STATE MEDICAID INTERVENTIONS FOR PREVENTING PRESCRIPTION DRUG ABUSE AND OVERDOSE: A REPORT FOR THE NATIONAL ASSOCIATION OF MEDICAID DIRECTORS
OCTOBER 1, 2014
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Executive Summary
The National Association of Medicaid Directors contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC to develop a report summarizing current practices and emerging opportunities for state Medicaid agencies to more effectively prevent prescription drug abuse and overdose. The challenge for states in addressing prescription drug abuse and overdose is implementing a coordinated statewide strategy that restricts access to prescription drugs for illicit use but ensures access for those who legitimately need them.¹

The report Introduction describes the current, national epidemic of prescription drug abuse and overdose, reviewing commonly abused and diverted prescription drugs paid for by Medicaid. The impact of this epidemic on Medicaid recipients and costs in fee-for-service and managed care environments for treatment and prevention services, as well as secondary and tertiary cost associated with member drug seeking behaviors and addiction is discussed.

Chapter 4 (Drivers and Challenges of Reform) identifies primary drivers and ongoing challenges contributing to the problem of prescription drug abuse and overdose, including the lack of: provider expertise, training, and education; clinical practice prescribing guidelines; patient education on appropriate use; coordination of care; and data and feedback tools.

A discussion of important federal opportunities that can be leveraged to support state initiatives and activities is found in Chapter 5 (Levers to Support Reform Efforts). As a payor, contract manager, and partner in cross-sector initiatives with other state agencies and the private sector, state Medicaid agencies have historical and unprecedented flexibility in program development, design, and funding support. Opportunities that support pilot and demonstration projects, increased emphasis on performance-based contracting and shared savings, State Plan and waiver opportunities that facilitate care coordination, health homes, and evidence-based practices for the treatment of substance use disorders (SUDs) can be leveraged to drive change and impact the problems associated with prescription drug abuse and overdose. Appendix A provides an overview of the research findings and highlights state efforts to address this growing national epidemic.

The final chapter of the report (Chapter 6: Recommendations), identifies the following promising approaches believed to be most relevant and beneficial for Medicaid agencies:

**Recommendations**

**Medicaid Infrastructure**
1. Leverage Medicaid’s role as payer in both fee-for-service and capitated arrangements to improve systems and controls by strengthening provider agreements and/or managed care contracts.
2. Invest in needed technology enhancements for Medicaid management information systems and claims processing systems.
3. Leverage federal funds to pay for Medicaid reimbursable SUD treatment benefits and to support integrated, coordinated care for individuals with co-occurring disorders.
4. Identify opportunities to support innovative, emerging approaches to address prescription drug misuse, abuse, and overdose within the Medicaid program.

**Proactive Prevention Measures**
1. Invest in provider education, both broad-based as well as targeted, as a prevention mechanism and to address inconsistencies in clinical practice and to promote evidence-based practices.
2. Apply recommendations for daily maximum of 120 mg morphine equivalent dosing for chronic non-cancer, non-terminal patients.
4. Encourage drug utilization review boards to develop prospective edits and retrospective reviews to address potential overutilization of prescription drugs.
5. Facilitate access to and the use of certified chronic pain centers.
6. Improve and expand both coverage of and access to non-pharmacological interventions for chronic non-cancer pain derived from functional assessments and self-reporting of pain as a preventive measure.
7. Support expansion of the clinical pharmacist’s role in pharmaceutical pain management to assist in the prevention and reduction of prescription abuse and misuse.

**Active Monitoring and Surveillance**
1. Monitor and address potentially excessive or problematic patient use of opioid or related prescription drug products.
2. Maximize robustness and utility of Prescription Drug Monitoring Programs (PDMPs).
3. Monitor, using paid claims and other data, for potential signs of aberrant provider prescribing or pharmacy patterns.
4. Establish or enhance lock-in programs to assist in the management and monitoring of recipients identified as high utilizers of narcotics.
5. Utilize clinical pharmacist resources to assist in evaluating prescribing and utilization patterns against evidence-based practice for both opioids and non-opioid products.

**Efficient and Effective Treatment of Addiction**
1. Optimize timely access to SUD services, including medication assisted therapy (MAT).
2. Appropriately treat comorbid, chronic pain when present.
3. Promote quality, outcomes-driven SUD services.
4. Support access to Nalaxone for persons with opioid addictions and provide education regarding its usage.

**Cross Agency Collaborative Efforts**
1. Introduce and participate in a larger partnership effort to impact prescription drug abuse and overdose.
2. Advocate for PDMP functionality.
3. Partner with other state agencies in monitoring efforts.
4. Require mandatory e-prescribing of CII–CV prescriptions to reduce opportunities for diversion, prescription errors, and fraud.
Collaboration with Medicaid Agencies from Other States
1. Advocate for a national network of PDMPs.
2. Collaborate with and learn from other states’ Medicaid agencies.
Introduction
The National Association of Medicaid Directors contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC to develop a report summarizing current practices and emerging opportunities for state Medicaid agencies to more effectively prevent prescription drug abuse and overdose. The challenge for states in addressing prescription drug abuse and overdose is implementing a coordinated statewide strategy that restricts access to prescription drugs for illicit use but ensures access for those who legitimately need them.¹

Prescription drug abuse and associated mortality has increased dramatically in the United States in recent years, creating an epidemic that claims the lives of tens of thousands of Americans each year, and affects millions more in the form of addiction and abuse morbidity. In addition to the numerous public health concerns, prescription drug abuse creates a significant economic burden for healthcare payers, both public and private. Data indicate this epidemic may disproportionately impact Medicaid recipients, placing a heavy burden on state agencies to develop adequate treatment and prevention initiatives. This report serves as a toolkit for state Medicaid programs to promote a standard of best practice interventions that can be implemented in states across the union in an effort to mitigate a serious public health concern. The implementation of well-chosen practices that address key risk drivers can result in reduction of prescription drug abuse, and should contribute to a decline in overall healthcare costs.

Background Information
As prescription drug abuse has become one of the most prolific problems in America today, it has developed into a societal and public health crisis. In the US, drug overdoses have become the leading cause of death from unintentional injury, recently surpassing motor vehicle accidents. Prescription drug overdoses now account for more than half of all drug overdose deaths, with the large majority of these deaths attributed to opioid pain medications. Mortality as a result of opioid pain medication overdose has quadrupled between 1999 and 2008, exceeding that of cocaine and heroin combined. In 2011 prescription drug overdoses were the cause of more than 22,810 American deaths across all age groups (nearly 62 each day).

The public health burden of prescription drug abuse is not limited to overdose mortality. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that for every fatal opioid prescription drug overdose, another nine people are admitted for substance abuse treatment, and 161 people report drug abuse and/or dependence.² SAMHSA estimates, as of 2009, approximately, 7 million Americans abused or misused prescription drugs each month.³ The Center for Disease Control and Prevention (CDC) reports the highest risk of prescription drug overdose in two primary population demographics — those who are prescribed long-term opioid analgesic medications for pain management, and those who report recent
nonmedical use of prescription drugs. The most commonly abused types of prescription medications are pain relievers such as hydrocodone (i.e., Vicodin®/Lortab®/Norco®) and oxycodone (i.e., Oxycontin®), muscle relaxants such as carisoprodol (i.e., Soma®) and cyclobenzaprine (i.e., Flexeril®), anxiolytic drugs such as alprazolam (i.e., Xanax®) and diazepam (i.e., Valium®), stimulants such as dextroamphetamine (i.e., Adderall®) and methylphenidate (i.e., Ritalin®), and sedatives and hypnotics such as zolpidem (i.e., Ambien®).

Prescription drug abuse has not only destroyed countless lives and families, it has consumed limited resources and increased costs for all payers. Individuals with drug seeking behaviors and addictions consume finite health care provider capacity, placing a significant economic and resource burden on providers and health systems. The percentage of emergency department (ED) visits associated with pharmaceutical misuse or abuse increased 114% between 2004 and 2011. According to the 2007 Coalition Against Insurance Fraud Report, persons who abuse prescription drugs incur excess health care costs totaling more than $72 billion annually to all public and private health insurers, including Medicaid.

The Impact on Medicaid
State Medicaid agencies face significant challenges in both preventing prescription drug abuse and overdose and in addressing the secondary and tertiary effects on individuals and families as evidenced by the following statistics in the table below:

<table>
<thead>
<tr>
<th>Prescription Drug Abuse Impact on Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid recipients are far more likely to receive a prescription for opioid pain medication than individuals covered by commercial insurance plans, and are also more likely to visit an emergency room for treatment, where opioids are often prescribed.</td>
</tr>
<tr>
<td>• Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid beneficiaries and are at six times the risk of prescription painkiller overdose.</td>
</tr>
<tr>
<td>• Rates of prescription drug misuse and overdose are elevated in individuals that are living in poverty, living in rural communities, have co-occurring mental illness, and/or have a history of substance abuse, all of which are disproportionately represented in Medicaid populations.</td>
</tr>
<tr>
<td>• The CDC estimates that more than 45% of fatal prescription drug overdoses were Medicaid enrollees.</td>
</tr>
<tr>
<td>• Between 2000 and 2009, the rate of newborns diagnosed with neonatal abstinence syndrome (NAS) and dependent on narcotics nearly tripled and the number of mothers using or dependent upon drugs more than quadrupled, while costs associated with treating these infants increased by 35%. Medicaid was the primary payer for over 75% of these births. In Tennessee, Medicaid officials have seen a 1.5% statewide increase in the number of newborns with NAS and increases in some counties as high as 5%.</td>
</tr>
<tr>
<td>• Medicaid opioid users demonstrating “pharmacy shopping” behaviors (i.e., four or more pharmacies in any 90 days) have a 1.8-fold increased risk of overdose compared to those who did not exhibit those behaviors, even after adjusting for dose and other risk factors.</td>
</tr>
<tr>
<td>• Among Medicaid recipients being treated for chronic pain, 10% of patients drive the majority of prescriptions for typical daily dosage of 100 morphine milligram equivalents or more, resulting in a greater risk of overdose.</td>
</tr>
<tr>
<td>• Abusers of opioids have been found to have total health care costs eight times that of non-abusers, with much of the additional costs attributed to related medical claims, such as office visits, diagnostic tests, and ED care.</td>
</tr>
</tbody>
</table>
Prescription Drug Abuse Impact on Medicaid

- Medicaid recipients have a higher rate of ED visits and hospitalization for poisoning by opioids and related narcotics than individuals with other forms of insurance or the uninsured. In 2010 in Arizona, Medicaid paid for more than half (52.5%) of all opioid-related ED admissions. Opioid overuse not only increases ED visits but leads to higher medical imaging, inpatient admissions, and other avoidable services and costs that may actually harm beneficiaries.

As illustrated above, the economic burden of prescription drug abuse and overdose on Medicaid is significant. Although estimates specific to Medicaid are not addressed, the Coalition Against Insurance Fraud estimates that prescription drug abuse costs commercial insurers nearly $25 billion annually. However, a study by the U.S. Government Accountability Office of Medicaid programs in six states identified more than $63 million in the fraudulent or inappropriate use of controlled substances, counting only the cost of the medications themselves. Additional Medicaid payments were incurred in these fraudulent and inappropriate cases, including payments to providers for office visits and other services provided. In addition to the financial implications of prescription drug abuse and overdose, chronic and severe social implications reverberate through Medicaid and social service programs as well in the areas of homelessness, domestic violence, unemployment, foster care, and others that can burden states for years in service and care needs.
Drivers and Challenges to Reform

The causes of prescription drug abuse are diverse and intensely complex, presenting significant obstacles to comprehensive reform and requiring an equally diverse set of solutions. Among the primary causes of prescription drug abuse and misuse are inadequate chronic pain management, inconsistencies in clinical practice and insurance benefit coverage, the presence of a drug culture in the US and the marketplace for illegally and fraudulently obtained prescription drugs, and a prevailing public perception of the relative safety of prescription medicines. Addressing these root causes requires a multi-level solution which includes participation from clinical providers, healthcare payers, and various state and federal agencies.

Challenges and Opportunities in Data Exchange

All of the reforms available to states to address this critical epidemic rely on the availability of timely, and multi-faceted data at all levels of the care equation. At the practice level, prescribers need data to assess opioid-seeking behavior, identify possible co-occurring disorders and avoid drug-drug interactions that could confound treatment or lead to addiction. This data must be historical as well as real-time to ensure the highest level of clinical quality.

At the plan and agency level, the need for data is different, but no less important. A Medicaid health plan with historical prescribing data could perhaps identify individuals at risk for opioid abuse and health care providers whose prescribing behavior may indicate a concern. Furthermore, Medicaid agencies need data to ensure that policy interventions, such as lock-in programs or prescribing limits, are having the intended effect on reducing the frequency of misuse and overdose. The deployment of electronic health information exchange and the increased focus on data analytics at all levels of practice and policy provide real opportunity to improve not just the ability to reduce misuse of prescription drugs, but also to prevent addiction to opioids in the first place.

While the data collection and analytics are a valuable tool in this effort, there are obstacles that must be overcome to realize their potential. These issues can vary by state, but most states face some hurdles in data exchange. Data limitations may include cash purchases of drugs that may not be reflected in patient records or different structures in prescription drug monitoring systems (e.g., a state may be able to access the prescription drug monitoring data only by individual patient record, but cannot look at data by provider). States also differ in whether they permit the e-prescribing of controlled substances. In cases where e-prescribing is not allowed, prescription data for these medications may not flow in the same ways, and can result in more laborious or outdated analyses.

One of the most frequently cited barriers include limitations in data exchange around SUDs because sharing of data among practitioners falls under different requirements (HIPAA versus 42 CFR part II privacy laws that govern SUD practitioners). These different data sharing frameworks result in the vast majority of SUD and some mental health data not being available to prescribers or for other data purposes. Methadone clinics often do not share data in the same
way or at all. These data challenges limit the utility and applicability of many emerging data analytics efforts.

**Challenges in Clinical Practice**

*Expanded Use of Opioids in Pain Management*

Chronic pain is the most common cause of morbidity in the US, impacting as many as 25% of adults and 50% of elderly Americans. Sources of chronic pain are diverse and include traumatic injury, environmental and occupational stressors, and primary medical conditions such as cancer, arthritis, and diabetes. In addition, pain is a personal and subjective experience, making it difficult for healthcare providers to objectively evaluate and properly address. Physicians and other medical providers are charged with the responsibility for managing their patients' pain and overall health, and must do so responsibly and within the confines of evidence-based clinical practice. More recently, the treatment of chronic pain has shifted from primary care to pain specialists, creating access bottlenecks in areas where pain specialists are few and far between. The complex and subjective nature of chronic pain makes it difficult to establish standardized treatment protocols, and this lack of best-practice standards contributes to the potential abuse and misuse of pain treatments, namely opioid analgesic medications.

During the 1990s, healthcare providers became concerned that pain was not being adequately treated in American practice. As a result, the Joint Commission on the Accreditation of Healthcare Organizations and other organizations campaigned for the inclusion of pain as a fifth vital sign. Subsequently, opioid pain medications, once reserved for acute and cancer-related pain, became commonplace in the treatment of chronic non-cancer pain (CNP). This expanded utilization led to a dramatic rise in the number of opioid pain prescriptions written throughout the US. The use of opioid pain medication to treat CNP has remained controversial, due largely to these drugs' high potential for abuse and the potential development of hyperalgesia, a condition in which patients experience increased sensitivity to pain and thus require increasing doses of pain relieving medication. As dosages of opioids have increased so has this new issue of opioid-induced hyperalgesia. Prescribers now must consider whether worsening chronic pain, without an obvious identifiable cause, may be the result of using high doses of opioids. Patients who can be slowly tapered off of excessive doses may find their chronic pain reduced.

**Debate about Standardized Dosing Thresholds**

In an effort to establish standardized dosing guidelines to be used in clinical practice, metrics such as morphine equivalent dosing (MED) and morphine milligram equivalency (MME) have been developed. Both MED and MME are used to evaluate the daily opioid intake for patients receiving chronic opioid therapy. The relative potency (compared to morphine) of an opioid is evaluated in conjunction with the prescribed daily quantity in order to arrive at a single numerical value, which expresses the equivalent amount of morphine needed to match to the patient's prescribed daily opioid intake. Pain medications prescribed in high quantities for CNP represent a significant risk for fraud, waste, and abuse (FWA). This type of prescribing must be
distinguished between cancer and end-of-life palliative prescribing where MED ceilings may not be applicable. When analgesic medications are prescribed and dispensed in greater quantity than necessary for treatment of the recipient’s pain, the excess medication represents not only wasted supplies and reimbursement funds, but also creates an opportunity for abuse by both the intended recipient and others who may seek to obtain the medications illicitly.

Although many providers recognize the value of standardized dosing conversions, there has been significant opposition to the adoption of restrictive clinical guidelines in opioid treatment. The American College of Physicians states that defined maximum quantities are not universally appropriate and should therefore not be mandated or legislatively enforced.\textsuperscript{15} The protection of clinical autonomy for physicians remains a primary concern for many provider groups, administrators, and policymakers, and there has been rare or modest success in legislative efforts to control prescriber behaviors.

Despite these concerns, precedence exists for setting thresholds and establishing procedures for when individual needs may not fit the typical situation.

**Educational Efforts Lag Behind**

The role of physicians and other healthcare providers in the prevention of prescription drug abuse is not confined to dosing limitations. Prescribers, especially primary care providers, are optimally positioned to identify suspicious or potentially dangerous behaviors related to prescription drug use. However, many providers do not receive appropriate training and education for the identification of these risk factors.

The American College of Preventative Medicine (ACPM) estimates that less than 40% of physicians receive training in medical school to identify prescription drug abuse or diversion. Similarly, it is estimated that more than 90% of primary care physicians are unable to properly identify symptoms of drug abuse in their patients.\textsuperscript{6} It is clear that physicians and other providers are in a unique position to help prevent prescription drug abuse among their patients, but it is equally apparent that adequate training and education in these areas is profoundly lacking. To address this problem, some states, including California and Washington, have put educational requirements in place to improve prescriber education on these issues.
Public and Medical Perception of Safety
Many providers struggle with a perceived lack of alternative pain treatment modalities which could decrease the use of opioid analgesics as the primary treatment for CNP. Public perception of prescription medications as inherently safe represents a significant challenge in the prevention of prescription drug misuse. Many patients maintain the belief that all medications prescribed to them by their healthcare providers are benign, despite the chemical similarity between prescription medicines and other illicit drugs which carry a vastly different public opinion. An individual with a strong opposition to taking heroin may not hesitate to take high doses of opioid pain medications, which share a remarkable similarity in both chemical structure and mechanism of action. Similarly, illicit methamphetamines carry significant public stigma, but prescribed central nervous system stimulants, which are chemically similar, are prescribed to millions of adults and children all over the US. Public education about the inherent risks associated with prescription medication use, particularly for controlled substances, is necessary to combat the prevailing sense of false security afforded to prescription medicines.

Diversion and Illicit Use
Prescription drug abuse is not limited to patients who misuse their own medications. An estimated 55% of persons who take prescription medications for nonmedical purposes obtain the drugs through a friend or relative. This behavior of transferring a prescription medicine from its intended user and medical purpose to an illicit use is known as diversion, and represents a significant driver of abuse which is difficult to prevent. Diversion can occur in a number of ways, with varying levels of involvement of the patient who is actually prescribed the medication. In some cases, medication or prescriptions are stolen from their intended recipients. In other cases, the individual may willingly give or sell their medication to others. In the most extreme cases, individuals may falsify or exaggerate their pain in order to receive additional medication which they intend to distribute or sell to others for illicit uses.

Recent developments in medication formulation development have greatly improved (e.g., tamper-resistant long acting oxycodone products such as reformulated Oxycontin®). These innovations are intended to prevent illicit, off-label use and prevent the extraction of the opioid ingredients for the purposes of illicit use or accelerated effect, activities commonly associated with potential overdose. Despite the effectiveness of these new formulations in preventing tampering and illicit use, the potential for dependence and abuse remains, particularly for the patients to whom the medications are prescribed.

Treatment of Co-Occurring Conditions
Chronic pain is an especially complex condition in patients who also suffer from comorbid mental health and SUDs, which is extremely common. Approximately 30% of patients with chronic pain conditions also suffer from clinical depression, and nearly 50% of patients who suffer from both anxiety and depression disorders have a comorbid pain diagnosis. The frequency of co-occurrence between pain and behavioral health disorders is further complicated by the synergistic effect the two (or more) comorbidities have on one another. Behavioral health conditions such as anxiety and depression, as well as mood and psychotic disorders become more difficult to treat in patients who also suffer from chronic comorbidities, including depression and alcohol abuse, have been associated with a three-fold increase in overdose risk, highlighting the need for collaborative, integrative care reform.
physical pain, and the same is true in reverse.\textsuperscript{20} Research suggests that comorbidities, including depression and alcohol abuse, have been associated with a three-fold increase in overdose risk, highlighting the need for collaborative, integrative care reform.\textsuperscript{11}

Further confounding the issues of co-occurring pain and behavioral health conditions is the lack of coordination between pain specialists, primary care providers, and behavioral health practitioners. Independent, segmented care is an inefficient use of healthcare dollars, and often results in sub-optimal health outcomes for patients. Coordination of care between primary care and behavioral health specialists can be difficult to implement due to differences in practice settings, clinical philosophies, and benefit structures, especially in state Medicaid programs in which behavioral health may be covered under a separate program (i.e., managed care carve-out) than the rest of somatic healthcare services.

**Variation in Medicaid Benefits and Structures**

Understanding prescription drug abuse in the present day and developing effective strategies to prevent it going forward requires a review of the history of the benefit structure. In the 1990’s, many payers and managed care organizations recognized that opioid medications were less expensive than the comprehensive pain management clinics available at many medical centers and may have opted to discontinue or limit reimbursement for those comprehensive pain management clinic services. As a result, responsibility for treating pain shifted more heavily to primary care providers, while reimbursable alternatives to medication therapies (e.g., physical therapy, chiropractic care, acupuncture) may have been limited or not available, leaving opioids as one of the mainstays in treatment.\textsuperscript{21} Today, public insurers, whose clients disproportionately include those at risk for adverse opioid-related events, may have a similar benefit coverage approach.

Medicaid and commercial payers have slowly begun to reverse this paradigm shift and now, in partnership with prescribers, realize that, although some patients are predisposed to addiction, the problem largely lies with drugs that have addictive qualities. This awareness reinforces the importance of using the appropriate therapy or intervention to treat a given condition. Examples include:

- Improved and expanded coverage of non-pharmacological interventions for CNP derived from functional assessments and self-reporting of pain as a preventive measure to prescription drug abuse.
- Development of prescribing guidelines in many states and the applicability of these guidelines in managed care environments to better educate prescribers on the risks associated with commonly abused prescription medicines and limit access to these drugs where appropriate.

However, challenges in operationalizing many important preventive and treatment measures remain. Current Medicaid benefit coverage and reimbursement structure is both complex and widely varied by state. Several states maintain large fee-for-service programs, while others contract for various levels of managed care. Pharmacy and behavioral health coverage is similarly varied, as some states have full or partial carve-in or carve-out models from managed care in both of these areas. Likewise, state Medicaid benefit packages for SUD treatment vary greatly as well, potentially creating funding challenges for robust and effective treatment programs. In states that are expanding Medicaid, it is estimated that former inmates and detainees of state and federal corrections systems will make up approximately 35% of all
persons eligible for expansion based on income.\textsuperscript{22} Prison and jail inmates are seven times more likely than individuals in the general population to have a SUD.\textsuperscript{23}

Given this enormous complexity, challenges in prescription drug abuse prevention and treatment become evident. For example, in states that have full or partial pharmacy benefit carve-outs from their managed care plans and those that defer lock-in program responsibilities to managed care organizations (MCOs), contract oversight and administration of pharmacy data collection can be difficult. Some Medicaid agencies face further alignment challenges to preventing prescription drug abuse in managed care environments in which MCOs may not apply uniform prior authorization controls or quantity limits for opioids.

These issues make it necessary for Medicaid to exert payer controls up to and including the placing of limits on inappropriate prescribing patterns, monitoring of pain management clinics for evidence of overprescribing of opioids, and monitoring for drugs that may be both prescribed and dispensed or administered at the same location.

**State Levers for Change**

Varying influences, state agency structures, and the uniqueness of each state create a wide array of program designs, authorities, and limitations within each. The impact of these dynamics and variances are undeniably important in addressing the public health epidemic of prescription drug abuse and overdose. To develop an effective response to prescription drug abuse, states need accurate and timely information about the incidence and scope of the problem within their own state. In order for interventions to be targeted for greatest effect, states need to know the drivers of drug abuse rates in their population and which demographics are at greatest risk of overdose. However, many state statutes have restricted access to opioid information (e.g., prescription drug monitoring program data) and, therefore, cannot fully analyze data sufficiently to inform the decision-making processes. Also, states need strong enforcement tools and meaningful ways to intervene with consumers and providers to ensure these efforts are successful.

**Claims Processing and Data Mining Capabilities**

Medicaid agencies may have challenges in pharmacy claims system management relating to prescription drugs. As prescribing guidelines and prior authorization criteria around opioid usage increase, systems must also mature in their ability to ensure that these quantity limits are followed in real-time point of sale pharmacy systems. While a number of states have adopted a maximum MED of 120 units, patients may be receiving concurrent prescriptions for both long and short acting opioids that contain differing amounts of opioids. State Medicaid management information systems (MMIS) and claims processing systems must be able to calculate these units to appropriately approve or deny prescriptions. Necessary system enhancements can be delayed in development and implementation by other organizational priorities or mandates. Similarly, states that operate managed care models must ensure that MCO pharmacy benefit managers (PBMs) maintain these capacities for consistent application of coverage and utilization control policies. Improved contracting language between MCO PBMs and pharmacies can create incentives to better manage prescribers who exceed acceptable standards of opioid prescribing. In these situations, PBMs, MCOs, pharmacies, and Medicaid agencies can drive more accountable prescribing.

Additional issues of overall data integrity arise when states are challenged by outdated or non-interoperable computer systems. While some state programs have begun more
sophisticated analyses of paid claims by managed care recipient for potential referral to lock-in programs, states are often limited in their ability to further mine data for suspected abuse because they do not receive sufficient information about denied claims in order to identify persons with drug seeking behaviors that would be appropriate for lock-in programs. Challenges with cash-only prescriptions and a frequent lack of data reporting from methadone clinics were also cited as “holes” in data initiatives.

These limitations thwart efforts to identify individuals who are potentially pharmacy shopping. For example, an inability to see denied MCO pharmacy claims, prescribing provider type, or the untimely delivery of claims information to health plans with drug carve-out situations hampers the ability for the plan to manage the “whole person”. As a result, analyses designed for patient and provider profiling are hindered by the system’s inability to capture and analyze claims data to identify outlier prescribing or usage patterns. States need access to meaningful data, to support evidence-based decisions about program enhancement, and identify issues within their state.

Most states also lack the capability to deny duplicate payment for claims submitted through physician’s offices and dispensed through a retail community pharmacy or to apply quantity limits or utilization controls on these prescriptions. This creates a scenario in which a patient may receive an injection or dispensing of a medication and then go to a retail pharmacy to fill a prescription for quantities outside of prescribing guidelines with no electronic means of identifying this duplication and denying the claim at the retail pharmacy. Furthermore, data limitations are further confounded when Medicaid agencies are unable to restrict or monitor prescription transactions in which the recipient pays cash and circumvents state system edits. Cash payments enable Medicaid enrollees to avoid detection by Medicaid Drug Utilization Review systems and to avoid targeting by Medicaid lock-in programs in which patients are limited to a single prescriber and/or pharmacy. With access to sources of payment information, state Medicaid programs could better detect “doctor shopping”, place these individuals in lock-in programs, and monitor compliance.

State Medicaid agencies may benefit from learning about processes used among private payers in developing multi-sector approaches to claims surveillance and interventions. “At Wellpoint, a private health benefit company, a comprehensive internal mechanism has been developed that proactively identifies members suspected of inappropriate use of pharmacy or medical benefits. Once identified, each case is carefully researched, the member and the healthcare provider involved are contacted, and subsequent interventions can range from provider and patient education, to addiction treatment services, and involvement of law enforcement if necessary.”

**Prescription Drug Monitoring Programs**

Although most states operate lock-in programs, a major theme within the literature review and in expert interviews is the limited access to and quality of data available to Medicaid agencies of prescription claims contained in state PDMPs. These programs are run through different state agencies, including state boards of pharmacy and public health agencies, to store and distribute information about prescriptions written and filled for controlled substances in an effort to limit their diversion and abuse. Although wide
variances exist among states in program requirements, functionality, and information sharing capacity, the tool is meant to help healthcare providers and pharmacies provide better patient care by managing their prescriptions.

Due to state-specific PDMP enabling laws, the ability of Medicaid agencies to access PDMP information varies widely. A select number of states, including Oklahoma and Washington, allow Medicaid officials to access PDMPs and the data contained therein – although sometimes there are limitations to that access. For example, states may not be able to access prescriber data, but only consumer information. Dr. Shellie Keast, from the University of Oklahoma’s College of Pharmacy, which supports SoonerCare pharmacy operations, stresses that collaboration between agencies, insurers, and other stakeholders is critical. Data and information sharing will become crucial going forward for monitoring and prevention of opioid abuse. As part of a larger state initiative, she believes that the Medicaid agency is ideally positioned to leverage collaborative efforts with other state agencies in the development of documents and best practice guidelines for intrastate work.

Emerging Prescribing Trends

Although the focus of many efforts is largely directed at opioid prescribing and abuse, other prescribing trends warrant similar concern and the need for increased state surveillance and possible intervention by Medicaid agencies. For example, while physicians and other healthcare providers wrote approximately 11 million fewer prescriptions for narcotic painkillers in 2013, representing about a 5% decrease from 2012 when 241 million were written, data illustrate an increased use of tranquilizers and weaker opioids such as tramadol (i.e., Ultram®). This may suggest that Americans are mixing their narcotics and trying new and potentially dangerous combinations.

For example, a January 2014 analysis of benzodiazepine usage among Oregon’s Medicaid population found that 37.5% of patients utilizing benzodiazepines used them longer than 90 days despite little clinical evidence to support use for longer than eight weeks. The mean length of use in Oregon’s data was approximately eight and one-half months.

While opioids are the most frequently abused prescription drugs and have the highest incidence of overdose, states also recognize that other powerful drugs are also being overprescribed and are exacerbating prescription drug abuse problems. Drugs used to treat attention deficit hyperactivity disorder (ADHD), anxiety, and sleep disorders have become increasingly problematic in both diversion and addiction. Between 2005 and 2010 the number of ED visits related to ADHD stimulant medications that involved nonmedical use more than tripled, with those involving adverse reactions increasing by more than 80%. Nearly half (45%) of ED visits during this period involved other pharmacological drugs in addition to ADHD stimulant medications and about one-fifth involved illicit drugs (21%) or alcohol (19%). As a result, states are challenged to address a growing list of medications that contribute to abuse, diversion, and cost-containment concerns. State Medicaid programs should find ways to tap law enforcement and other information resources to stay abreast of these trends. Similar surveillance activities can then be applied to emerging behaviors and prior authorization criteria and prescriber education can be adapted.

Leveraging Existing Efforts

Most states can cite some specific examples of progress. Many health plans, including Medicaid managed care, are implementing a wide-range of targeted programs for beneficiaries and
providers. As discussed in the section on Data Mining, plans may already be engaged in tracking efforts, and plans have described a host of diversion and prevention programs. Further, law enforcement, public health and addiction agencies may be engaged in efforts to stem the growing trends of prescription drug abuse. Medicaid agencies can be an important mobilizing force in supporting the adoption and spread of such programs. Tapping the power of policy change, data analytics and payment incentives for plans and providers will accelerate others' efforts and Medicaid's own initiatives.

These multiple contributing factors have resulted in a difficult challenge between treatment of underlying conditions such as chronic pain and prevention of abuse, addiction, and diversion. However, tools that can be leveraged and strategies that can be implemented to address these contributing factors are available.
Levers to Support Reform Efforts

As Medicaid agencies recognize the growing urgency to reduce and prevent prescription drug abuse and overdose, numerous federal opportunities can be leveraged to support state efforts. Whether states choose to take advantage of one or all of these opportunities, each offers potential benefits for addressing prescription drug abuse.

Expansion of Covered Populations and/or Covered Medicaid Benefits

The inclusion of treatment for SUDs as an essential health benefit represents a significant opportunity for states in their efforts to prevent prescription abuse and overdose among new expansion populations. Federal funds can be leveraged to pay for Medicaid-covered benefits as included in Medicaid State Plans or under a waiver of the plan for single adults. Increased access to treatment for SUDs would be available to new Medicaid-eligible members. Likewise, Medicaid agencies can expand the array of covered services, including SUD treatment services, through an amendment to State Plan and/or under a waiver of the plan, thus being able to benefit from federal match.

Provider Enrollment and Monitoring

Section 6401 of the Affordable Care Act (ACA) significantly increases requirements of Medicaid agencies to establish procedures to screen providers of medical or other items or service and suppliers in order to prevent FWA. Federal regulations at 42 CFR 455.410 and 455.450 require that all participating Medicaid providers be screened according to their categorical risk level, upon initial enrollment, and at re-enrollment or revalidation of enrollment. Section 444.410 requires that all ordering and referring physicians and other professionals providing services under the Medicaid State Plan or under a waiver of the plan be enrolled as participating providers. These requirements will support state efforts in provider monitoring as a prescription drug abuse prevention strategy.
Pharmacy Lock-In Programs
Most states have developed pharmacy lock-in programs under 42 CFR 431.54(e) that allow Medicaid agencies to implement restriction programs for individuals identified as being appropriate based on their utilization patterns. These restrictions often take the form of “locking in” an enrollee to a single pharmacy and/or prescribing provider. The criteria used to identify candidates for lock-in vary from simple numeric thresholds to an extensive list of criteria that include a wide variety of behaviors indicative of overutilization or fraud.12

Promotion of Health Homes
Under Section 2703 of the ACA, states are incentivized to transform primary care delivery and enhance care coordination through development of health homes. By providing a comprehensive system of care coordination for Medicaid recipients with chronic conditions and tailoring models and interventions specific to persons at-risk of or already abusing prescription drugs, Medicaid agencies can more effectively coordinate care to prevent abuse and identify and treat addictions. Through this legislation, states have the flexibility to target programs based on disease, state, and/or geographic area while obtaining a 90% federal match for eight quarters.

Parity in Treatment of Mental Health and SUDs
Although Medicaid agencies await regulations from the Centers for Medicare & Medicaid Services (CMS) to assist in their implementation of requirements of the Mental Health Parity and Addiction Equity Act of 2008, this new era of on-par access to mental health and SUD treatment represents enormous opportunities for Medicaid agencies to shape policy in the treatment of addiction to prescription drugs and the prevention of overdose due to addiction.

However, future Medicaid parity requirements may also present challenges as states try to impact prescription drug abuse and overdose. If the current parity rules are applied directly to Medicaid, both quantitative and non-quantitative limits must be diagnostic neutral in order to align with the current parity rules. For example, management of narcotics and other potentially abused medications used for the treatment of medical conditions is acceptable; the use of opioids for the treatment of pain is not a parity issue (e.g., methadone for pain). However, management of narcotics and other potentially abused medications to treat mental health or substance use conditions must be managed consistent with parity rules (e.g., methadone for addiction).

Integration of other Clinical Specialists and Support
States will be required to define their 340B drug purchasing and dispensing fee structures in their State Plans under proposed changes in rules governing Medicaid outpatient drug reimbursement. States could use this opportunity to obtain Medicaid support for the involvement of an integrated clinical pharmacist in primary care settings to work with high-risk pain patients and to provide Medication Therapy Management (MTM) and counseling through the 340B entities. For example, states could develop requirements for MTM services for all individuals receiving opioid prescriptions through federally-qualified health centers (FQHCs) and incent
patient counseling by clinical pharmacists for persons identified as at-risk through screening and assessment tools. These activities could assist with overdose prevention efforts.

Medicaid also supports face-to-face consultations by pharmacists prior to patients being discharged from inpatient settings with opioids for post-operative pain management. Through this mechanism, Medicaid can be an active catalyst in promoting patient education about the highly addictive nature of opioids. As the clinical role of pharmacists expands, prescribers can benefit from having a medication expert as a collaborator, especially when potentially dangerous and addictive medications are involved.

Primary care settings report that productivity demands, reimbursement limitations, and other financial constraints can limit the time and availability of other support staff to devote to opioid risk management. To the extent that Medicaid fee-for-service programs and MCOs can encourage, promote, and incentivize these types of patient-clinical pharmacist interactions and consultations through payment reforms, the benefits in preventing prescription drug abuse, diversion, and overdose could be significant. Additionally, through contract provisions, Medicaid agencies possess the leverage to require Medicaid MCOs to employ clinical pharmacists for the provision of consultation and education to providers on best practices for controlled substance prescribing.

The use of an “embedded” psychologist is another approach being implemented that is reimbursable by Medicaid. When a physician prescribes pain medication, the individual is also referred to the psychologist to learn pain management techniques. The goal is, while the individual is taking the medication, he/she is also learning alternative techniques, so when the individual is weaned off the medication, these skills will be in place. From initiation of the medication, whenever possible, there is a “discharge” plan from pain medication developed.

Inclusion of other clinical and support specialists on the treatment team could also be considered and may be amenable to payer support, including case management and promotion of non-pharmacologic therapies such as acupuncture, massage, and health/wellness classes. Together these ancillary providers may help in shifting the focus away from prescribing opioids as a primary or exclusive means of pain relief.

**Screening for Co-Occurring Behavioral Health Conditions**

In 2008, Medicaid ("H"), Medicare ("G"), and current procedural terminology codes designed specifically to reimburse for SUD screening and brief interventions (e.g., Screening, Brief Intervention, and Referral to Treatment [SBIRT] models) became effective. These screening tools incentivize healthcare providers in primary care settings and EDs to proactively assess for risky or problematic substance use so intervention and/or treatment can be initiated. Detection of substance use risks through automatable processes at the payer level can also provide healthcare providers with useful information about their patients without increasing the prescriber's burden. These practices align with national prescription drug abuse prevention goals, which identify screening and detection tools as essential components of a public health approach to drug abuse. These interventions are key prevention tools that can be incented through payment reform and medical home models.
Recommendations

Based on the available research, interviews with key informants, professional experience, and the current Medicaid environment, this section identifies actionable approaches and strategies for Medicaid agencies. Recommendations are organized into six overarching strategies:

• Medicaid infrastructure – actions state Medicaid agencies can implement for a foundation to support larger systems movement.
• Proactive prevention measures – steps to prevent prescription drug misuse, abuse, and overdose.
• Active monitoring and surveillance – strategies to assist Medicaid agencies to promptly identify potentially problematic prescribing or use so affirmative action can be taken.
• Efficient and effective treatment of addiction – activities aimed to facilitate access and availability to evidence-based best practices.
• Cross-agency collaborative efforts – recommendations that require support and/or involvement of other state agencies and stakeholders.
• Collaboration with Medicaid agencies from other states – actions requiring collective support or multiple Medicaid agencies.

Within each strategy, recommendations are prioritized after consideration of the (a) level of effort required for implementation, (b) potential for return on investment, and (c) opportunity to promote change. Specific examples of recommendations implementations are also provided.

These recommendations will help state Medicaid agencies in making both strategic and operational decisions in addressing prescription drug abuse and overdose. By incorporating recommendations across the six strategies, states can reasonably expect to bring about a reduction in prescription drug abuse and overdose, resulting in an overall reduction in healthcare expenses and an improvement in the health outcomes of Medicaid beneficiaries.

Medicaid Infrastructure

1. Leverage Medicaid’s role as payer in both fee-for-service and capitated arrangements to improve systems and controls by strengthening provider agreements and/or managed care contracts.

Examples

• Language in provider agreements and MCO contracts can be strengthened and effectively used to:
  — Require providers to access their state PDMPs as a condition of provider agreement and payment, as allowed by current PDMP state rules, especially under specific circumstances such as early refills and extended duration of therapy. See Recommendations Active Monitoring and Surveillance #2 for additional information.
  — Require PDMP participation for all enrolled pharmacy providers.
  — Address inconsistencies in clinical practice and the adoption of evidence-based approaches.
  — Address concerns with access to needed services for pain management or SUD treatment.
Examples

- Performance guarantees or incentives can be incorporated into provider and/or MCO contracts to drive system change, integration of services, and unified care plans for individuals with co-occurring conditions.
  - States can require a percentage of administrative dollars within the capitated rate be at risk and dependent on reaching established performance benchmarks related to treatment (e.g., include the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 2014 Healthcare Effectiveness Data and Information Set measure in MCO contracts).
- Incorporate SUD treatment financial incentives into provider contracts (e.g., Medicaid agencies or their contracted MCO, could include 7 day and 30 day ambulatory follow up after discharge from the American Society of Addiction Medicines [ASAM] level of care into provider contracts).
- In states with managed care, Medicaid agencies can require strong contracting language between MCO PBMs and pharmacies to better manage prescribers who exceed acceptable standards of opioid prescribing to drive more accountable prescribing.
- Utilize pharmacy claims history review and other program information to identify and evaluate selection of risk assessment categories for provider enrollment and contract renewals (i.e., prescriber outliers into highest risk category undergo most stringent screening for contract renewal).

2. Invest in needed technology enhancements for MMIS and claims processing systems.

Examples

- Develop or enhance system capacity, in both fee-for-service (FFS) and/or MCO PBM arenas, to use MED calculation in editing to approve or deny claims, trigger prior authorization, and tie to drug utilization review (DUR) reporting functions.
- Enhance the capabilities of real-time DUR and point-of-service administrative and therapeutic edits in a manner that is diagnosis neutral and consistent with federal guidance.
  - Utilize quantity restrictions to ensure appropriate and efficient dosing of all medications, with particular emphasis on scheduled drugs.
  - Prevent automatic or early refills for commonly misused medications and require patient-provider interaction prior to refill of those prescriptions.
  - Develop capability for analysis of denied claims based on therapeutic edits to identify patterns in prescriber and enrollee behaviors.
  - Implement prior authorization requirements for long-term use of short-acting opioids.
  - Implement criteria to review and restrict the concomitant use of opioid analgesics with other sedative drugs, including benzodiazepines, which could increase the respiratory risks associated with both drug classes.
  - Consider the implementation of step therapy requirements for non-preferred pharmacological agents.
3. **Leverage federal funds to pay for Medicaid reimbursable SUD treatment benefits and to support integrated, coordinated care for individuals with co-occurring disorders.**

**Examples**

- Identify ASAM levels of care not currently incorporated into the Medicaid State Plan and/or under a waiver of the plan that should be potentially added. Options include:
  - Obtain rehabilitation option authority to fund the entire array of ASAM outpatient and residential levels of care, peer support services, medication assisted therapy (MAT), and other recovery-oriented addiction treatment services. For example, Delaware recently received CMS approval to amend its State Plan to include a full array of outpatient and residential SUD levels of care using the rehabilitation option of its State Plan, including:
    - Use 1915(i) or 1115 demonstration home- and community-based services (HCBS) authority to fund services and supports for individuals recovering from addictions who have functional deficits.
- Medicaid eligibility can be expanded to populations meeting institutional financial eligibility through HCBS authority or to new populations such as childless adults.
- Utilize managed care treatment planning authority to have MCOs screen, assess, and manage target populations such as substance abusing pregnant women, individuals with co-occurring diagnoses, and IV-drug users (e.g., Kansas, Iowa, Louisiana, North Carolina).
- Utilize targeted case management authority to provide care management for individuals with SUD.
- Increase use of person-centered medical homes and/or health home to target individuals at risk of or already abusing prescription drugs with program designs specific to mental health and/or SUD treatment.

4. **Identify opportunities to support innovative, emerging approaches to address prescription drug misuse, abuse, and overdose within the Medicaid program.**

**Examples**

- Facilitate testing of pilot and demonstration projects that include clearly-defined baseline measures, goals, and evaluation criteria. Consider ease of replication and scalability.
- Support provider and/or MCO efforts to design, tailor, and test interventions to respond to targeted sub-populations (e.g., youth, incarcerated individuals upon re-entry) or unique challenges (e.g., remote regions).

**Proactive Prevention Measures**

1. **Invest in provider education, both broad-based as well as targeted, as a prevention mechanism and to address inconsistencies in clinical practice and to promote evidence-based practices.**

   Education efforts should include more than just physicians – as primary care nurses and other practitioners may be prescribers or well-situated to identify risky behaviors and the need for prevention.
Examples

- Develop and disseminate best-practice clinical guidelines targeting: (a) CNP management; (b) the use of stimulant medications in ADHD; and (c) the use of anxiolytics, sedatives, and hypnotics.
  - Washington developed an Emergency Department Opioid Abuse Work Group, sponsored by the Washington State Department of Health, to develop a set of ED opioid prescribing guidelines and a series of guidelines for opioid use in the treatment of CNP.

- Provide education to enrolled providers regarding best practices for pain management therapy and/or the safe use of opioid medications.
  - SAMHSA has recently updated its Opioid Overdose Prevention Toolkit, which provides information for first responders and treatment providers available at http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742.

- Adopt the American Academy of Pain Medicine’s recommendations regarding the use of opioids for the treatment of chronic pain which includes, but is not limited to:
  - Thorough review of every patient’s medical history, including baseline urine drug screens (UDS).
  - Documented treatment plan including actionable pain contracts, step therapy (non-pharmacological therapies, non-opioid medications, short-acting opioid trials), and mandatory periodic screenings and evaluations, including UDS.
  - Coordinated care plans involving primary care provider, specialist providers, pharmacists, and behavioral health practitioners.
  - Frequent, mandatory face-to-face evaluations. CIII–CV prescriptions should be valid for only six months, and patients should be seen by provider for each additional prescription renewal (or more frequently).
  - Limit utilization of short-acting opioids to treatment of acute and breakthrough pain. Long-acting formulations should be the foundation of chronic opioid analgesic treatment.
  - Evaluate potential requirements for concomitant non-pharmacological therapies with all chronic opioid regimens (e.g., physical manipulation, physical therapy, occupational therapy, cognitive behavioral therapy [CBT]) based on recognition that treatment with opioids alone is not a best practice for non-terminal, non-cancer pain patients.

- Promote learning collaboratives for providers and payers to foster best practices specific to prescription drug abuse screening, prevention, and treatment.
  - Learning collaboratives, similar to those facilitated by the CMS Comprehensive Primary Care Initiative, can foster best practices specifically focused on prescription drug abuse screening, prevention, and treatment.
  - Promoting provider and multipayer forums not only share best practices and learned experiences, but lead to innovation in practice and prevention approaches while promoting cross-sector collaboration and engagement.
2. **Apply recommendations for daily maximum of 120 mg morphine equivalent dosing for chronic non-cancer, non-terminal patients.**

This threshold can be established with protocols that allow prescribers to request authorization to go beyond these limits. An evidence-based dosing threshold with provider buy-in and academic backing would provide states and others with a strong tool to prevent and reduce misuse.

Although this guideline is not binding, and providers maintain clinical autonomy, prescribers should be aware that exceeding recommended dosing subjects their prescribing patterns to review.

**Examples**

- Washington State has developed an Opioid Dose Calculator available in downloadable, web-based and mobile applications at [http://agencymeddirectors.wa.gov/mobile.html](http://agencymeddirectors.wa.gov/mobile.html).

3. **Promote coordinated care, early detection, and early intervention of potential prescription drug abuse.**

**Examples**

- Require incorporation of SBIRT model screening tools in primary care and ED settings to better detect risky and/or problematic substance use patterns.

- Person-centered medical homes and/or health homes should include timely access to mental health and SUD services.
  - Identification and treatment of co-occurring mental health conditions such as depression, anxiety, and post-traumatic stress disorder or SUDs can increase the effectiveness of pain management and decrease risks for abuse and addiction.


4. **Encourage DUR boards to develop prospective edits and retrospective reviews to address potential overutilization of prescription drugs.**

**Examples**

- Align prospective drug utilization review (ProDUR) and retrospective analysis of historical claims (RetroDUR) functions with MMIS and claims processing systems, as discussed in Recommendations Medicaid Infrastructure #2.
5. **Facilitate access to and the use of certified chronic pain centers.**

**Examples**

- Identify and support access to certified chronic pain centers with (a) documented policies and procedures to limit excessive dosing, such as well-defined pain contracts, early fill policies, and drug testing programs; (b) established connections to primary care provider offices and coordination of care; and (c) staff with American Board of Internal Medicine certification (i.e., neurology, anesthesia, or who have attended a fellowship in pain management).

6. **Improve and expand both coverage of and access to non-pharmacological interventions for CNP derived from functional assessments and self-reporting of pain as a preventive measure.**

**Examples**

- Consider requiring alternative pain treatment modalities including exercise therapy, fitness programs, and other physical rehabilitation approaches before approval of opioids as primary treatment for CNP.
- MaineCare implemented restrictions on opioids that require many patients to seek alternative pain management treatment as well as limitations in the amount of painkillers that can be prescribed.

7. **Support expansion of the clinical pharmacist’s role in pharmaceutical pain management to assist in the prevention and reduction of prescription abuse and misuse.**

**Examples**

- Incentivize use of SBIRT models by community pharmacists, in conjunction with nominal reimbursement for interventions and addiction MTM counseling. As the healthcare provider with frequent face-to-face interactions with patients and the most training around medication safety, pharmacists are ideally positioned to assist with state SBIRT efforts.

**Active Monitoring and Surveillance**

1. **Monitor and address potentially excessive or problematic patient use of opioid or related prescription drug products.**

**Examples**

- Identify and monitor prescription utilization for individuals who are utilizing multiple pharmacy providers with or without the multiple prescribers.
Examples

- Utilize retrospective claims review to identify and review aberrant utilization and prescribing. Use all available data, including other insurance paid claims such as Medicare Part D if available, to flag patients. Examples of patterns to identify and review may include:
  - Patients being prescribed above 120 MED daily dose of opioid analgesic and who are not in hospice, being treated in a long-term care facility, or diagnosed with conditions such as sickle cell anemia, cancer or human immunodeficiency virus/acquired immunodeficiency syndrome. These individuals may need a referral to a qualified pain specialist and/or a lock-in program. Washington State is an example of this practice. Information about their program is available at http://www.agencymeddirectors.wa.gov/opioiddosing.asp.
  - Potential therapeutic duplication, which may indicate FWA (e.g., greater than four opioid analgesic prescriptions within 30 days).
  - Potentially excessive quantities for short- and long-acting opioid pain medications in the treatment of CNP. Patients requiring consistent supplementation of long-acting therapy with short-acting doses, due to increased pain or hyperalgesia, should receive increased dosing of long-acting products rather than high monthly quantities of short-acting formulations.
  - Concomitant use of buprenorphine products with potentially abused drugs such as benzodiazepines, opioid and opioid-like analgesics, and muscle relaxants.

- Facilitate access and strongly encourage Opioid Treatment Program (OTP) providers to monitor the PDMP for the presence of potentially abused medications that are not an approved component of the patient’s treatment plan.

- Evaluate claims to identify patients attempting to fill or having prescriptions for potentially abused medications dispensed from multiple pharmacies (pharmacy shoppers). These patients may warrant referral to the state’s “lock-in” program if they are a Medicaid recipient.

2. Maximize value from PDMPs.

   See recommendations on Cross-Agency Collaborative Efforts if Medicaid does not have access to, or only limited access to, PDMPs or if there are other challenges with the PDMP.

Examples

- Create a real-time data infrastructure between pharmacy point-of-sale systems and PDMP, including cash transactions.

- Ensure PDMP accessibility for all necessary stakeholders, including prescribers, pharmacies, and appropriate Medicaid clinical staff that allows real-time access.

- Utilize PDMP data to determine if Medicaid enrollees are filling opioid prescriptions outside of the Medicaid benefit (e.g., cash payment) and/or at polypharmaceutical risk.

- Utilize the PDMP data to identify payment information for prescription drug claims, potential doctor shoppers and assist in the placement of enrollees into lock-in programs and compliance monitoring.

3. Monitor, using paid claims and other data, for potential signs of aberrant provider prescribing or pharmacy patterns.

Examples

- Monitor pain management clinics for evidence of overprescribing of opioids, including drugs that may be both prescribed by the provider and also dispensed or administered at the provider location.

- Monitor individual prescribers at pain clinics and review the prescribing patterns of physicians who are not board certified pain specialists to identify potentially inappropriate prescribing patterns.
Examples

• Utilize top prescribers’ lists and algorithms to identify the top prescribers by number and percentage of controlled substance claims as done in Tennessee, Oklahoma, and other states to develop interventions accordingly.

• Routinely review prescribing patterns of providers suspected to be over prescribing drugs of potential abuse, including reviewing providers that appear to require cash payment at time of service by patients and who generally do not contract with third-party payers.

• Monitor prescribing patterns of providers identified to have a high volume of patients who are chronic users of high dose opioids, especially those patients attempting to fill prescriptions after they have been through the prior authorization process.

• Evaluate denied claims for opioids to identify outlier provider prescribing patterns and potential cash payments for prescriptions written under Medicaid paid prescriber.

• Ensure communication between pharmacy program and Medicaid agency staff responsible for monitoring alerts from CMS on provider terminations, including deceased or sanctioned providers, for timely provider file maintenance.

• Develop audit plans to review past prescribing, dispensing, and/or billing practices of prescribers and pharmacies.

• Develop routine and frequent audit reporting functions by PBM or MMIS administrator that provides actionable information on suspect pharmacy dispensing and billing practices of opioids.
  – Review audit reports to identify and refer pharmacies for formal audit or investigation when indicated (e.g., unauthorized refills, old prescription retention, dispensed more than authorized, drug billed different than drug dispensed, correct national drug codes for actual product/size dispensed, correct units, correct prescriber's ID, clients paying cash).

4. Establish or enhance lock-in programs to assist in the management and monitoring of recipients identified as high utilizers of narcotics.

Examples

• Develop specific administrative rules for lock-in enrollees.

• Support lock-in programs with a treatment component that addresses development of alternative pain management skills and/or treatment of the addiction.

• Ensure that MCOs operating their own lock-in programs are effectively coordinating their lock-in criteria and patient management with the state Medicaid program.
  – Require MCOs to provide state Medicaid agency with information on denied claims to assist in monitoring and surveillance of suspected abuse.
  – Ensure consistent and uniform prior authorization controls or quantity limits for opioids among managed care plans.
5. **Utilize clinical pharmacist resources to assist in evaluating prescribing and utilization patterns against evidence-based practice for both opioids and non-opioid products.**

**Examples**
- Deploy similar surveillance activities to target other types of prescriptions that are commonly abused, including the development of prior authorization criteria and prescriber education, as is being done at several FQHCs in Oregon.

### Efficient and Effective Treatment of Addiction

1. **Optimize timely access to SUD services, including MAT.**

**Examples**
- If prior authorization is used, mandate short preauthorization/concurrent authorization turnaround times for all levels of care and use of MAT.
- Prohibit “step therapy” criteria as requisite for MAT eligibility.

2. **Appropriately treat comorbid, chronic pain when present.**

   The inter-relationship between addiction and pain, which frequently are present together, makes treatment of both conditions more challenging. Both conditions must be optimally managed in order to achieve desired results.

**Examples**
- Require multidisciplinary treatment teams, including addiction specialists and pain management specialists, to collaborate when determining appropriate treatment settings and interventions for patients with co-occurring addiction and chronic pain conditions.
- Develop and disseminate guidelines for providers for the treatment of co-occurring addiction and chronic pain conditions. Differences in pain tolerance, medication dosing, and potential drug-drug interactions should be considered. For example, buprenorphine/naloxone products can decrease the efficacy of opioid analgesics at typical doses. Guidelines could:
  - Educate providers on SAMHSA guidelines, which state patients receiving methadone or buprenorphine MAT for SUDs are not prohibited from receiving additional pharmacological treatment for pain, including additional opioids when necessary.
  - Reinforce that, although concomitant use of methadone/buprenorphine with other commonly abused medications (such as opioids, benzodiazepines, and muscle relaxants) is not expressly prohibited, such utilization should be avoided when other treatment modalities are reasonable and appropriate. When a patient requires both MAT and treatment with these commonly abused and misused drugs, active monitoring and therapy management are essential in order to mitigate the risk of potential abuse and misuse.

3. **Promote quality, outcomes-driven SUD services.**

**Examples**
- Develop SUD-related quality improvement projects/performance improvement projects with MCOs (e.g., provider fidelity audits or the creation of a learning collaborative for network MAT providers).
4. **Support access to Nalaxone for persons with opioid addictions and provide education regarding its usage.**

A CDC report summarizing the efficacy of community naloxone distribution programs in 15 states reports that more than 10,000 opioid overdoses have been successfully reversed through the administration of naloxone provided by these programs available at [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm).

### Examples

- In June of 2014, the New Mexico Human Services Department announced that the state’s Medicaid program, Centennial Care, would begin covering naloxone rescue kits for beneficiaries at risk for opioid overdose.35
  - New Mexico has also expanded prescriptive authorities for pharmacists, who are being trained to both issue and fill prescriptions for naloxone to at-risk patients.

- The Rhode Island Board of Pharmacy, in conjunction with Walgreens and a local physician, allows anyone to walk into a Walgreens pharmacy and receive a filled prescription for naloxone, along with education regarding its use. The collaborative practice agreement functions by taking the single physician’s blanket order to dispense naloxone to any patient who requests it.36
  - CVS has also begun participation in the program, expecting to offer naltrexone to patients in all Rhode Island locations by August 31, 2014.37
  - Although Rhode Island Medicaid covers methadone and buprenorphine products, as well as injectable Vivitol (naltrexone), naloxone is not covered by the current prescription benefit.38
  - Five other states also allow naloxone to be dispensed by a pharmacist without a prescription from a physician: Washington, New Mexico, New York, Vermont, and California.39
Cross-Agency Collaborative Efforts

1. **Introduce and participate in a larger partnership effort to impact prescription drug abuse and overdose.**

   **Examples**
   - Take lead to convene a task force to design and implement a multi-pronged strategy to decrease the use of opioid pain medication for CNP.
   - Establish and participate in a collaborative interagency task force comprised of other state agencies (and Pain Commissions), payers, providers, and consumers to develop state-specific data collection, surveillance, and intervention programs.
     - Include subject matter experts in the fields of pharmacy, primary care, pain management, mental health, SUDs, and public health. Consider law enforcement and legislative representation.
     - Maintain a public health focus, with primary goals targeted on the dissemination of information and guidance to key stakeholders and the implementation of actionable, evidence-based reform.
     - Consider regional subcommittees focused on addressing issues and extending services to specific communities.
       - The Washington collaborative task force led the implementation of a Good Samaritan law, which protects individuals receiving treatment for an overdose from prosecution for drug possession charges, and affords similar protections to individuals who refer or assist users in receiving such treatments.
       - Maryland has taken a regional approach, in which the Department of Health and Mental Hygiene coordinates and directs local initiatives such as data collection and sharing, comprehensive prevention plans, and needs assessments.
       - Ohio has a multi-tiered collaborative partnership involving state government, community-based task forces, and five professional work groups. The five work groups in Ohio’s program each maintain a distinct focus: enforcement, professional education, public education, recovery, and treatment. In addition, Ohio has established 23 local task forces, each tasked with targeting opioid abuse within their respective communities.

2. **Advocate for PDMP functionality.**

   **Examples**
   - In states where Medicaid does not have access to, or only limited access to PDMPs, state Medicaid directors should advocate directly with State Boards of Pharmacy and speak to receptive state legislators, when appropriate, to promote access, as this will facilitate state efforts to combat prescription drug abuse and as well as FWA.
   - In states where Medicaid has access to PDMPs, but data is incomplete or not in a usable format, state Medicaid directors should collaborate with other involved parties to implement enhancements that will facilitate state efforts to combat prescription drug abuse and as well as FWA.
   - Follow successful collaborative initiatives in Oklahoma, Washington State, and others to gain full access to PDMP data for monitoring purposes (e.g., Oklahoma which is available at [http://www.ok.gov/odmhsas/documents/Rx%20Abuse%20Prevention%20Plan.pdf](http://www.ok.gov/odmhsas/documents/Rx%20Abuse%20Prevention%20Plan.pdf)).
3. Partner with other state agencies in monitoring efforts.

**Examples**

- Develop relationships with key persons at state Office of Inspector General, Attorney General’s Office, or correlating agencies to establish process for tracking, monitoring, and prosecuting, as necessary, suspected cases of patient and prescriber fraud as is done in Tennessee.

- Create mechanisms with partner agencies for information sharing as is done in Tennessee that allows Medicaid to know about trends in diversion and geographic hot spots.

- Actively conduct prescriber and pharmacy provider maintenance.
  - For example, monitor sanctions and licensure status as well as death notices from state pharmacy and prescriber licensing boards and ensure MMIS downloads occur on a routine and frequent basis to remove providers from the payment system.
  - Ensure comprehensive screening process occurs for all participating Medicaid providers according to their categorical risk level, upon initial enrollment, re-enrolment, or revalidation of enrollment as required by law.

4. Require mandatory e-prescribing of CII–CV prescriptions to reduce opportunities for diversion, prescription errors, and fraud.

Electronic prescribing of controlled substances remains optional for states and likely requires changes or additions to State Plans and/or laws before policies can be implemented. Reasonable exceptions for emergency prescriptions could be allowed. Many states currently prohibit electronic prescribing of Schedule II medications. Drug Enforcement Administration Electronic Prescribing of Controlled Substances (DEA EPSCS) guidelines published in 2010 provide a framework and guidance for appropriate security and authentication methods for prescribers and pharmacies.

**Examples**

- Beginning in March of 2015, New York will mandate electronic transmission of all Schedule II through IV prescriptions, based on DEA ECPS guidelines.

- Electronic prescribing and the use of appropriate electronic health records (EHR) systems are required for providers seeking to obtain “meaningful use” designation by CMS.

- Medicare Part D requires drug plans to support electronic prescribing, including controlled substances, but the service remains optional for pharmacies and prescribers.

Collaboration with Medicaid Agencies from Other States

1. Advocate for a national network of PDMPs.

**Examples**

- Collectively state Medicaid directors represent leadership of one of the largest payer pools in the country. State Medicaid directors can use this influence to advocate for a national network of PDMPs, rather than stand-alone state databases. A national network of PDMPs would support interstate sharing of information and nationwide efforts to curb prescription drug abuse.
2. **Collaborate with and learn from other states’ Medicaid agencies.**

<table>
<thead>
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<th>Examples</th>
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<td>• Utilize shared and collective resources, such as the MED Project, to (a) expand in-house knowledge of evidence-based and promising practices in coverage and benefit design that minimizes opportunities for prescription abuse, and (b) design and implement standards for pharmacy and prescriber lock-in programs.</td>
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Current State Efforts and a Summary of the Literature

Provider Monitoring and State Level Surveillance Systems

Many states maintain a robust process for provider file maintenance. The importance of monitoring alerts from CMS of providers terminated for cause by Medicare or any Medicaid agency is vital in state prescription drug abuse prevention efforts. If this process is only done quarterly or semi-annually, prescribers may continue to provide services and write prescriptions for opioids or other medications that should not be covered by Medicaid. In addition, regular updates to eligible provider files allow states to prevent potential fraudulent use of a deceased provider’s medical license and Drug Enforcement Administration numbers.

Although often limited by staffing resources, some state programs actively monitor the activities of providers suspected to be running “pill mills”. This includes monitoring providers that require cash payment at time of service and which do not contract with third-party payers. States may monitor individual prescribers at pain clinics and review the prescribing patterns of physicians who are not board certified pain specialists to identify potentially inappropriate prescribing patterns.

Effective screening and identification of high-risk or outlier providers in a manner that is diagnosis neutral may prevent diversion and assist in monitoring of outlier prescribers of opioids and other frequently abused and diverted medications. Linking to Part D data when possible can supplement these prescribed medication monitoring efforts.

The Oregon Health Plan’s clinical pharmacy contractor recently completed an analysis that found, of patients who had been previously denied opioids due to reaching established high-dose limits, 29% continued to attempt to fill additional prescriptions. The presence of multiple denials for a single member suggests the possibility of cash transactions. Dr. Ted Williams from the Oregon State University College of Pharmacy’s Drug Use Research and Management Group, which supports the Oregon Health Plan, stresses the importance of looking at chronic users of high dose opioids, especially those individuals that are not going through the prior authorization process. He further suggests that evaluation of denied claims for opioids represents a significant opportunity to identify outlier providers. It is believed that state Medicaid agencies would benefit greatly from the ability to identify payment information for prescription drug claims reimbursed outside of Medicaid to better detect “doctor shopping” so restriction programs can be implemented when appropriate, SUD treatment can be pursued when indicated, and targeted monitoring can be used.

Oklahoma’s state PDMP is among the most robust in the nation, with mandated participation and rigid, time-sensitive requirements. Providers must report prescription activity to the PDMP within five minutes of dispensing a drug.

Washington State’s PDMP program allows access for Medicaid agency staff as long as they are licensed health care providers whose primary role is to coordinate and improve medical treatment for Medicaid recipients. They can request reports for individual patients and receive bulk data transfers of PDMP records for Medicaid recipients. This allows agency staff to identify all providers prescribing and dispensing to a particular recipient and to track methods of
payment. The PDMP data identifies pharmacies that accept cash payments for prescriptions duplicating those paid by Medicaid. These kinds of data analyses help state agency staff identify providers who are the most active opioid prescribers and those most likely to prescribe or dispense to patients paying cash for prescriptions. The Washington State program also allows sharing of this information with the state’s medical-dental assurance committee, which can pass the information on to the appropriate licensing board.

A review of Washington PDMP data for Medicaid enrollees in 2012 identified more than 2,000 individuals receiving Medicaid and cash-paid prescriptions for controlled substances on the same day. It also found 478 clients for whom cash and Medicaid prescriptions for the same drug were filled less than 10 days apart and from a different prescriber. Without the availability of PDMP data to the Medicaid agency, this activity would be difficult to identify, quantify, and address.  

While clearly some states are making progress with their PDMP systems, the consensus in the literature and among experts interviewed is that PDMPs will remain limited in their effectiveness until they meet a set of criteria, including: (a) the ability to be used as a real-time reporting tool; (b) mandated use by prescribers of narcotics and pharmacies; (c) the ability to capture payment type (i.e., cash); (d) access for Medicaid officials; and (e) border state interconnectivity or access. In 2010, the PDMP Center of Excellence reported that only 15 state PDMPs were permitted to provide data to state Medicaid agencies, and of those some Medicaid agencies only had limited access or the utility of that access was limited due to the sophistication of the PDMP system in the state. Most Medicaid pharmacy officials and their clinical contractors express a desire to have better access to PDMP data. For those who already have in-state access, they would find additional benefit in having access to neighboring states, especially when there are border cities that serve large numbers of out-of-state Medicaid recipients. Until this occurs, PDMPs will remain of limited value to Medicaid agencies in increasing their role in prescription drug abuse and overdose prevention by limiting the ability to better identify patients who are drug seeking and anomalous prescribing habits by prescribers. In order for PDMP information to be used to its fullest extent, it must be accessible. In 2011 the Obama Administration released an action plan to respond to this epidemic which included evaluating the potential for state PDMPs to reduce Medicare and Medicaid fraud.

When Medicaid agencies monitor claims data for controlled substances, they are typically only able to track data for providers reimbursed by Medicaid. This does not capture prescriptions to clients that may have been prescribed by non-Medicaid providers, or that may have been paid for in cash or by other third-party payers. This limits the ability of Medicaid programs to monitor the prescription behavior of its clients and; therefore, the effectiveness of lock-in programs.  

In both FFS and managed care environments, Medicaid agencies can deploy front end edits and utilization controls to help ensure appropriate usage of drugs prone to addiction and overdose. Melnikow et al, (2012) reported that Medicaid opioid users who had overlapping prescriptions (same drug type with more than 25% overlapping supply days) have approximately a three-fold increase in overdose risk. While utilization controls can be highly effective programs, careful consideration is required when restricting opioids to ensure that the controls do not discriminate on the basis of diagnosis. The overwhelming frequency of opioid scripts, the federal requirements for urgent use during after-hours, and issues of prescriber autonomy require discussion and careful planning. These include:
- Quantity limits that set a unit per day or month limit.
- Early refill edits (i.e., 80% or more of the medication must be used before refill is allowed).
- High dose limits for products that contain acetaminophen such as Vicodin®, Percocet®, and various other formulations of codeine/acetaminophen combinations.

Other utilization controls can be deployed to identify ingredient duplication limits for drugs like hydrocodone where different strengths of the same chemical entity have been prescribed concurrently. State DUR boards, unless states are legislatively prohibited from enacting step therapy, can be used to require short acting medications until the patient can tolerate longer acting and necessary higher doses as long as these interventions do not discriminate on the basis of diagnosis. In managed care environments, contract administration by staff with sufficient policy and clinical experience is necessary to ensure appropriate and consistent policies that will reduce potential for abuse and diversion, as well as to monitor compliance with those policies.

In states where behavioral health services and related medications are carved-out of physical heath managed care plans, Medicaid agencies and MCOs are further challenged to gather and coordinate prescribing information and utilization in a timely manner to help prevent potential abuse and diversion through the ProDUR process.

Tennessee Medicaid (TennCare) has taken additional steps to define “target pharmacies and prescribers” in administrative rule and has developed sophisticated claims monitoring algorithms to identify prescribers and pharmacies that may be appropriate for interventions. A targeted pharmacy in TennCare is defined as meeting one of the following criteria:

(a) Located outside the State of Tennessee.
(b) Previous controlled substance violations with the State Board of Pharmacy.
(c) Outlier to the norm in its dispensing of controlled substances.
(d) Filled controlled substance prescriptions that are covered by TennCare for members locked in to a different pharmacy after being notified that the member was locked in to a different pharmacy.

A targeted prescriber in TennCare administrative rule is defined as a prescriber with prescribing authority who is ranked as a top prescriber of controlled substances based on multiple factors which may include, but are not limited to any of the following:

(a) The percentage of controlled substances prescribed.
(b) The percentage of Schedule II controlled substances prescribed.
(c) The percentage of Schedule III controlled substances prescribed.
(d) The percentage of short-acting, single-ingredient opioids prescribed.
(e) The percentage of short-acting, combination product opioids prescribed.
(f) The percentage of long-acting opioids prescribed.
(g) The average morphine equivalents per day prescribed.
(h) The percentage of rejected claims of controlled substances.

The TennCare pharmacy staff use a comprehensive approach to their “Top Prescriber” list that includes no fewer than 11 variables that are evaluated on a points system utilizing a volume multiplier that clusters prescribers into 10 groups according to their ranking on volume of controlled substance prescriptions. The program design is rooted in evidence-based prescribing guidelines with sensitivities to the treatment of chronic pain with both long and short-acting
opioids as well as average morphine equivalents per day as a measure of the relative potency of opioid prescribing. As robust and impressive as this program is, Ray McIntyre, D.Ph., Director of Pharmacy Operations for TennCare, still humbly calls the algorithm very much of a work in progress and welcomes suggestions from other states and stakeholders.

This broad based approach allows staff to flag individual providers and pharmacies for monitoring. TennCare works closely with its Office of Inspector General (OIG) in tracking and prosecuting suspected cases of patient and prescriber fraud. This kind of collaboration among agencies has tangible effects on reducing the number of opioids being diverted. TennCare is a member of a provider fraud task force which includes members of various agencies and meets regularly to discuss cases to avoid duplication and overlap and foster transparency.

In Tennessee, doctor shopping, or using the state’s Medicaid benefits to go to multiple doctors in a short period of time to obtain controlled substances, is a Class E felony carrying a sentence of up to two years per charge. Class E doctor shopping is defined as receiving the same prescription from two doctors within 30 days without alerting the prescribers to the duplication. The OIG’s collaborative relationships with local law enforcement agencies make these kinds of investigations and information sharing possible. Inspector General Deborah Faulkner was recently quoted in an OIG press release as saying, “We are intent on eliminating this type of activity in TennCare. With the help of agencies like Metro Nashville police, we’re getting out in front of this problem as it relates to TennCare”.

Notably, a new tool was developed by the UC Davis Center for Healthcare Policy and Research in 2012 called the Approaches to Drug Overdose Prevention Analytical Tool (ADOPT) in response to a CDC request to examine the effectiveness of Medicaid lock-in programs. ADOPT, designed to help inform policy decisions regarding prevention of prescription drug overdose, is an Excel-based, micro-simulation model that simulates patterns of prescription opioid use by Medicaid recipients to evaluate associated health outcomes and cost. The model’s interactive features allow users to customize the population demographics and policy details, and perform a “what-if” analysis to project the outcomes of a specified policy within that population. Although implementation data is not yet available, this highly complex model warrants review and consideration by Medicaid agencies based on the user’s ability to simulate individual prescription consumption behavior not only to identify policy options but to summarize cost and health outcomes of simulated cohort groups based on calibration with MarketScan® data.

Patient Review and Restriction Programs — Lock-In
Individual states’ abilities to develop and maintain comprehensive lock-in programs vary by the resources committed in both staffing and funding. Lock-in criteria include both objective and subjective measures and reflect the specific needs of the state (e.g., address illicit sale of pharmaceuticals). It is noteworthy that most literature published relating to the effectiveness of lock-in programs focuses on cost avoidance of drugs, rather than the effectiveness of avoiding prescription drug abuse and overdose.

Effective lock-in programs include the expertise or assistance of clinical pharmacists and the Medicaid DUR committee in setting standards and controls for lock-in programs, including how to identify appropriate enrollee referrals and sharing of information consistent with all state and federal privacy laws. Some states, including Oklahoma and Oregon, contract with the colleges of pharmacy at their state universities for expert clinical support of their programs. Notably, Oklahoma’s efforts have resulted in decreases in overall utilization of narcotic medications and a
reduction in overall ED visits. Dr. Shellie Keast, from the University of Oklahoma College of Pharmacy which supports SoonerCare, reports that most doctors do not want to be caught in an abuse cycle and are thus receptive to information sharing. SoonerCare sends updates to providers of recipients identified as potentially doctor shopping and/or pharmacy shopping. SoonerCare also requires pain contracts for some recipients that have been documented as high utilizers of hydrocodone and alerts prescribers when patients are locked-in to a single specified pharmacy.26

TennCare’s administrative rules for locking-in enrollees include specific language about activities such as forging or altering prescriptions, selling TennCare paid prescriptions, trading, swapping, or selling a TennCare card, and failing to promptly report the loss or theft of a TennCare card or allowing anyone other than the intended enrollee to use it to receive or attempt to receive services. These actions are seen as not only justifiable reasons for the lock-in program but also for potential prior approval status, which is an automatic requirement for any enrollee for whom criminal process alleging TennCare fraud has been issued or who has been convicted of TennCare fraud.45 The OIG informs TennCare of intent to arrest and the member can then be automatically locked-in.

Lock-in programs have become the subject of increasing debate in recent years as states are developing more sophisticated methods for patient selection. Findings from the ADOPT model (2012) discussed previously found that less selective lock-in criteria demonstrate larger overall reductions in prescription opioid abuse and overdose, but have a small effect in reducing the average number of prescriptions per member. Conversely, the study suggests that “more selective criteria are less effective but more efficient in targeting the high-risk user and more likely to identify those actually misusing or abusing prescription opioids.”11

Coordinated Care through Medical/Health Homes

Because rates of prescription drug misuse and overdose are elevated in individuals that have co-occurring mental illness and/or have a history of substance abuse,2 access to and effective coordination of care is essential. The Patient-Centered Medical Home (PCMH) and the health home models serve as a mechanism to better integrate and coordinate care across multiple providers and when co-occurring physical and behavioral health conditions are present. Medical and health home models establish a care coordinator (can be a primary care provider in the medical home model) that oversees treatment for the patient and coordinates care with various specialty providers and services. Mental health and SUD treatment can be fully integrated into these models, but regardless of the level of integration, the care coordinator is responsible to ensure that services for both behavioral health and somatic health conditions are appropriately provided and that those services are well coordinated.

The frequency of co-occurring physical and behavioral health conditions highlights the importance of coordinated care, in which patients have access to collaborative treatment plans incorporating the specialized expertise of both physical and behavioral health providers. The complexity of treatment regimens for chronic health conditions, both physical and behavioral, enhances the need for integrated care plans. The care coordinator, the centerpiece of the PCMH/health home model is ideally positioned to facilitate the integration of therapy regimens from providers of varying specialties, thus providing complex, comorbid, and historically disenfranchised patients with comprehensive, patient-centered treatment plans. The care coordinator’s role could include reminding a patient that the pain medication is not going to be a
long-term solution and skills must be learned for use when the medication is discontinued or stops having the desired effect.

An example is Vermont’s *Hub and Spoke* initiative. Vermont has established a number of regional comprehensive addiction treatment center *hubs* as the center point, providing integrated SUD treatment and rehabilitation services, including MAT, peer support services and counseling services from behavior health specialists, as well as coordinated services for other co-occurring behavioral health and somatic health conditions. Patients with less complex substance use needs receive similar care through a system of *spokes* which consist of primary care health homes and FQHCs in conjunction with counseling and addition services coordinated through their designated coordinator (e.g., primary care provider, case manager, or psychiatrist).47

Another example, using 340B entities, includes the Community Health Centers of Benton and Linn Counties in Oregon, which have three clinical pharmacists to support four clinics through direct education and patient-specific feedback to doctors and other providers. Their role includes collaboration with disease management protocols, managing prescription refill services, and participating in pain management contracts between the patient and prescriber. A Medicaid coordinated care organization pilot program by Pacific Source in Oregon has integrated clinical pharmacists into primary care teams at five clinic locations.48 As Medicaid agencies expand and develop medical home programs in conjunction with private payers, the ability to leverage and support collaboration between clinical pharmacists and prescribers increases the level of onsite physician education toward more evidenced-based prescribing guidelines.

**DUR**

One area of commonality that all states share is the requirement for DUR programs under 42 CFR 456.703, which states that “the goal of the State’s DUR program must be to ensure appropriate drug therapy, while permitting sufficient professional prerogatives to allow for individualized drug therapy”.45 Subsequently, states are required to have DUR boards under 42 CFR 456.71649 that are to carry out specific operational tasks, including making retrospective DUR recommendations to the Medicaid agency to help identify patterns of fraud, abuse, overuse, or inappropriate or medically unnecessary care. Requirements for DUR board activities include identifying and developing educational topics, as well as making recommendations regarding interventions leading to improvement in the quality of drug therapy. For example, recommendations from DUR boards can be used to develop appropriate utilization controls such as PA requirements for benzodiazepine prescriptions extending beyond four weeks for newly started patients.

DUR boards represent an opportunity for Medicaid agencies to ensure broad clinical knowledge, further enhanced by the potential for appointees from the pain management and emergency medicine fields that have direct knowledge of prescribing realities. In states that operate both FFS and managed care programs, appointments of medical professionals from MCOs can ensure consideration and inclusion of best practices from the managed care environment, while appointments from medical professional organizations support alignment in utilization controls between FFS and managed care recipients. As an example, New York State has tasked its DUR Board to collaborate with MCOs in addressing drug utilization concerns and to ensure consistent strategies are implemented across both FFS and managed care to manage pharmacy benefits.50
ProDUR edits evaluate claims at the point-of-sale, for clinical appropriateness. Relative to curbing opioid overuse, ProDUR screenings are implemented by every major PBM and Medicaid health plan throughout the country. ProDUR screenings are effective tools for identifying potentially dangerous interactions between prescribed drugs and patients’ existing medication regimens, allergy history, and medical conditions, and often include quantity limit edits and therapeutic duplication alerts, which are helpful in identifying overutilizers. However, ProDUR edits are specific to the payor, so if a patient pays cash, the prescription is not captured by their primary payor’s edit system, thus allowing excessive opioid doses to pass over the prescription counter.

A RetroDUR can provide an effective means of identifying potentially dangerous, fraudulent and abusive medication utilization patterns by the pharmacies. RetroDUR and pharmacy claims data enable Medicaid agencies to identify patterns among individual providers and patients, as well as identify opportunities for increased management of drug classes and disease states. The TennCare Medicaid program in Tennessee has implemented a thorough ongoing review of RetroDUR data, including denied pharmacy claims, in order to identify both providers and patients whose behavior is indicative of potential drug abuse. The TennCare RetroDUR model identifies patients whose utilization patterns warrant monitoring or potential inclusion in the lock-in program (multiple prescribers, multiple pharmacies for controlled substances).

Legislation, Policy, and Leadership
While Medicaid operates within varying state and federal authorities, the one constant across all programs is their ability to significantly influence health care practices and to drive system-wide changes in the way healthcare is delivered within the state. Medicaid often is the largest (or one of the largest) insurers in the states and, with that comes influence necessary to drive major initiatives. Through Medicaid-specific policy changes, promoting administrative rule revisions, and taking positions on legislative issues around prescription drug abuse, state Medicaid agencies can assume a leadership role in confronting this growing epidemic.

Given the concerns expressed earlier in the Provider Monitoring and State Level Surveillance Systems section of this report, it is evident that legislation is being used to drive improvements in PDMPs:

- In 2012, New York State Governor, Andrew Cuomo, signed the Internet System for Tracking Over-Prescribing (I-STOP) Act into law, which requires prescribers to have an account with the State’s PDMP and requires all prescribers to consult with the PDMP prior to prescribing Schedule II, III, an IV controlled substances. I-STOP also requires real-time data entry into the PDMP system by pharmacists. At a recent public hearing on his agency’s 2014–2015 executive budget proposal, Dr. Irav Shah, Commissioner of the New York State Health Department, reported a 74.9% decrease in doctor shopping in the fourth quarter of 2013 compared to the same period the previous year and called the program a “national model” for controlling substance abuse.
- In March of 2014, Massachusetts Governor, Deval Patrick, directed the Department of Health Services to mandate the use of the PDMP by physicians and pharmacies to better safeguard against abuse and misuse. Previously, PDMP was a voluntary program.

The Alliance of States with Prescription Monitoring Programs’ PDMP Model Act 2010 Revision recommends providing PDMP data to Medicaid agencies and to Medicare. However, there is no current linkage of PDMPs with the Medicare program and, as yet, very limited national level
policy dialogue with the U.S. Department of Health and Human Services’ CMS regarding the coordination of PDMPs with the Medicaid and Medicare programs. The establishment of both Medicare and Medicaid PDMP systems is an important step in healthcare information data sharing. The lack of interoperability and coordination between these systems leaves a potential gap in surveillance efforts and an opportunity for continued enhancement.

As another example of state Medicaid agencies driving systems change, the State of Washington leveraged its Medicaid purchasing power with the Washington State Hospital Association, the Washington State Medical Association, and the American College of Emergency Physicians to curb the frequency of preventable ED visits that are largely attributable to prescription drug seeking behaviors and high-cost Medicaid patients. The Washington Health Authority required hospitals to implement best practices in 2012 addressing: exchange of patient health information between EDs, patient education, high-user client information/identification, high-user client care plans, reduction of drug-seeking and prescribing in high-user clients, prescription monitoring and coordination, and use of feedback information for continued progress.

By January of 2013, Washington hospitals were required to demonstrate a reduction in low acuity visits or face major funding reductions to physicians and hospitals for Medicaid emergency room payments up to $38 million. As a result of the dissemination of best practice guidelines, Washington experienced an overall decrease of 9.9% in ED visits by 2013. This included a 10.7% decrease in ED use by overutilizers (e.g., those who visited EDs five or more times annually), and a 14.2% decrease in ED use by individuals with low acuity diagnoses. Additionally, the rate of ED visits resulting in a scheduled drug prescription decreased by 24%.

MaineCare implemented restrictions on opioids that require many patients to seek alternative pain management treatment as well as limitations in the amount of painkillers that can be prescribed. For example, painkillers may only be approved for two week intervals and require special authorization for continued use. Patients with chronic pain lasting beyond eight weeks are tracked differently but are required to also try alternative treatments such as cognitive behavioral therapy or chiropractic care for additional pain relief. These new rules have resulted in a 17% reduction in the number of patients taking opioid painkillers from 2013 to 2012. The program paid for fewer prescriptions and smaller doses representing a decrease in the number of pills being dispensed by 27% or 6 million pills dispensed to 15,000 less patients. Patients in nursing homes and hospice are exempt from the program and persons with cancer, human immunodeficiency virus, and pain from end of life conditions continue to have access to narcotic prescriptions.

Incorporation of Best Practices

The improvement of clinical practice standards in medical, pharmacy, and behavioral health settings are among the most effective means of reducing prescription drug abuse. These practice improvements include the use of evidence-based practices (EBPs), as well as the expanded use of available and emerging technology, such as e-prescribing tools and other tamper-resistant prescription materials, PDMP, and DUR tools. Patient screening and monitoring techniques such as UDS and SBIRT protocols are also effective means of enhancing clinical practice as it pertains to the use of prescription drugs with high potential for abuse and misuse.
Although universal standardization is pragmatically unrealistic for the treatment of subjective medical conditions such as chronic pain, EBPs should comprise the foundation of clinical interventions. According to the American Academy of Pain Medicine, evidence-based best practice guidelines for pain management include, but are not limited to:\textsuperscript{55}

- A thorough evaluation of every patient and their complete medical history, including evaluation of comorbid conditions, both physical and behavioral, as well as treatment history and medication reconciliation. This may include a baseline drug screening and any necessary evaluations of pain-inducing primary medical conditions.
- Consideration of potential alternatives to chronic opioid therapy, including physical manipulations, psychological and behavioral treatments, exercise, and non-opioid medication therapy.
- A well-documented treatment plan, which may include restrictive pain contracts, short-term opioid trials, frequent monitoring and treatment methods which are based in demonstrated improvement in pain, function and quality of life, without evidence of adverse events or inappropriate behavior.
- Consultation with specialist providers when necessary, including pain management specialists, behavioral health specialists, and care coordinators.
- Periodic review of the efficacy of treatments and monitoring for adverse effects or maladaptive behaviors. Compliance evaluations may include a UDS, pill counting, and review of PDMP data, in addition to clinical presentation of symptoms and behaviors.

Best practice guidelines regarding the appropriate use of central nervous system stimulants and benzodiazepines may be dependent on coverage criteria and benefit structure for a given Medicaid program. Likewise, best practices for the use of benzodiazepines may vary depending on practice setting and patient demographics. The identification of appropriate best practice guidelines is important, in order to establish a consistent standard of practice which is grounded in evidence-based medicine, and takes appropriate measures to prevent inappropriate use. SAMHSA publishes numerous Treatment Improvement Protocols on best and promising practices pertaining to the prevention and treatment of SUDs.\textsuperscript{56}

Additional best-practices for physicians prescribing potentially abused and misused medications include the use of prescribing methods which are resistant to tampering and fraud. Electronic prescribing systems have become more prevalent over the past decade, as they enable prescribers to instantaneously transmit legible, standardized prescription orders directly to the dispensing pharmacy. Many e-prescribing systems also incorporate varying degrees of DUR edits, which warn prescribers of potential drug-drug, drug-disease, and other potential concerns with new prescription orders. E-prescribing has been identified by the Institute of Medicine as a means for reducing prescription errors and protecting patient safety, and was included in the 2003 Medicare Modernization Act. CMS issued incentive payments to providers utilizing e-prescribing systems in their practice between 2009 and 2013.\textsuperscript{57}

Beginning in October 2008, all prescriptions for Medicaid beneficiaries must be written/ transmitted using tamper-resistant technology, as required by Section 7002(b) of the U.S. Troop Readiness, Veterans’ Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007.\textsuperscript{57} These technologies include electronic prescriptions and prescription pads with advanced tamper-resistant features such as watermarks, micro-printing and redundant quantity expressions (numerical quantity and alpha-character spelling of quantity). Although electronic prescribing is not permitted for Schedule II medications, which include some of the most...
commonly abused drugs (i.e., oxycodone derivatives, such as Percocet®, morphine products such as Kadian®, and central nervous system stimulants like Ritalin® and Adderall®), most electronic prescribing software systems allow for standardized, tamper-resistant printed prescriptions which must be signed by the prescriber. These prescriptions are still well-documented in the patient’s EHR, allowing prescribers to carefully monitor the manner in which these prescriptions are produced and delivered to patients.

The DEA issued guidance in March of 2010 regarding the EPCS. The final rule, which went into effect in June of 2010, allows for the electronic prescribing of all Schedule II through IV prescription drugs. The regulations allow for electronic prescribing of controlled substances only when the provider’s EHR application complies with standards established by the EPCS interim rule. In order to transmit electronic controlled substance prescriptions, practitioners must also apply for and be granted a two-factor authentication credential or digital certificate, which may include a knowledge factor password, a hard token key, or biometric identification such as a fingerprint. Although the DEA EPCS guidelines are federally applicable, electronic prescribing of controlled substances remains optional for individual states. Permitting or mandating electronic prescribing of these medications likely requires states to amend legislation and rules governing medical and pharmacy practices, but EPCS provides a framework through which to enact these changes.

Amendments to New York State Rules approved in March 2013 allow for the electronic submission and receipt of controlled substance prescriptions, in accordance with DEA EPCS guidelines. The rule, which will take effect on March 27, 2015, calls for mandatory electronic prescribing of Schedule II through IV controlled substances. The New York regulations require that both prescribing practitioners and participating pharmacies adhere to federal security requirements as described in the ECPS interim regulations. New York’s regulations allow for exceptions to electronic prescribing of controlled substances in cases where electronic prescribing is temporarily unavailable due to transmission failure or computer downtime, the prescribing practitioner has been granted a waiver, or the prescription will be presented to a pharmacy outside of New York State. New York’s early adoption of EPCS policies represent a significant and commendable step towards limiting diversion of prescription drugs and the potential abuse and misuse that follows.

Addressing prescription drug abuse and misuse in Medicaid is not limited to preventative interventions, as those already afflicted with substance abuse disorders require evidence-based treatment for their conditions. Access to treatment services is lacking in many populations, as it’s estimated that only about 12% of those who need substance abuse treatment are currently receiving services. As such, the identification of individuals in need of substance abuse treatment and the timely referral to quality services is a necessary component of a comprehensive public health response to prescription drug abuse. The SBIRT approach is a best-practice that has been adopted in a number of states, and has demonstrated efficacy in trial studies.

The SBIRT method can be used to identify risky behavior associated with the use of alcohol, prescription drugs, or other illicit substances and has been incorporated into state best-practice guidelines in a number of states, including Oklahoma, New York, Oregon, and Colorado and is administered in EDs, primary care centers, community behavioral health clinics, and trauma centers across the nation. SBIRT functions through a series of screening questions which are used to identify individuals at risk for substance abuse, followed by a brief intervention which
consists of education and awareness counseling services provided by the SBIRT screener. When necessary, a referral to more comprehensive treatment follows the brief intervention discussion. An effective SBIRT program requires coordination of services and consistent follow through when individuals are identified as at risk for potential substance abuse (NIH SBIRT); and any clinic-based program must have a well-established working relationship with a SUD treatment program to be effective. Simple screening is not effective.

SAMHSA, in collaboration with the Center for Substance Abuse Treatment (CSAT), has launched a series of SBIRT medical residency trainings in order to educate the next generation of healthcare providers in order to raise awareness and increase the safety net for one of the nations’ leading causes of morbidity. SAMHSA and CSAT have implemented SBIRT training in nearly 20 residency training sites across the country and have established their goal of making substance abuse screening a routine component of primary care services and collaborative healthcare delivery models of all kinds. SBIRT has received federal support at the executive level as well. The White House set a goal in 2011 of increasing the number of states reimbursing for SBIRT of 25%. Although clinical data regarding the efficacy of SBIRT programs in identifying and minimizing prescription drug abuse is still emerging, SBIRT has been shown to be effective in reducing the prevalence of both alcohol and illicit substance abuse in trial studies (NIH SBIRT).

**Alternative Pain Management Strategies**

As Medicaid agencies work across sectors in developing and supporting the uptake of alternative and complimentary treatments to chronic opioid therapy, significant opportunities exist for collaboration with providers, stakeholders, and advocacy groups. In the context of comprehensive care plan development for chronic pain, Medicaid agencies should promote providers’ ability to address tangible personal goals that can lead to decreased pain including, improved sleep, increased physical activity, and stress management techniques.

Alternative non-opioid pharmacologic analgesics for pain management can include acetaminophen (Tylenol®) and non-steroidal anti-inflammatory drugs for treatment of mild to moderate pain. Muscle relaxants and antispasmodics such as cyclobenzaprine and tizanidine may be useful as an adjunct to analgesics. Chronic pain may also be treated with tricyclic antidepressants (TCAs). Other antidepressants such as selective serotonin reuptake inhibitors as well as dual reuptake inhibitors that increase norepinephrine and serotonin may also be used in place of TCAs, which may have more severe side effect profiles. Gabapentin, pregabalin, and other anticonvulsants can be effectively used for the treatment neuropathic pain. For some types of secondary pain such as diabetic neuropathy, topical therapies such as capsaicin have demonstrated efficacy. Insomnia may also be treated with TCAs or the sedative antidepressant trazadone.

Exercise therapy, fitness programs, and other physical rehabilitation approaches are common in chronic pain management and can be supported by Medicaid as part of a larger paradigm shift towards outcome-based reimbursement. Different types of exercise appear to be equally efficacious including group aerobic, low-impact exercises/stretching physical therapy and various exercises for muscle conditioning and strengthening. Fitness programs should include cardiovascular, flexibility, and balance enhancing exercises. Supervised or individualized exercise and self-management techniques may increase exercise adherence. Research also supports the use of manipulative therapies such as massage therapy, chiropractic practices, and
physical, and occupational therapies as effective alternative pain management treatments and thus may warrant consideration for reimbursement under FFS or capitated models.

Numerous studies suggest that chronic pain patients are more likely to have a co-morbid depressive disorder than pain-free primary care patients and thus benefit from more integrated approaches to care, including cognitive-behavior therapy (CBT), an EBP for the treatment of depression as well as in the treatment of chronic pain in non-depressed patients. Primary care physicians can implement preliminary cognitive-behavioral strategies such as education of chronic pain, affirmation of the reality of the patient’s pain, emphasis on pain self-management and regularly schedule follow up appointments, and recruitment of the family involvement in the patient’s plan of care.

Relaxation therapies are useful for decreasing general arousal level. Promising and best practices include the use of biofeedback to voluntarily control physiological responses, mindfulness-based stress reduction to help the patient learn to manage stress, the use of imagery and diaphragmatic breathing as well as progressive muscle relaxation training. Hypnosis is used to not only promote relaxation but also for perceptual alteration that allows the patient to lessen the impact of the pain.

Cognitive restructuring techniques, another CBT strategy, can also help patients change their understanding of their pain and develop more effective coping strategies. Patients learn to identify and stop those thoughts that lead to negative emotions which intensify the suffering associated with their pain. Other CBT techniques, including problem-solving therapy, can help patients develop alternative solutions to their difficulties and challenges. In addition to traditional approaches to treatment, some complementary medical strategies have proven effective, including the use of acupuncture in alleviating pain. Although research supports its effectiveness, reimbursement and funding may create barriers for states to including acupuncture in treatment.

**SUD Treatment and Prevention of Overdose**

An effective statewide SUD treatment program includes an adequate and coordinated system of care that promotes accountability and the use of evidence-based and promising practices, and ensures the quality of addiction services. In order to create an adequate system of care, some states have expanded their state plan to support the full array of ASAM level of care SUD services. Other states have expanded access to SUD services by expanding Medicaid eligibility to include low-income childless adults and pregnant women.

The SUD recovery community evolved from treatment for alcoholism, using 12-step programming that values a complete abstinence from all drugs and other substances. With the rise of opioid addictions and the current strategies for the management of chronic diseases, this philosophy warrants careful review, as it does not accommodate effective treatment of prescription pain medication addiction. The culture that has been effective in supporting recovery from alcoholism should be broadened to include an “all paths to recovery” philosophy that respects multiple pathways to recovery. This approach will require new and strengthened levels of collaboration among Medicaid agencies, providers, and advocacy groups and successful coalescing around difficult issues and debates about best practices and reimbursement methodologies.
MAT is an EBP for opioid addiction. Effective MAT programs include access to methadone, buprenorphine (i.e., Suboxone®/Subutex®), and naloxone (i.e., Narcan®) as well as concurrent behavior therapy, psychosocial supports, and treatment for any comorbid physical and/or mental health issues. Changes to existing service delivery systems to deliver effective MAT may include: (a) increased funding for and expansion of SUD treatment services; (b) restructuring pharmacy benefits and eliminating silos in pharmacy; (c) integrating physical health and behavioral health service delivery; and (d) improving reporting structures.63

Some states restrict the use of buprenorphine due to concerns with the risk of abuse and costliness. However, research suggests that risks and costs associated with buprenorphine and its use as an alternative to methadone indicates that buprenorphine can be more cost effective and decreases mortality rates over drug-free SUD treatment.64 Buprenorphine, while an effective treatment for opioid abuse should be considered a time limited benefit, consistent with U.S. Food and Drug Administration recommendations, that requires close coordination between prescribers and SUD education and treatment programs. When buprenorphine fails, consideration for enrollment in a methadone replacement program may be necessary for those with excessive doses and previous histories of addiction.

Many states are addressing opioid overdose by increasing the availability of naloxone (i.e., Narcan®), an opioid antagonist that can reverse the respiratory depression that accompanies opioid overdose. Historically, naloxone has been used by healthcare and emergency medical service providers. Medicaid coverage and prior authorization criteria vary by state. Current efforts to curb deaths by overdose focuses on expanding access to naloxone. Initiatives include universally providing all first responders with naloxone; prescribing naloxone to patients who are prescribed high opioid doses; providing naloxone and education to at-risk individuals and families concerned about the possibility of opioid overdose; and disseminating information on the use of naloxone. Some states such as Washington have also enacted the complementary strategy of immunity-from-prosecution laws to encourage people to find help during an overdose emergency and to protect them or helpful bystanders from prosecution. Massachusetts’s overdose education and nasal naloxone distribution program resulted in a decline in deaths due to overdose.65

In order to increase accountability and quality of SUD treatment, states have implemented various strategies, including:

- Maine and Massachusetts have implemented performance-based contracting with providers.
- Maine, Massachusetts, and Vermont established learning collaboratives with providers to improve SUD treatment services by sharing innovative and promising practices. For example, Maine increased efficiency by participating in the Network for Improvement of Addiction Treatment Strengthening Treatment Access and Retention-State Implementation project. Preliminary data indicates that the initiative enabled providers to provide treatment to more people with the same level of funding.66

**Public Health Programs**

Public health initiatives sponsored with a state’s department of health can be a key component of any comprehensive approach to minimize prescription drug abuse. Carefully designed initiatives are able to target numerous stakeholder groups, including the provider community, and are effective strategies for addressing public health concerns of various magnitudes.
Prescription drug abuse is a quintessential public health issue, involving various stakeholder groups and affects a large number of people within a given population.

Public health approaches include public prescription drug take-back programs and campaigns to educate parents and youth about the dangers of sharing prescribed medications (e.g., parties where unknown drugs are consumed). This popular community activity helps prevent potential abusers from accessing dangerous and frequently abused medications. Educational materials providing instructions for proper disposal of prescription medications are disseminated in a number of states, including Kentucky, Oklahoma, and Ohio.

Community engagement activities and public education initiatives are essential components of a public health approach to reducing prescription drug abuse, and are vitally important in order to raise awareness and address the prevailing sense of inherent safety with prescription drugs. Ohio’s Surviving Our Loss and Continuing Everyday (SOLACE) program functions as a statewide ground-level community engagement program which provides support to individuals and families impacted by SUDs and advocates for changes at both the community and legislative levels. Public awareness and education campaigns have also been implemented in a number of states, including Kentucky, Oklahoma, Tennessee, and West Virginia.

**Collaborative Task Forces and Work Groups**

Many of the findings and initiatives highlighted above have benefitted from support and engagement of other stakeholders. In fact, collaborative interdisciplinary programs across state agencies and stakeholders are some of the most promising prevention and treatment responses currently in place. These cooperative efforts take the form of several distinct structures, including cooperative task forces and work groups and interagency and interstate public health outreach and treatment initiatives. States across the nation have recognized that in order to address a problem as complex and diverse as prescription drug abuse, an equally multifaceted solution is required.

Collaborative interagency task forces and work groups have been formed in a number of states in an effort to develop comprehensive responses to growing concerns about prescription drug abuse. Some of the primary goals of these task forces and work groups have included provider education, evaluations of practice guidelines, surveillance and diversion initiatives, outreach activities, and legislative proposals. One state with a strong record of interagency cooperation is Washington, which has enacted both a collaborative task force for the development of comprehensive state initiatives to combat prescription drug abuse, and the Washington Emergency Department Opioid Abuse Work Group, which is sponsored by the Washington State Department of Health. These collaborative groups have developed a set of ED opioid prescribing guidelines, as well as a series of guidelines for opioid use in the treatment of CNP.

The Washington collaborative task force has been a strong proponent of expanded use of the state PDMP, as well as outreach and education efforts for both providers and the general public. Washington’s task force has also been successful in driving the implementation of a Good Samaritan law, which protects individuals receiving treatment for overdoses from prosecution for drug possession charges, and affords similar protections to individuals who refer or assist users in receiving such treatments. Grant funding for the Washington interagency initiatives were provided by the Washington State Office of the Attorney General, and the treatment guidelines produced by the taskforce in 2007 had been well received in the Washington provider
community, with nearly half of surveyed providers reporting that they had applied the treatment guidelines in their clinical practice as of 2009. Other states have taken different approaches in the development of their collaborative task forces, but share a common sentiment that a systems approach is necessary in order to achieve the greatest possible impact. While Washington has seen success in the creation of self-directed interagency teams, Maryland has taken a regional approach, in which the Department of Health and Mental Hygiene coordinates and directs local initiatives such as data collection and sharing, comprehensive prevention plans, and needs assessments. Ohio has implemented a multi-tiered collaborative partnership involving state government, community-based task forces, and five professional work groups. The five work groups in Ohio’s program each maintain a distinct focus: enforcement, professional education, public education, recovery, and treatment. In addition, Ohio has established 23 local task forces, each tasked with targeting opioid abuse within their respective communities.

Exciting opportunities exist for Medicaid agencies to sponsor and foster learning collaboratives similar to those led by the CMS Comprehensive Primary Care Initiative to foster best practices specifically focused on prescription drug abuse screening, prevention, and treatment. Promoting provider and multipayer forums like these not only share best practices and learned experiences, but lead to innovation in practice and prevention approaches while promoting cross-sector collaboration and engagement.
APPENDIX B

Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>ACPM</td>
<td>American College of Preventative Medicine</td>
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<td>ADHD</td>
<td>attention deficit hyperactivity disorder</td>
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<tr>
<td>ADOPT</td>
<td>Approaches to Drug Overdose Prevention Analytical Tool</td>
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<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
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<tr>
<td>CBT</td>
<td>cognitive-behavior therapy</td>
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<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CNP</td>
<td>chronic non-cancer pain</td>
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<tr>
<td>CSAT</td>
<td>Center for Substance Abuse Treatment</td>
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<tr>
<td>DEA EPCS</td>
<td>Drug Enforcement Administration Electronic Prescribing of Controlled Substances</td>
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<tr>
<td>DUR</td>
<td>drug utilization review</td>
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<tr>
<td>EBP</td>
<td>evidence-based practice</td>
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<td>ED</td>
<td>emergency department</td>
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<tr>
<td>EHR</td>
<td>electronic health record</td>
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<tr>
<td>FFS</td>
<td>fee-for-service</td>
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<tr>
<td>FQHC</td>
<td>federally-qualified health centers</td>
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<tr>
<td>FWA</td>
<td>fraud, waste, and abuse</td>
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<tr>
<td>I-STOP</td>
<td>Internet System for Tracking Over-Prescribing</td>
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<tr>
<td>MAT</td>
<td>Medication Assisted Therapy</td>
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<tr>
<td>MCO</td>
<td>managed care organization</td>
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<tr>
<td>MED</td>
<td>morphine equivalent dosing</td>
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<tr>
<td>MME</td>
<td>morphine milligram equivalency</td>
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<tr>
<td>MMIS</td>
<td>Medicaid management information systems</td>
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<tr>
<td>MTM</td>
<td>Medication Therapy Management</td>
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<tr>
<td>NAS</td>
<td>neonatal abstinence syndrome</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<tr>
<td>OTP</td>
<td>Opioid Treatment Program</td>
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<tr>
<td>PBMs</td>
<td>pharmacy benefit managers</td>
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<tr>
<td>PCMH</td>
<td>The Patient-Centered Medical Home</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>PDMP</td>
<td>Prescription Drug Monitoring Programs</td>
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<tr>
<td>ProDUR</td>
<td>prospective drug utilization review</td>
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<tr>
<td>RetroDUR</td>
<td>retrospective drug utilization review</td>
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<tr>
<td>SAMSHA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SBIRT</td>
<td>Screening, Brief Intervention, and Referral to Treatment</td>
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<tr>
<td>SOLACE</td>
<td>Ohio's Surviving Our Loss and Continuing Everyday</td>
</tr>
<tr>
<td>SUD</td>
<td>substance use disorder</td>
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<tr>
<td>TCA</td>
<td>tricyclic antidepressants</td>
</tr>
<tr>
<td>UDS</td>
<td>urine drug screens</td>
</tr>
</tbody>
</table>
APPENDIX C

References


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