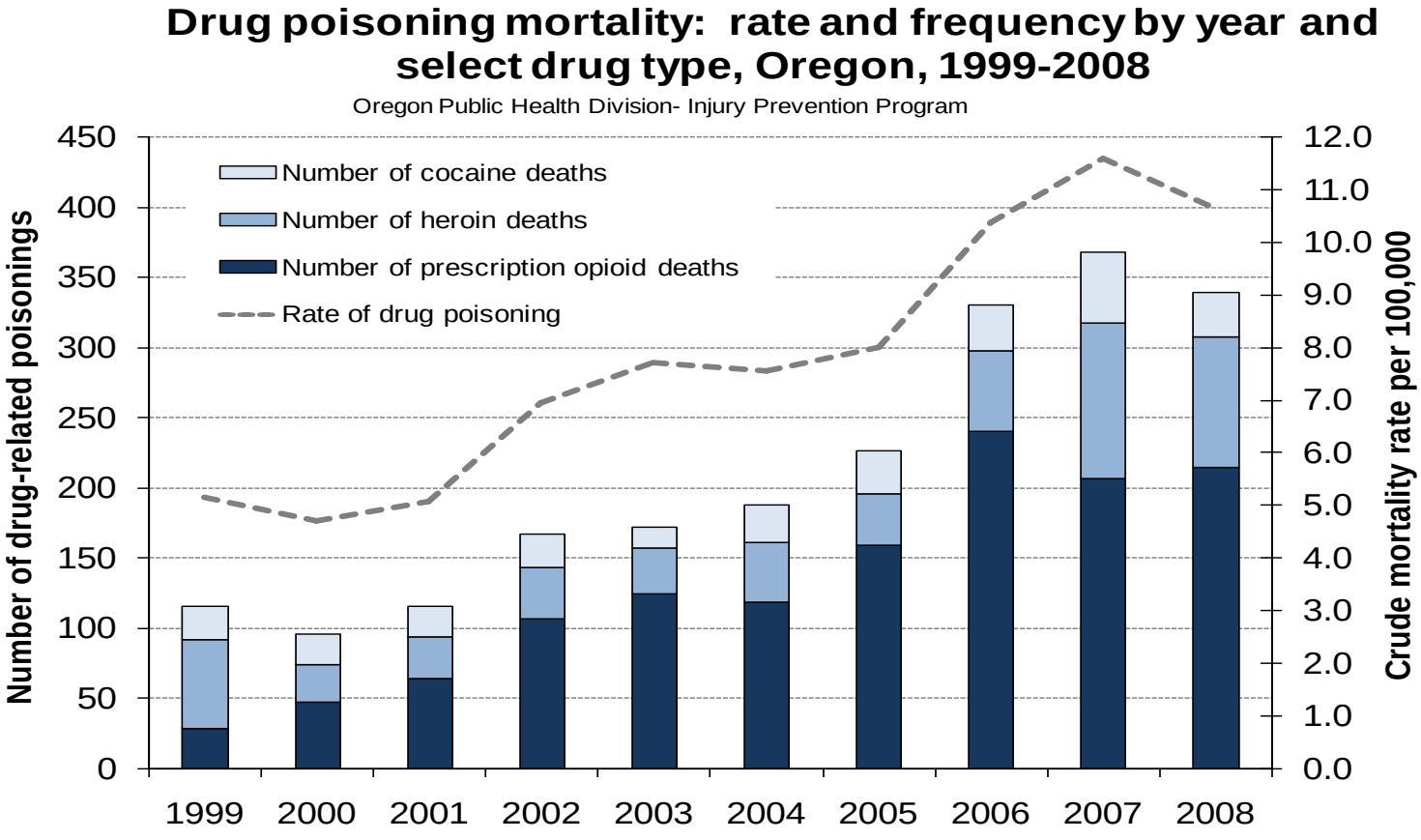
Agenda - Oregon

- Epidemiologic Investigation to Understand How Methadone Contributed to Mortality in Oregon
- Oregon Health Authority's State Pharmacy Director Actions
- Summary

Epidemiologic Investigation: Working Group Objectives

- Matt Laidler, MPH, Injury Prevention Epidemiologist created a special report for an agency wide Prescription Opioid Overdose Prevention workgroup
- Working group objectives
  - What are the magnitude and trends in sales, morbidity and mortality?
  - What are the relative rates by drug and drug type?

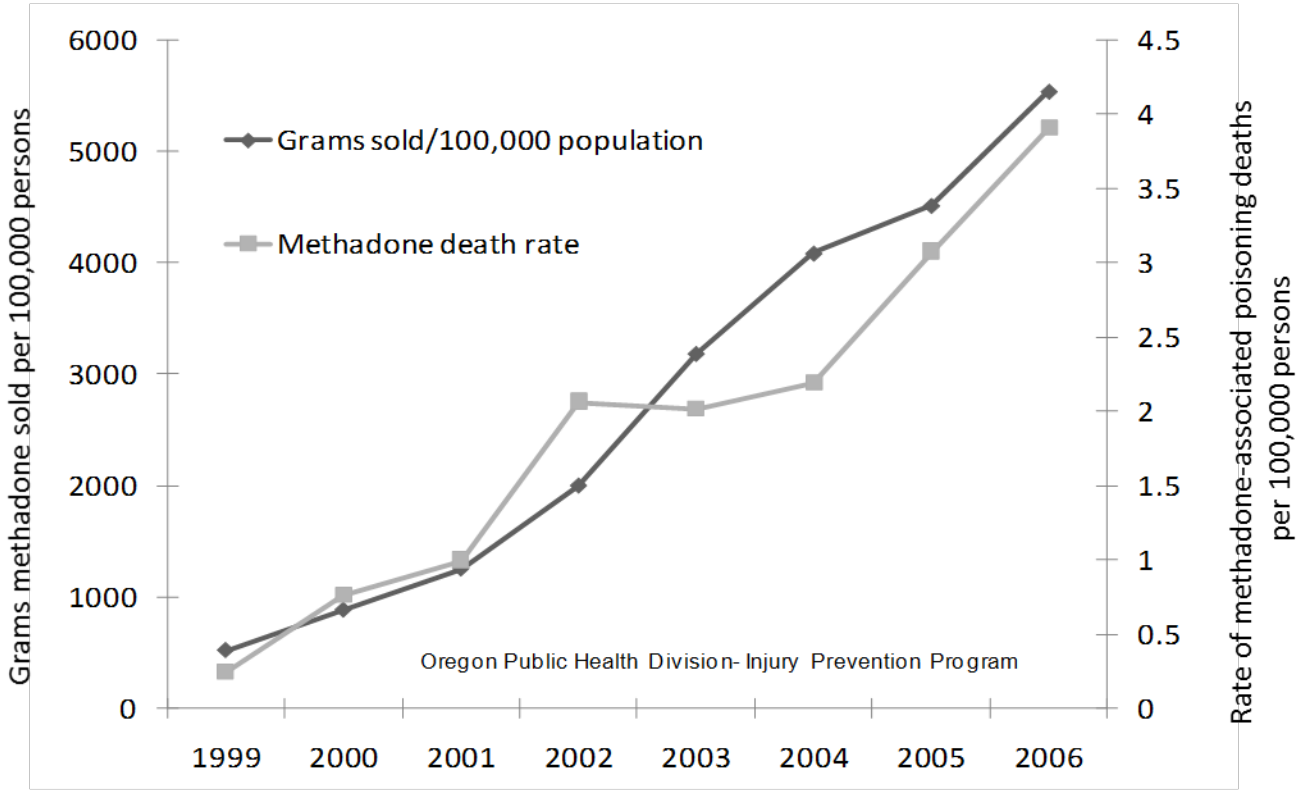
Epidemiologic Investigation, part 1



*2008 mortality data are preliminary; drug death categories are not necessarily mutually exclusive- deaths may involve multiple drugs. Includes uninetional and undetermined drug poisonings. Data source: Oregon Center for Health Statistics mortality data file.

Epidemiologic Investigation, part 2

Retail distribution of methadone in Oregon and poisoning mortality rate associated with methadone in Oregon, 1999-2006

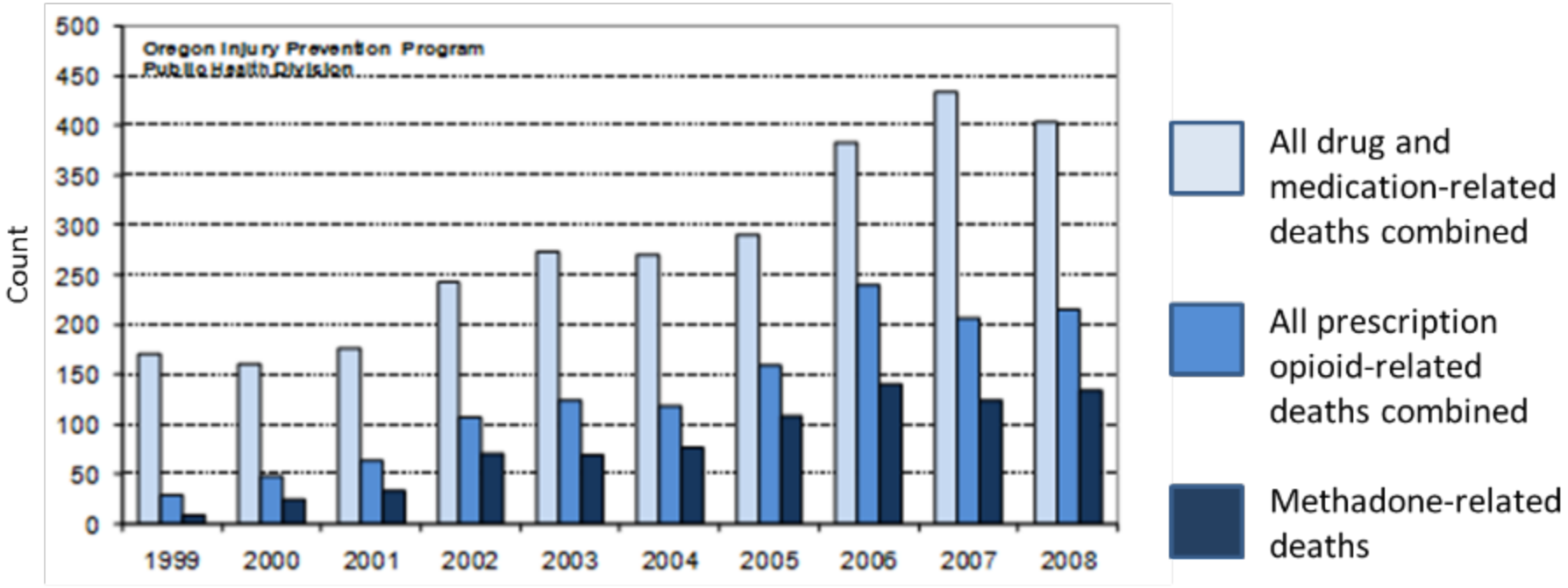


Note: grams sold on left axis, death rate on right axis

Source: US Dept. of Justice, Drug Enforcement Administration, Office of Diversion Control, Automation of Reports and Consolidated Orders System (ARCOS); Oregon Center for Health Statistics mortality data files. Includes unintentional and undetermined intent deaths.

Epidemiologic Investigation, part 3

Drug Poisoning mortality: the role of methadone, Oregon, 1999-2008



2008 data are preliminary. Categories are not mutually exclusive- many deaths simultaneously involve several types of drugs. Includes only deaths with an X40-X44 & Y10-Y14 ICD-10 code for underlying cause of death (unintentional and undetermined intent).

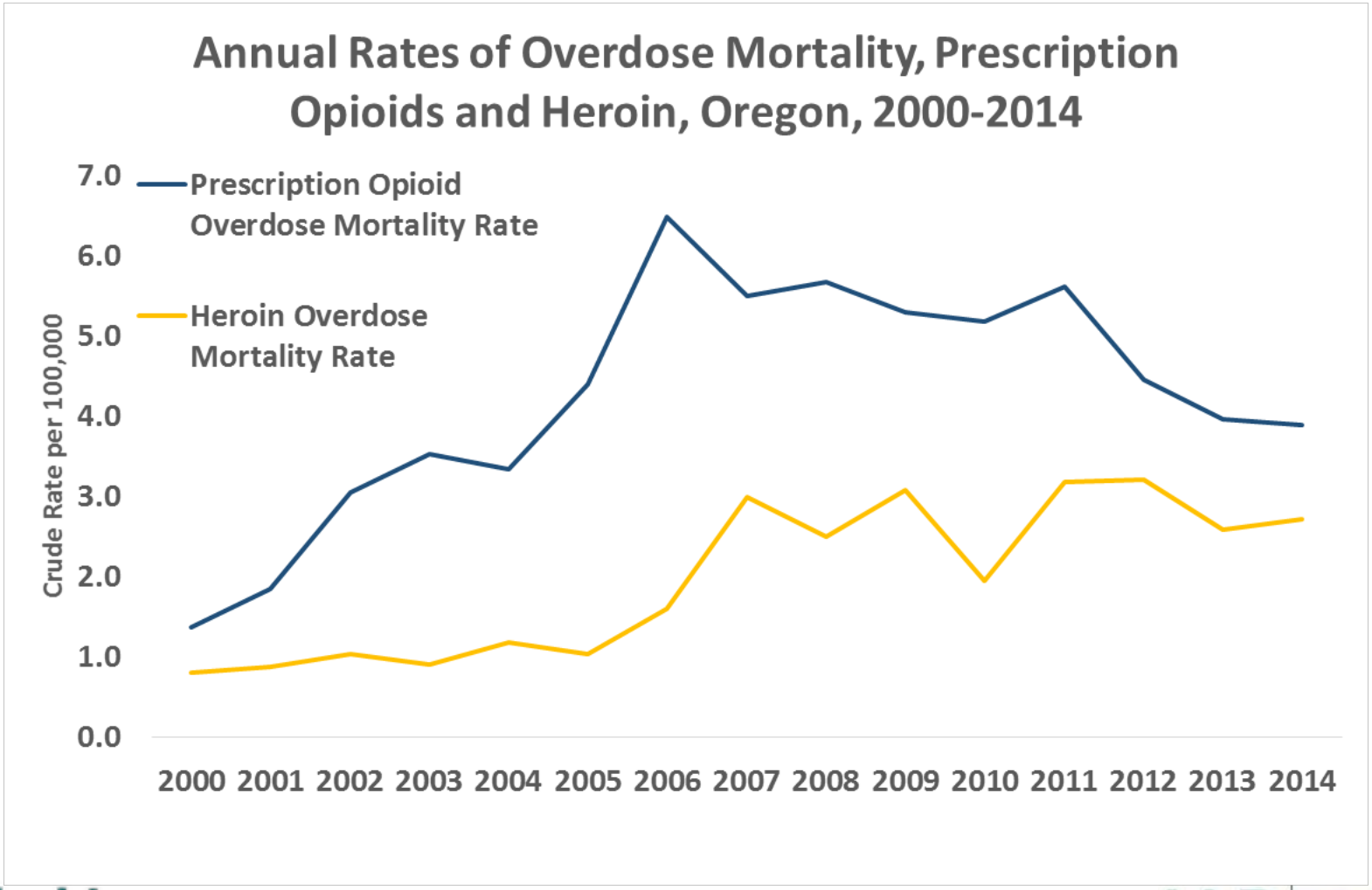
Epidemiologic Investigation: Report Findings

- Methadone contributed to much of the increase in overdose deaths
- Methadone
  - Very low cost opioid compared to alternatives
  - Pharmacological properties of the drug may increase the risk of adverse outcomes—including death
  - Drug often stays in the blood stream longer than the pain relieving effects
  - Drug's half-life partially depends on the individual taking the drug, so treatment must be adapted to each patient

Removing Methadone from Preferred Status on the Medicaid Formulary

- Push from State Pharmacy Director, Tom Burns
  - Presented the epidemiologic data to the OHA's Prescription Opioid Overdose Prevention working group
    - Highlighting that methadone accounted for nearly 50% of prescription drug overdoses
    - Persons with a history of mental illness and substance use were over-represented in overdose deaths
  - Discussed high mortality among persons taking methadone for chronic pain with Pharmacy & Therapeutics Committee (Oregon Medicaid)
    - State Pharmacy Director asked the committee to remove methadone's preferred status
    - Committee voted to remove preferred status
    - Change went into effect in January 2014

Oregon Health Authority's State Pharmacy Director Actions



Summary - Oregon

Partnerships focused on simultaneous implementation of key strategies

- Improved outcomes for patients, communities, provide a return on investments made to address the problem
- This is a winnable battle
  - Saves lives
  - Improves patient safety
  - Improves community safety
  - Creates a bridge to recovery and better health outcomes

Polling Question - Oregon

- Has your state implemented any of the following restrictions on methadone? Select all that apply.
  - Removed from PDL
  - Introduced new clinical criteria
  - Prior authorization requirement
  - Step therapy/quantity limits
  - Other restriction(s)
  - No change- full access remains

Discussion and Questions - Oregon

NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

State Experience: New York

Robert Kent, JD

Chief Counsel, Office of Counsel and Internal Controls, Office of Alcoholism & Substance Abuse Services (OASAS)

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Agenda – New York

- Legislative Changes to the Prescription Drug Monitoring Program
- Changes in Prescribing Behavior
- Keys to Success
- Other State Initiatives

Early PMP Usage

- In February 2010, Bureau of Narcotic Enforcement implemented a prescription monitoring program (PMP)
  - Provided secure online access to patients' recent controlled substance prescription histories
- Available to practitioners only
  - Available 24 hours a day, 7 days a week
  - Underused
- Between February 16, 2010 & June 16, 2013
  - 5,087 practitioners (of a population of over 100,000 practitioners) conducted only 465,639 searches

Implementation of I-STOP Act

- On August 27, 2013, the updated PMP and the **mandatory** duty to consult was officially implemented
- Internet System for Tracking Over-Prescribing (I-STOP) Act

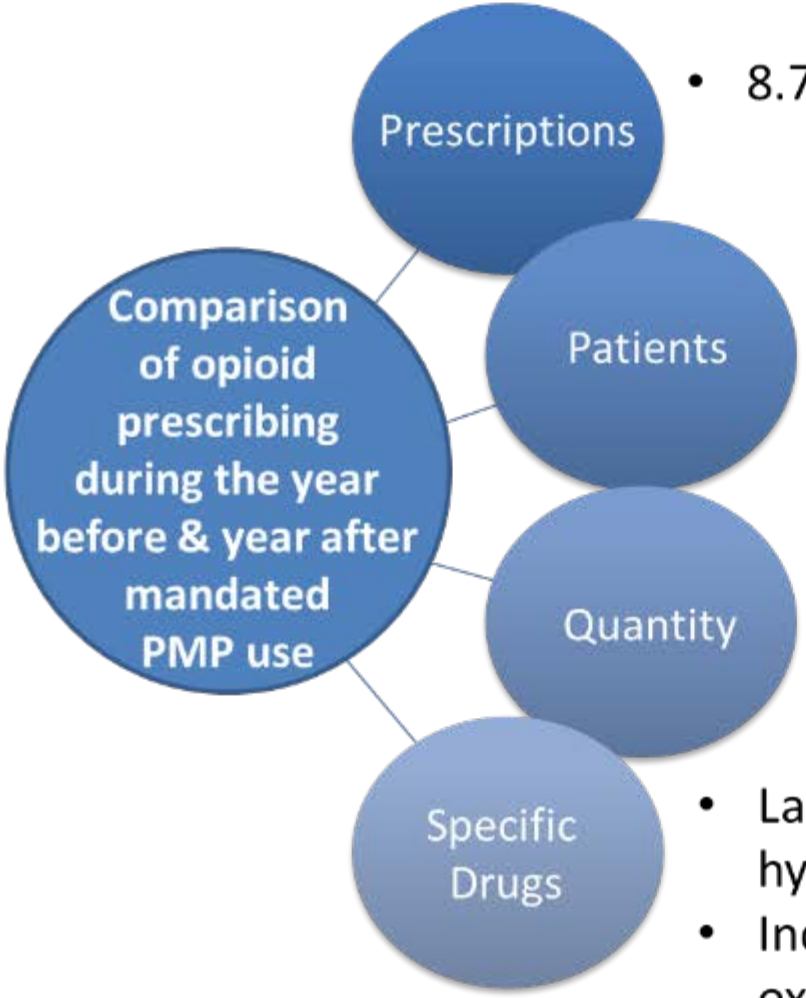
Since then…

Over **34 million** PMP searches performed

On more than **11 million** patients

By over **98,000** searchers

Change in Prescribing Behavior



- 8.7% decrease in total prescriptions
- 10.4% decrease in patients with a prescription
- 10.3% decrease in total quantity dispensed
- Largest decreases were for codeine 5 (-24%), hydrocodone (-17.7%), codeine 3 (-14.3%)
- Increases for fentanyl (3.5%), morphine (2.2%), oxycodone (0.2%)

Results: "Doctor Shopping"

Doctor Shopping **decreased by 75%** in the first year of the mandated use of the PMP

82% decrease between 4th Quarter 2012 and 4th Quarter 2014

Keys to Success

- **Mandatory** for all prescriptions
- Provider friendly
  - Investment in usable interface
  - Allow designated assistant to check PMP
- Education and outreach to providers

Next Steps – New York

- Interstate data sharing with other PMPs
- EHR integration
- Expanded data analytics
- Opioid prescriber education

Other State Initiatives

- State Parity Law
- Removal of ‘Fail First’ Requirements
- Standardized use of criteria to determine level of care for Medicaid beneficiaries

State Experience: West Virginia

James Becker, MD
Medical Director, WV Bureau for Medical Services

Rahul Gupta, MD, MPH, FACP
Commissioner, State Health Officer, WV Department of Health and Human Resources, Bureau for Public Health

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Agenda - West Virginia

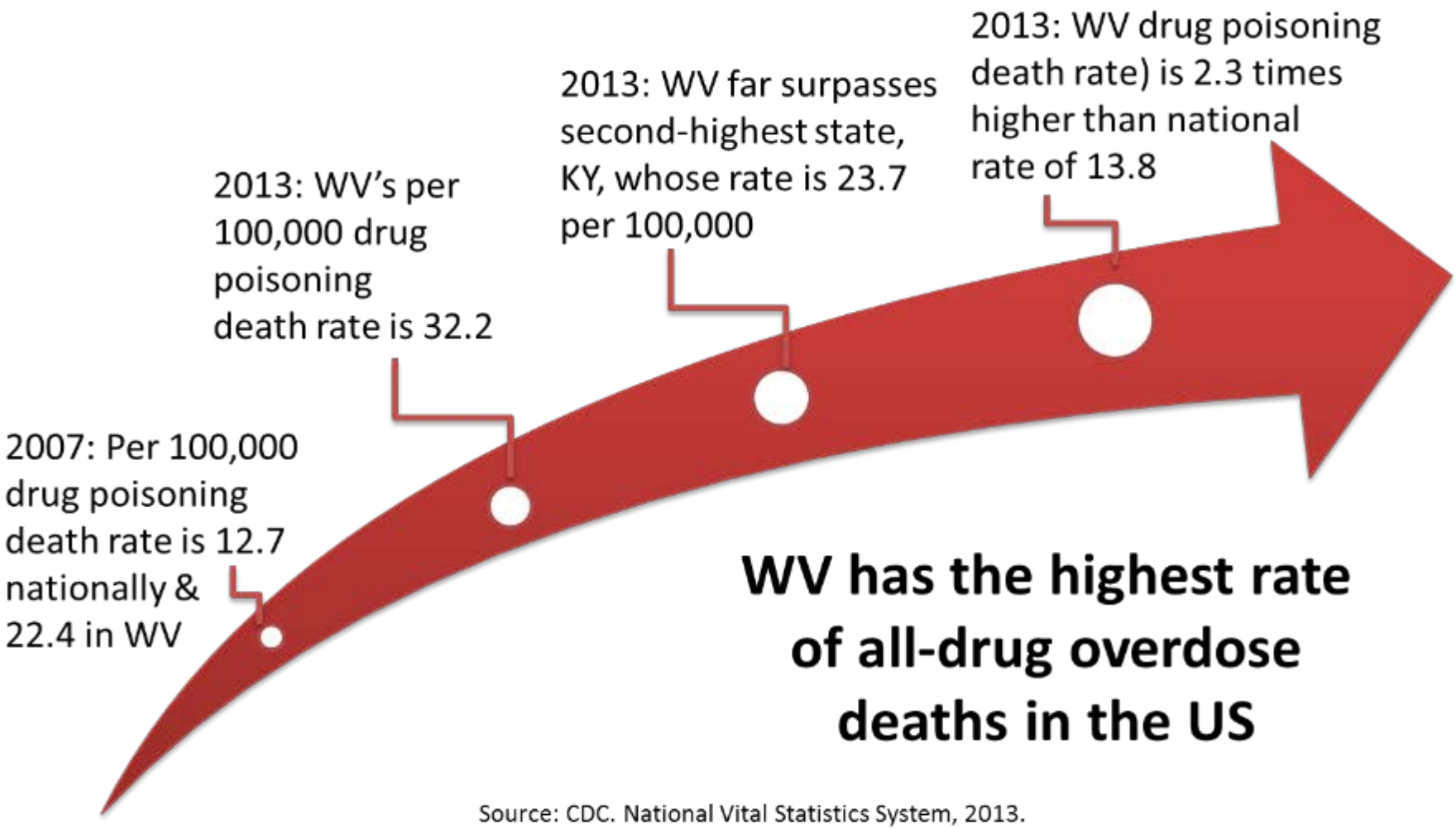
- Identifying the Problem in West Virginia
- Medicaid and DHHR Action Steps
  - Methadone & Non-Methadone Treatment Options
  - Prescription Drug Monitoring Program
  - Best Practice Prescribing
- Other State Partnership Initiatives with Medicaid
  - Statewide Helpline
  - Naloxone
  - Needle Exchange

Identifying the Problem in West Virginia: Illicit Drug Use

- Approximately 8.4% of WV residents report past-month illicit drug use
  - National average is 8.82%
  - Illicit drugs include street and prescription drugs used for nonmedical purposes
- Between 2009-2010, WV was one of the top 10 states for drug use
  - Illicit drug dependence, 12 or older
  - Past-year nonmedical pain reliever use, ages 18-25
  - Past-month illicit drug use (excluding marijuana), 12 and older

Source: Substance Abuse and Mental Health Services Administration. State Estimates of Substance Use from the 2009-2010 National Survey on Drug Use and Health.

Identifying the Problem in West Virginia: Overdose Rate



Source: CDC. National Vital Statistics System, 2013.

West Virginia Action Steps

WV Medicaid Coverage of Methadone

- Not Covered for Methadone Maintenance
- Approved only for the treatment of refractory neuropathy & some cancer pain
- Prior authorization required as of January 1, 2014
- Not covered for treatment of drug addiction
- Non-methadone treatment options for opioid addiction
  - WV Medicaid does cover Suboxone, Subutex, Vivitrol
  - All drugs require a prior authorization
  - Strict management including counseling requirement

Non-Methadone MAT

Therapy/Visit Requirements

- 4 hours of therapy/month
- 1 hour individual therapy is required of the 4 hours requirement
- 2 urine drug screens/month

Initial Dose Requirements

- Maximum is 24mg/day for 60 day period
- Prior Authorization is available in exceptional cases

Maintenance Dose Requirements

- Maximum is 16mg/day
- Tablet splitting for lower doses is required when appropriate

WV Prescription Drug Monitoring Program

Collaborate

- WV Board of Pharmacy collaborates with Medicaid to allow access to prescription database for drug utilization review

Analyze Patterns

- Review of appeals takes place to analyze of use by payment type (i.e. Medicaid, cash, private insurance)

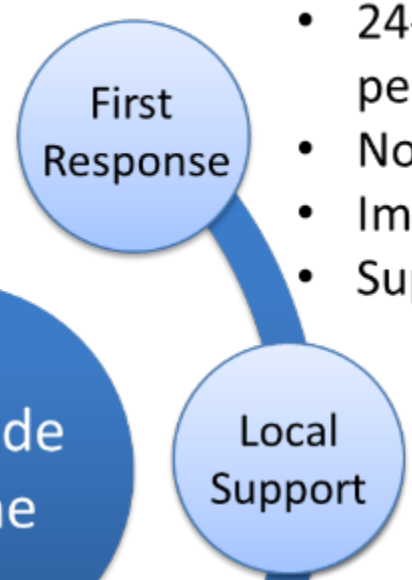
Notify Prescribers

- WV Board of Pharmacy sends letters to providers of individuals filling prescriptions in multiple locations & when patients are admitted to the ER

Best Practice Prescribing

- Medicaid DUR Initiatives
- State legislative requirements for Continuing Medical Education Programs
  - WV State Code 30-1-7a, Legislative Rules 11CSR6 & 11CSR1B
  - Successful completion of training provides 3 hours of AMA Category 1 CME
    - Required for license renewal criteria for all Board of Medicine licenses
  - Progress: 38 Continuing Medical Education trainings on Approved Best Practice and Drug Diversion Training have taken place in WV since 2013
    - Trainings for physicians
    - Approved by WV Board of Medicine

Other State Partnership Initiatives with Medicaid

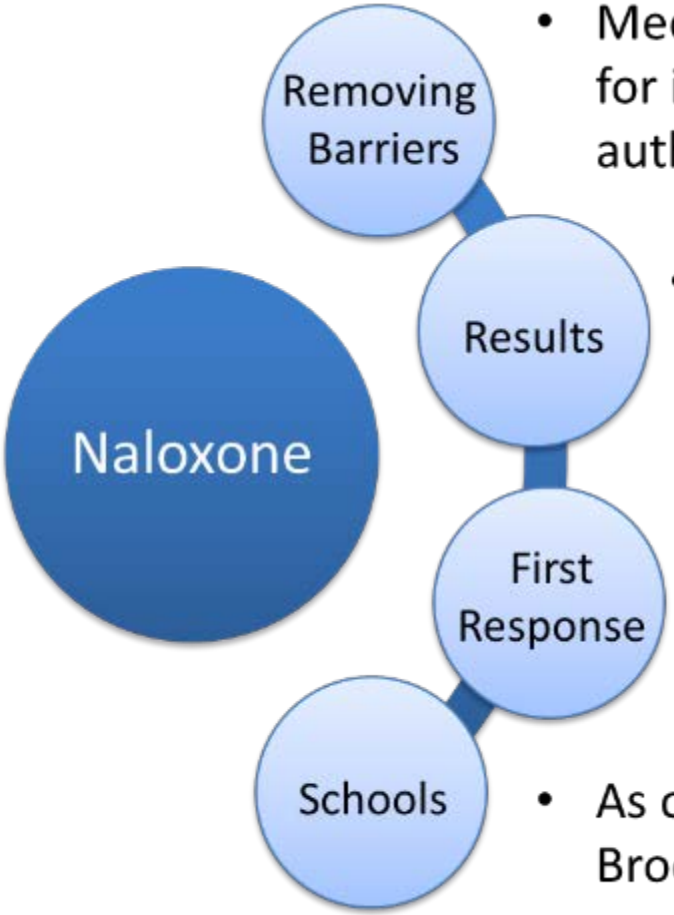


- 24-hour, year-round call center with in-person call takers
- No one is placed on hold
- Immediate in-call crisis support linkage
- Support timely access to services

- Expanded community outreach to support callers
- Single point of contact to learn about & access statewide SUD treatment resources

- Identify service gaps
- Provide data collection & analysis aimed at highlighting outcome measures & supporting providers' data-driven decision-making

Other State Partnership Initiatives with Medicaid, continued



- Medicaid provides free naloxone syringes for inhalation and injection without prior authorization or quantity limits
- Increase in family members of opiate dependent individuals wanting access so they can store naloxone in their homes
- As of 5/27/15, law requires all first responders (EMTs, firefighters, police) to carry Naloxone
- As of 11/12/15, WV Board of Education allows Brooke Co. schools to stock a overdose resuscitation drugs

Polling Question - West Virginia

- Has your state implemented any of the following activities to improve access to Naloxone? Select all that apply
  - Included on PDL
  - Community training in OD prevention/response
  - Co-prescribing w/ opioid analgesic
  - Available w/o prescription
  - Other
  - No current initiatives for Naloxone

Discussion and Questions - West Virginia

Polling Question - Conclusion

- Would your state be interested in having a post-webinar discussion with the speakers to address any additional questions or reflections on today's webinar?
  - Yes
  - No

Resources

- *State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose: A Report for the National Association of Medicaid Directors.* Mercer.
- *Opioid Overdose Toolkit.* Substance Abuse and Mental Health Services Administration.
- *National Alliance for Model State Drug Laws Website*

Resources, continued

- *Interagency Guideline on Prescribing Opioids for Pain, 3RD Edition*, Washington State Agency Medical Directors' Group.
- *Best Practices for Prescription Monitoring Programs*, Prescription Monitoring Program Center of Excellence, Brandeis University

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