Smart Care California
Meeting #7

Friday, October 6, 2017
9:30am-3:00pm

Oakland City Center Conference Center
500 12th St, Oakland, CA 94607
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator</th>
<th>Meeting Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 am</td>
<td>Light Breakfast and Networking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30 am</td>
<td>Welcome and Introductions, Role of Smart Care CA</td>
<td>Lance Lang, MD, Covered CA</td>
<td>• Participant List</td>
</tr>
<tr>
<td>9:45 am</td>
<td>Reducing Opioid Overuse</td>
<td>Julia Logan, MD, MPH. DHCS</td>
<td>• Levers to Reduce Opioid Overuse</td>
</tr>
<tr>
<td></td>
<td>- Opioid overuse recommended strategies for payers and providers,</td>
<td></td>
<td>• Draft Opioid Payer and Provider Strategies</td>
</tr>
<tr>
<td></td>
<td>new integrated checklist: discussion and recommendation for</td>
<td></td>
<td>• Smart Care California revised opioid checklist (October 2017)</td>
</tr>
<tr>
<td></td>
<td>endorsement</td>
<td></td>
<td>• CHCF white paper: Why Health Plans Should Go to the “MAT” in the</td>
</tr>
<tr>
<td></td>
<td>- Review of new CHCF publication on health plans and MAT</td>
<td></td>
<td>Fight Against Opioid Addiction</td>
</tr>
<tr>
<td></td>
<td>- Discussion of new CVS high-dose policy; potential role of</td>
<td></td>
<td>• Article: CVS tightens restrictions on opioid prescriptions in bid to</td>
</tr>
<tr>
<td></td>
<td>Smart Care in sharing tapering resources and tools</td>
<td></td>
<td>stanch epidemic</td>
</tr>
<tr>
<td></td>
<td>- Discussion on recognizing health plans who are leading the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>way for reducing opioid overuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00 am</td>
<td>Break 10 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:10 am</td>
<td>Reducing Opioid Overuse Continued</td>
<td>Julia Logan, MD, MPH. DHCS</td>
<td></td>
</tr>
<tr>
<td>11:45 am</td>
<td>Reducing C-sections for Low Risk, First Time Births</td>
<td>Lance Lang, MD, Covered CA</td>
<td>• Levers to Reduce C-section</td>
</tr>
<tr>
<td></td>
<td>- Update on Consumer Education Materials Development</td>
<td></td>
<td>• California C-section Consumer Education: Audience Research Findings</td>
</tr>
<tr>
<td></td>
<td>2017 Honor Roll Update</td>
<td></td>
<td>and Prototypes (slide deck)</td>
</tr>
<tr>
<td>12:30 pm</td>
<td>Lunch 30 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00 pm</td>
<td>Reducing C-sections for Low Risk, First Time Births Continued</td>
<td>Lance Lang, MD, Covered CA</td>
<td>• Smart Care California Draft C-section Menu of Payment and Contracting</td>
</tr>
<tr>
<td></td>
<td>- C-section Menu of Options for Payment and Contracting:</td>
<td></td>
<td>Options</td>
</tr>
<tr>
<td></td>
<td>discussion and recommendation for endorsement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:50 pm</td>
<td>Reducing Inappropriate Treatment for Low Back Pain</td>
<td>Richard Sun, MD, MPH, CalPERS</td>
<td>• Levers to Reduce Inappropriate Treatment for Low Back Pain</td>
</tr>
<tr>
<td></td>
<td>- Low Back Pain Dashboard Measures-Imaging, Opioid Use, and Time to</td>
<td></td>
<td>• Next Steps for Low Back Pain</td>
</tr>
<tr>
<td></td>
<td>Physical Therapy</td>
<td></td>
<td>• Draft Low Back Pain Dashboard Measures</td>
</tr>
<tr>
<td></td>
<td>- How measures support a high-value care model for low back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:50 pm</td>
<td>Wrap up and Next Steps</td>
<td>Jennifer Wong, MPH, IHA</td>
<td>• Next Meeting: Mon Jan 29, 2018</td>
</tr>
<tr>
<td>3:00 pm</td>
<td>Adjourn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Parag Agnihotri, MD  
Medical Director, Population Health & Post-Acute care  
Sharp Rees-Stealy Medical Group  

Eric Antebi  
Director of Communications  
California Health Care Foundation  

Christine Fenlon, MSSL  
Health Program Specialist  
California Department of Public Health  

Ann Marie Giusto, RN  
Director of Variation Reduction  
Sutter Health  

Ruth Haskins, MD  
President  
California Medical Association  

Emma Hoo  
Director  
Pacific Business Group on Health  

Sharon Isonaka, MD  
Vice President, Clinical Transformation  
Cedars-Sinai Health System  

Angela Kline, MPH  
Project Manager  
Integrated Healthcare Association  

Lance Lang, MD (CO-CHAIR)  
Chief Medical Officer  
Covered California  

Julia Logan, MD, MPH (CO-CHAIR)  
Quality Officer  
CA Department of Health Care Services  

David Lown, MD  
Chief Medical Officer  
Safety Net Institute  

Elliott Main, MD  
Medical Director  
California Maternal Quality Care Collaborative  

Cathie Markow, BSN, MBA  
Administrative Director  
California Maternal Quality Care Collaborative  

Pooja Mittal, DO  
Central Medical Director, CA State Health Programs  
Health Net  

Dana Moore, MPH, CPH (GUEST)  
Health Systems Strategist, Fusion Center  
California Department of Public Health  

Robert Moore, MD, MPH, MBA  
Chief Medical Officer  
Partnership HealthPlan of California  

Joanne Peschko  
Health Program Specialist  
CA Department of Health Care Services  

Susan Perez, PhD, MPH  
Research Associate  
Center for Healthcare Decisions  

Kelly Pfeifer, MD  
Director, High-Value Care  
California Health Care Foundation  

Lindsay Petersen, MS  
Senior Quality Analyst  
Covered California  

Susan Pon-Gee  
Director, Health & Welfare Policy and Program Design  
University of California Office of the President  

Jeff Rideout, MD  
President and CEO  
Integrated Healthcare Association  

Katie Rodriguez, MPP  
Senior Program Officer, State Health Policy  
California Health Care Foundation  

Beccah Rothschild, MPA  
Senior Outreach Leader  
Consumer Reports  

3
Jennifer Sayles, MD, MPH  
Chief Medical Officer  
Inland Empire Health Plan

Jean Shahdadpuri, MD, MBA  
Senior Medical Director  
Health Net

Karen Shore, PhD  
Consultant  
Golden State Health Policy

Julia Slininger, RN, BS, CPHQ  
VP, Regional Quality Network  
Hospital Quality Institute

Steven Steinberg, MD  
Family Medicine Physician  
Kaiser SCPMG

Diane Stewart, MBA  
Senior Director  
Pacific Business Group on Health

Richard Sun, MD, MPH (CO-CHAIR)  
Chief Medical Officer  
CalPERS

Erin Taylor, MPH (GUEST)  
Senior Consultant  
Bailit Health

Stephanie Teleki, PhD  
Senior Program Officer, High-Value Care  
California Health Care Foundation

Barbara Wentworth, PhD  
Senior Quality Improvement Specialist  
Health Net

Steve Wirtz, PhD  
Chief, Injury Surveillance and Epidemiology  
California Department of Public Health

Mike Witte, MD  
Chief Medical Officer  
California Primary Care Association

Jennifer Wong, MPH  
Project Manager  
Integrated Healthcare Association
Topic 1: Opioid Overuse
Meeting Materials
Multi-Lever Model for Change

Reduce Opioid Overuse

- Data/Transparency
- Purchaser Requirements
- Workforce
- Quality Improvement (QI)/Clinician Interventions
- Consumer Engagement
- Payment
- Public Policy
### Potential Ways to Address Opioid Overuse Levers

| Data/Transparency | • CDPH Dashboard with CURES data  
| • Smart Care California Opioid Dashboard |
| QI/Clinician Interventions | • Implement clinical decision support tools to promote CDC Guidelines: safer opioid use for acute and chronic pain  
| • Offer or support specific programs that help providers develop taper plans for patients on high opioid doses or combinations (opioids and benzos)  
| • Expand access points for medication-assisted treatment (in primary care, specialty addiction treatment, ED, inpatient, jail and prison) |
| Payment | • Implement formulary controls to limit new starts, implement quantity limits for new starts  
| • Implement formulary dose limits  
| • Increase access to non-pharmacological therapies such as physical therapy, acupuncture, yoga, mindfulness  
| • Remove prior authorization requirements and lower copays for buprenorphine for addiction management, and naloxone for overdose reversal |
| Purchaser Requirements | • Require health plans to adopt payment and benefit design strategies that decrease new starts, identify and manage patients on risky opioid regimens, streamline access to buprenorphine and methadone to treat opioid addiction and streamline access to naloxone for overdose reversal |
| Workforce | • Offer or support provider education on co-prescribing naloxone and prescribing buprenorphine  
| • Behavioral health integration in primary care  
| • Use Project ECHO to provide free training on opioid addiction treatment |
| Consumer Engagement | • Distribute consumer facing materials on risks of taking opioids to patients, members, and employees  
| • Provide member education on naloxone |
| Public Policy | • Opioid prescribers required to participate in CURES  
| • CA 2017-2018 Assembly Bill 40: CURES health IT integration |
Reducing Opioid-Related Morbidity and Mortality: Payer Strategies

**GOAL:** By January 2019, every payer (including health plans, purchasers, and risk-bearing provider organizations) should launch an organization-wide opioid safety initiative. Its goal should be to lower overprescribing and to reduce opioid-related morbidity and mortality while increasing addiction treatment access.

**METRICS:** Total MME pmpm (morphine milligram equivalents, from CDPH Dashboard),¹ high-dose prescribing (>120 MME pmpm, HEDIS measure),² concurrent use of opioids and benzodiazepines (PQA measure),³ number of people diagnosed with opioid use disorder treated with medication-assisted treatment (MAT) (ASAM measure),⁴ acute low back pain treated with opioids (AHRQ measure)⁵

<table>
<thead>
<tr>
<th>CORE PRIORITIES</th>
<th>APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. PREVENT:</strong> Decrease the number of new starts — fewer prescriptions, lower doses, shorter durations</td>
<td><strong>Medical management.</strong> Remove prior authorization requirements for initial physical therapy series for acute lower back pain episodes, streamline access to nonpharmacological pain treatments (e.g., physical medicine/rehabilitation, acupuncture, chiropractic care, complementary therapy)⁶ <strong>Benefit design.</strong> Lower copay burden for physical therapy (e.g., one copay for series of physical therapy treatments)⁶ <strong>Pharmacy benefit.</strong> Implement quantity limits for new starts (e.g., three or seven days’ supply),⁷ ensure access to nonopioid pain medications⁶</td>
</tr>
<tr>
<td><strong>2. MANAGE:</strong> Identify patients on risky regimens (high-dose opioids, or opioids and sedatives) and work with them to taper to safer doses</td>
<td><strong>Provider network.</strong> Offer or support programs that help providers develop tapering plans for patients on high opioid doses or combinations (e.g., opioids and benzodiazepines)⁷⁹ <strong>Medical management.</strong> Offer case management services for patients with chronic pain on high-risk regimens <strong>Pharmacy benefit.</strong> Limit concurrent prescriptions for opioids and benzodiazepines,⁹ remove high-dose formulations from formulary,⁸ remove methadone from pain formulary¹⁰</td>
</tr>
<tr>
<td><strong>3. TREAT:</strong> Streamline access to buprenorphine and methadone to treat opioid addiction</td>
<td><strong>Provider network.</strong> Evaluate network adequacy for opioid addiction treatment with buprenorphine and methadone, develop action plan to meet demand and incentivize providers to prescribe buprenorphine¹¹¹³ <strong>Pharmacy benefit.</strong> Remove authorization requirements and implement lower copays for buprenorphine¹¹¹²</td>
</tr>
<tr>
<td><strong>4. STOP overdose deaths:</strong> Streamline access to naloxone for overdose reversal</td>
<td><strong>Provider network.</strong> Offer or support provider education on co-prescribing naloxone¹⁴¹⁵ <strong>Pharmacy benefit.</strong> Remove authorization requirements and implement lower copays for naloxone¹⁴¹⁵</td>
</tr>
</tbody>
</table>
Endnotes


9. Dowell et al., “CDC Guideline.” The 2016 CDC guidelines for opioid prescribing recommend against concurrent use of opioids and benzodiazepines due to the increased risk of fatal overdose. Thirty percent of opioid overdose deaths include benzodiazepine use.


12. David Kan, Insurance Barriers to Accessing Treatment of Opioid Use Disorders Identified by California Physicians, California Society of Addiction Medicine, November 2016, www.csam-asam.org (PDF). Sixty-two percent of physicians whose patients have insurance coverage find it difficult to access medication-assisted treatment.


## Reducing Opioid-Related Morbidity and Mortality: Provider Strategies

**GOAL:** By January 2019, all medical groups and health systems should launch a systemwide opioid safety initiative, with the goal of lowering opioid overprescribing and opioid-related morbidity and mortality while increasing addiction treatment access.

### Core Priorities

<table>
<thead>
<tr>
<th>PREVENT</th>
<th>MANAGE</th>
<th>TREAT</th>
<th>STOP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decrease the number of new starts — fewer prescriptions, lower doses, shorter durations</strong></td>
<td><strong>Identify patients on risky regimens (high dose, or opioids and sedatives) and work with them to taper to safer doses</strong></td>
<td><strong>Streamline access to buprenorphine and methadone to treat opioid addiction</strong></td>
<td><strong>Stop overdose deaths:</strong> Streamline access to naloxone for overdose reversal</td>
</tr>
</tbody>
</table>

### How will we know a change is an improvement?

- Percentage of patients with new opioid prescription
- Timely access to nonpharmacologic modalities (physical therapy, alternative therapy)
- Number of patients taking both opioids and benzodiazepines per 1,000 patients (CDPH Dashboard)
- Percentage of patients on >90 morphine milligram equivalent (MME) daily (CDPH Dashboard)
- Number of buprenorphine prescriptions per 1,000 patients (CDPH Dashboard)
- Number of people diagnosed with opioid use disorder treated with medication-assisted treatment (MAT)
- Percentage of patients on daily opioids prescribed naloxone

### Provider Approaches

- **Guidelines.** Adopt CDC and/or California Medical Board prescribing guidelines
- **Provider education.** Offer or support provider education on:
  - Pain management based on guidelines
  - Buprenorphine prescribing
  - Naloxone co-prescribing
  - Taper plans for high-risk regimens
- **Acute pain management.**
  - Use nonopioid alternatives for acute pain (e.g., physical therapy, acupuncture, chiropractic, complementary therapy, nonopioid medications)
  - Refer to physical medicine/rehabilitation before nonemergent spine surgery
- **Data.** Use data to identify and reduce variations in opioid prescribing practices
- **Integrated care.** Increase numbers of buprenorphine prescribers in primary care
Endnotes


4. Deborah Dowell et al., “CDC Guideline.” The 2016 CDC guidelines for opioid prescribing recommend against concurrent use of opioids and benzodiazepines due to the increased risk of fatal overdose. Thirty percent of opioid overdose deaths include concurrent benzodiazepine use.


8. Managing Pain Safely: Multiple Interventions to Dramatically Reduce Opioid Overuse, Partnership HealthPlan of California, www.partnershiphp.org (PDF). This measure, adopted from Partnership HealthPlan, looks at patients in the measurement period (months) who did not have an opioid prescription in the 90 days before the first day of the measurement period.

9. Timeliness standards will vary depending on the health system. Medi-Cal Managed Care Plans are required to provide ancillary services within 15 days of call.


11. Measure looks at patients taking >90MME daily for 30 days or more.

12. The ASAM Performance Measures for the Addiction Specialist Physician, American Society of Addiction Medicine, November 19, 2014, www.asam.org (PDF). The number of patients receiving MAT serves as a balancing measure. Data for this measure will come from payer claims sources.


Curbing the Opioid Epidemic:
Checklist for Health Plans and Purchasers

Smart Care California is a public-private partnership working to promote safe, affordable care in California, including a focus on opioid-related morbidity and mortality. This checklist of health plan approaches is based on the most up-to-date evidence emerging from literature review, case studies, interviews, and surveys of California health plans. See the California Health Care Foundation’s publication Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic and Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction for details and references.

Smart Care California is focused on four priority areas with the strongest evidence for impact:

<table>
<thead>
<tr>
<th>Goal</th>
<th>EXAMPLES OF DATA SUPPORTING GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent. Decrease the number of new starts.</td>
<td>Large health plan study showed 67% of members taking opioids for 90 days continued regular use two years later. Opioid prescriptions fell 20% when Blue Cross Blue Shield of Massachusetts required authorization for more than a 30-day supply.</td>
</tr>
<tr>
<td>Manage. Identify patients on risky regimens (high-dose, or opioids and sedatives) and work with them to taper to safer doses.</td>
<td>Doses &gt;100 morphine milligram equivalents (MME) a day increase the death rate almost nine-fold compared to 1 to 20 mg daily. 30% of opioid overdose deaths include concurrent benzodiazepine use. High-dose opioid use fell 70% through Partnership HealthPlan’s multipronged initiative (treatment guidelines, formulary controls, prescriber education, and detailing).</td>
</tr>
<tr>
<td>Treat. Streamline access to evidence-based treatment for substance use.</td>
<td>Buprenorphine and methadone decrease rates of death, HIV, and hepatitis rates and increase retention in treatment compared to social model treatments. 62% of physicians whose patients have insurance coverage find it difficult to access medication-assisted treatment.</td>
</tr>
<tr>
<td>Stop overdose deaths. Streamline access to naloxone for overdose reversal.</td>
<td>Co-prescribing of naloxone with chronic opioid prescriptions lowered ED visits by 47%. Communities with increased naloxone availability have lower death rates.</td>
</tr>
</tbody>
</table>

## Approaches to Decrease New Starts and Support Safer Pain Management

### Provider Network
- Offer or support provider education on pain management based on prescribing guidelines (CDC or medical board).
- Offer or support specific programs that help providers develop taper plans for patients on high opioid doses or combinations (opioids and benzodiazepines).
- Analyze data to identify outlier prescribers and flag for education, coaching, and/or fraud investigation.
- Ensure access to in-network pain specialists aligned with CDC guidelines for peer consultation or secondary case review.
- Create dashboards to measure comparative opioid prescribing rates and share them with providers.
- Participate in local opioid safety coalitions to support community prescribing guidelines.

### Medical Management
- Remove prior authorization requirement for first course of physical therapy for back pain, and ensure timely access to care.
- Add chiropractic services as a benefit.
- Add acupuncture services as a benefit.
- Add health education or mindfulness resources as a benefit.
- Train case managers on common issues in chronic pain.
- Increase access to behavioral health services for patients with chronic pain.
- Identify members losing prescribers (through retirement or loss of license, for example) and coordinate referrals to pain management or addiction treatment where needed.

### Pharmacy Benefit (all interventions should have an exception for palliative care)
- Implement formulary dose limits (total morphine milligram equivalents, with prompt authorization review to manage exceptions).
- Implement quantity limits for new starts (with authorization requirements for ongoing treatment after first fill).
- Remove high-dose formulations from formulary (e.g., 80 mg Oxycontin, 100 mcg fentanyl).
- Remove methadone from formulary for pain.
- Remove Soma (carisoprodol) from formulary.
- Limit concurrent prescriptions for opioids and benzodiazepines.
- Remove prior authorization requirements for common non-opioid pain medications (e.g., anti-depressants, neuroleptics with indications for pain).
- Implement pharmacy lock program for patients using multiple prescribers.
- Implement prescriber lock program for patients using multiple prescribers.

### Member Services
- Provide member education on opioid risks and non-opioid pain management strategies.
## Strategies to Increase Access to Addiction Treatment and Naloxone

### Provider Network

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluate network adequacy for specialty addiction treatment and develop action plan to meet demand.</strong></td>
<td>IN PLACE</td>
</tr>
<tr>
<td><strong>Evaluate network adequacy for primary care addiction treatment (buprenorphine and naltrexone) and develop action plan to meet demand.</strong></td>
<td>IN PLANNING</td>
</tr>
<tr>
<td><strong>Contract with medication-assisted treatment telehealth providers.</strong></td>
<td>NOT A PRIORITY</td>
</tr>
<tr>
<td><strong>Offer or support provider education on buprenorphine prescribing (e.g., waiver training).</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Offer financial incentives or alternative payment models to encourage primary care providers to treat addiction with buprenorphine.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work with emergency departments (EDs) to treat addiction with buprenorphine and refer for ongoing management in the ED, and to dispense naloxone to high-risk patients.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Place navigators in EDs to help facilitate entry into addiction treatment.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work with hospitalists to start buprenorphine or methadone treatment with patients hospitalized with addiction-related diagnoses (e.g., endocarditis or osteomyelitis).</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work with correctional settings to offer buprenorphine, methadone, and naltrexone on re-entry.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ensure adequate access to buprenorphine and methadone for pregnant women.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work with hospitals to ensure evidence-based treatment of neonatal abstinence syndrome.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Incentivize behavioral health integration through pay-for-performance or direct grants.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Offer or support provider education on co-prescribing naloxone.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work with local opioid safety coalitions to build new MAT access points. Offer or support provider education on co-prescribing naloxone for patients on daily opioids.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Management

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Train case managers to guide members to addiction treatment.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Identify outlier members and refer to case management.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Notify outpatient prescribers about hospital and ED admission for overdose events.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Minimize copays for addiction treatment (prescriber visits and behavioral health).</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Pharmacy Benefit

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remove authorization requirements for initiating and maintaining buprenorphine for addiction, including eliminating requirements for detox in lieu of maintenance.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Remove authorization requirements for initiating and maintaining buprenorphine for pain.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Work with pharmacy network to support stocking and furnishing naloxone.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Remove authorization requirements and copays for naloxone.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Member Services

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide member education on naloxone.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ensure that members at high risk of addiction or opioid overuse receive outreach from peers, recovery support, or a case manager.</strong></td>
<td></td>
</tr>
</tbody>
</table>
Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction
About the Authors
Julia Elitzer, MPH, DrPH, is a senior consultant in the San Francisco office of Health Management Associates, a national research and consulting firm that focuses on the health care industry. Margaret Tatar is the managing principal of Health Management Associates.

About the Foundation
The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Contents

3 Executive Summary
What
Why
How

4 Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction
Methods
What Is MAT?
Review of Comparative Effectiveness of MAT
Access Barriers to MAT
Health Plan Actions
Return on Investment: The Financial Case for MAT
Legislation Related to Health Plans and MAT
Medicaid Managed Care and MAT in California

16 Conclusion: Next Steps for Health Plans

17 Appendices
A. FAQ on Implementation of ACA and Parity Act
B. Alkermes Registry Data, VICTORY Trial

20 Endnotes
Executive Summary

What
The opioid epidemic in the United States continues to be an urgent health and social crisis. In 2015, the nation saw more than 33,000 opioid-related deaths, correlating with a fourfold increase in opioid prescribing over the last 15 years, the increasing availability (and lower costs) of street heroin and fentanyl, and the ongoing dearth of addiction treatment resources.\(^1,2\) Prescription opioid misuse, addiction, and overdose cost the US over $78 billion annually in health care, criminal justice, and lost productivity.\(^3\)

Why
While the epidemic requires a coordinated response from government and policymakers, law enforcement, and health care, health plans have a uniquely influential role. Along with community partners, health plans can influence opioid prescribing across large geographies through comparative data, provider educational campaigns, practice guidelines, formulary and utilization policies, and value-based payment.\(^7\) Plans can assess network adequacy and expand their networks to ensure better access to addiction and pain treatment, and can incentivize integration of behavioral health services. Plans have a strong business case for building better access to addiction treatment regardless of whether or not substance use disorders are the financial responsibility of the plan. Streamlining access to medication-assisted treatment (MAT — prescription medication combined with behavioral health) has been shown to lower emergency department and hospitalization costs,\(^7\) lower hepatitis C and HIV rates, and decrease overdose deaths.

This report was commissioned for a health plan audience and aims to make the case for commercial and public plans to take action and make better access to MAT a top health plan priority, as part of a broader initiative aimed at lowering opioid-related morbidity and mortality.

How
The literature review and interviews with health plan leaders indicate that plans are working to increase treatment access through multiple coordinated approaches:

► Pharmacy benefit:
  ► Changing formularies to promote safer opioid prescribing
  ► Eliminating prior authorization requirements and copays for MAT and naloxone
  ► Starting lock-in programs
  ► Incentivizing or training local pharmacies to furnish naloxone without a prescription

► Provider network:
  ► Assessing opioid use disorder prevalence and ensuring sufficient MAT access in all regions
  ► Promoting new MAT access points in primary care, emergency departments, inpatient settings, and the justice system through supporting trainings, increased reimbursement, pay-for-performance (P4P) programs, or grants
  ► Contracting with telehealth providers
  ► Training providers to offer co-prescriptions of naloxone
  ► Incentivizing behavioral health integration through P4P or direct grants
  ► Working to increase access to MAT for pregnant women
  ► Working with hospitals to ensure evidence-based treatment of neonatal abstinence syndrome

► Medical management:
  ► Providing data analytics to identify patients at risk for addiction
  ► Training case managers to guide members to treatment
  ► Starting care management programs for addiction
  ► Notifying prescribers of emergency department and hospital overdose admissions
The opioid epidemic in the United States continues to be an urgent health and social crisis. In 2015, the nation saw more than 33,000 opioid-related deaths, correlating with a fourfold increase in opioid prescribing over the last 15 years, the increasing availability (and lower costs) of street heroin and fentanyl, and the ongoing dearth of addiction treatment resources.5,6 Prescription opioid misuse, addiction, and overdose cost the US over $78 billion annually in health care, criminal justice, and lost productivity.7 The Centers for Disease Control and Prevention (CDC) estimates that the US spends $52.4 billion annually on the nonmedical use of opioids, $55.7 billion on misuse and addiction, and $20.4 billion associated with overdose. In 2012, total outpatient prescription opioid sales were estimated at $9 billion, an increase of 120% from 2002.8

While the epidemic requires a coordinated response from government and policymakers, law enforcement, and health care, health plans have a uniquely influential role. Along with community partners, health plans can influence opioid prescribing across large geographies through comparative data, provider educational campaigns, practice guidelines, formulary and utilization policies, and value-based payment. Plans can assess network adequacy and expand their networks to ensure better access to addiction and pain treatment, and can incentivize integration of behavioral health services. Plans have a strong business case for building better access to addiction treatment regardless of whether or not substance use disorders are the financial responsibility of the plan. Streamlining access to medication-assisted treatment (MAT — prescription medication combined with behavioral health) has been shown to lower emergency department and hospitalization costs,9 lower hepatitis C and HIV rates, and decrease overdose deaths.

This report was commissioned for a health plan audience and aims to make the case for commercial and public plans to take action and make better access to MAT a top health plan priority, as part of a broader initiative aimed at lowering opioid-related morbidity and mortality.

**Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction**

**Data analytics:**
- Creating dashboards to measure progress on opioid prescribing and MAT access, and sharing them with providers and delegated medical groups
- Identifying outlier prescribers to provide education and, when appropriate, refer for fraud
- Identifying outlier members to refer to case management

**Community engagement:**
- Working with local opioid safety coalitions to adopt community prescribing guidelines and ensure adequate access to MAT and naloxone
- Over 35 of California’s 58 counties have active opioid safety coalitions; see [www.chcf.org/oscn](http://www.chcf.org/oscn)

“**We don’t require diabetics to prove they are attending nutrition visits… for their insurance to cover insulin — a medicine that is deadly in overdose. However, insurance companies frequently cut patients off treatment if we don’t submit detailed clinical records proving attendance at counseling, and drug screens showing perfect compliance — something we don’t see or expect in any other chronic disease.**”

— David Kan, MD, President, CSAM
Methods
Health Management Associates reviewed the literature and interviewed health plan leaders to understand current health plan policies and practices, collect data and evidence where available, and explore barriers and opportunities for commercial and public plans to improve access to MAT. The report also reviewed legislative actions affecting plans. This paper builds on the 2016 California Health Care Foundation (CHCF) report Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic, which focuses on judicious prescribing practices, improving patient outcomes, addressing overuse, and working with others to increase safety in communities.

What Is MAT?
Modern addiction medicine treats opioid use disorder (OUD) as a chronic disease, since long-term opioid use can permanently change brain chemistry function and, as with other chronic diseases, there is no cure, meaning patients often require long-term management of relapse and remission. Like other chronic diseases, addiction requires both medication and lifestyle changes, and tends to relapse when treatment is unavailable or prematurely discontinued.

MAT is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders (SUD). Improved access to MAT is one of three federal priorities for curbing the opioid epidemic, along with addressing opioid overprescribing practices and expanding distribution of naloxone, a drug that reverses the effect of opioids, for emergency treatment of an opioid overdose. Without medication treatment, individuals with OUD are at high risk for overdose and death.

The FDA has approved three medications for treatment of OUD: (1) methadone (generic oral and injectable forms, Dolophine or Methadose), (2) buprenorphine (generic sublingual tablets or Probuphine intradermal implant; buprenorphine is often combined with naloxone [available as Suboxone, Zubsolv, Bunavail, or generic sublingual tablets], since the naloxone component can deter misuse), and (3) naltrexone (generic tablets, ReVia, or Vivitrol long-acting injectable form). Methadone is a full opioid receptor agonist, meaning it fully binds to opioid receptors in the brain. Buprenorphine is a partial opioid receptor agonist, meaning it acts on some opioid receptors (those involved with pain, motivation, and cravings), but its moderate activity level limits respiratory suppression, the main cause of overdose death associated with full agonists. Other buprenorphine formulations are FDA-approved for pain but not addiction; more detailed information on buprenorphine is available from CHCF. Methadone and buprenorphine stabilize brain chemistry, thereby reducing or eliminating opioid withdrawal symptoms and cravings, and improving the individual’s ability to plan, organize behavior, and participate in recovery.

Naltrexone is a full opioid receptor antagonist, meaning it blocks opioid receptors and prevents their activation, so illicit opioids taken do not produce euphoria. Naloxone, while not a medication for addiction treatment, is commonly prescribed to people with addiction to prevent accidental overdose. Naloxone, when administered in nasal spray or injection, fully displaces all opioids from their receptors. This action restores consciousness and respiration in the case of overdose, while resulting in immediate withdrawal symptoms for patients with opioid dependence. Fentanyl and carfentanyl, increasingly used illicitly, are so potent that multiple doses of naloxone are typically required to restore respiration.

Table 1 shows the medications available, how they work, and how they are provided. (See page 6.)

“A general principle of authorization is it should serve a function of weeding out inappropriate care. Since nearly all the care we reviewed was appropriate, our authorization requirements were adding unnecessary administrative burden on the plan and our providers, and making it more difficult for members to access treatment.”

— Health plan leader
in two peer-reviewed articles, showing that methadone dosages greater than 60 mg and buprenorphine doses ranging from 16 to 32 mg produce similar reductions in illicit opioid use, with subtherapeutic doses leading to poorer health outcomes.

Short-term use of buprenorphine ("detox") is rarely effective unless detox is followed by maintenance doses, since relapse generally occurs after medication discontinuation. The risk of overdose death is increased in all forms of detoxification, including both medically supervised withdrawal and unplanned discontinuation of treatment. A frequently cited 2003 *Lancet* article randomized patients to detox (with placebo) or buprenorphine maintenance, and found 4 out of 20 (20%) in the detox placebo group had died and none had engaged in treatment at 12 months, compared to no deaths in the buprenorphine group in the same period.

### Review of Comparative Effectiveness of MAT

Extensive research has demonstrated the effectiveness of opioid agonist treatment (methadone and buprenorphine) in opioid use disorder. A meta-analysis of 50 studies showed methadone's retention rate ranging from 70% to 84% at one year, buprenorphine ranging from 60% to 90% at one year, with both treatments resulting in significant reductions in overdose death, illicit drug use, criminal activity, arrests, risk behaviors, HIV and hepatitis C incidence, as well as improvements in health status, functioning, and quality of life.

In 2013, SAMHSA sponsored research to analyze meta-analyses, reviews, and individual studies from 1995 through 2012 as part of its Assessing the Evidence Base series. SAMHSA provided an overview of the findings on methadone and buprenorphine maintenance treatment...
A meta-analysis showed that the mortality rate doubled when buprenorphine was discontinued and tripled when methadone was discontinued.26

Naltrexone is approved for both alcohol and opioid use disorder, and has both an oral (daily) and injectable (monthly) formulation. Naltrexone completely blocks opioid receptor sites, which reduces cravings and prevents euphoria from opioid use. Naltrexone has a good evidence base for treatment of alcohol addiction27,28 but limited evidence supporting its use in OUD.29 A Cochrane meta-analysis of oral naltrexone showed no difference compared to placebo when comparing retention in treatment, use of illicit opioids, or side effects. Studies of injectable naltrexone show lowered cravings and illicit drug use compared to placebo but are limited by short duration (two months30 to six months31) and high dropout rates. Unpublished manufacturer registry data (see Appendix B) showed that only 34 of 403 patients (9%) met goals of treatment at 12 months, and over 90% did not complete treatment, with 61 days as the median dropout rate.32 For those who drop out of treatment, overdose rates are high — heroin overdose rates were three times higher with naltrexone compared to buprenorphine or methadone in an Australian study, and almost eight times higher after treatment ended.33 Since the combination of high dropout rates and lowered tolerance can contribute to overdose rates, the evidence suggests that naltrexone should be used cautiously, especially in high-risk populations with longer addiction durations, less social support, and potentially higher overdose risk.34 The evidence of benefit for naltrexone is much stronger for employed patients with substantial psychosocial support (such as executives35 and health care providers36), and naltrexone is frequently used to prevent relapse for patients after complete detoxification from opioids.

Access Barriers to MAT
Despite the evidence that MAT is effective, only 10% of Americans seeking treatment can access it. Barriers to MAT include a shortage of primary care buprenorphine prescribers, addiction specialists, and opioid treatment programs; restrictive health plan authorization requirements; lack of sufficient behavioral health workforce; stigma (leading patients to avoid opioid treatment programs); and lack of provider knowledge and training.37 Prior to the Affordable Care Act, addiction treatment was not an essential health benefit, and treatment was unavailable in many Medicaid programs and excluded (or severely restricted, with high consumer costs) in commercial plans. While addiction treatment is now an essential health benefit, incremental dismantling and defunding of the Affordable Care Act remains an ongoing threat to substance use disorder coverage.

Due to historical fragmentation of coverage, many opioid treatment programs do not accept health insurance, and many commercial plans have difficulty ensuring a network sufficient to meet demand. Most health plans do not have medical, pharmacy, or care management staff knowledgeable about addiction treatments, which can impact policy decisions and the resources available to providers and members. Finally, privacy restrictions, such as federal 42 CFR Part 2 regulations, result in challenges to coordinating care. As more care settings become integrated, confusion about what is and is not allowed has led California to publish a State Health Information Guidance document to facilitate data sharing between treatment providers.38

HEALTH PLAN STRATEGIES
Support new MAT access points through grants, enhanced reimbursement, or improvement initiatives:

> Provide or support buprenorphine waiver training programs for providers, residents, and staff teams; promote mentoring and coaching support for new prescribers, including the Providers’ Clinical Support System and the Clinician Consultation Center’s Substance Use Warmline.

> Incentivize providers to become buprenorphine prescribers through building payments into pay-for-performance (P4P) programs and increasing reimbursement for inductions and medication management.

> Incentivize behavioral health integration, including providing grants for practices building new MAT or mental health services.

> Work with local coalitions to identify new MAT access strategies, including new access points in emergency departments, jails, primary care, and specialties.

> Support quality improvement initiatives in emergency departments to start buprenorphine treatment in the ED.

> Work with local jails to provide all FDA-approved forms of MAT during incarceration or on re-entry.
Research found that less than one-quarter of publicly funded, and one-half of private-sector, addiction treatment programs reported using MAT. According to SAMHSA, only 21% of SUD treatment centers offered methadone or buprenorphine maintenance in 2014. Many rural areas have no access to opioid treatment programs, and offer very few behavioral health resources. Substance use treatment providers for jails and prisons have been slow to add MAT to their treatment regimens. As of January 2017, fewer than a dozen state departments of corrections offered MAT in their drug treatment programs for incarcerated people, beyond limited methadone maintenance for pregnant women, despite two-thirds of American inmates suffering from addiction to alcohol or other drugs. Moreover, only 130 local and county jails in 21 states provided MAT, and just 17 states’ drug courts offered MAT, and many of these only offered naltrexone. Arizona Medicaid responded to this problem by creating programs to facilitate enrollment in Medicaid and facilitate access to MAT on re-entry after incarceration.

Few primary care providers have applied for and received the federal waivers needed to prescribe buprenorphine. Nationally, only half of waivered providers treat any patients with buprenorphine, and those who do treat these patients work with only a small number. Barriers for primary care providers to prescribing buprenorphine include a lack of training and experience, administrative burdens (including health plan authorization requirements), lack of mentorship, lack of available behavioral health resources, and concerns about the impact of DEA site visits on providers and staff.

Insurance Barriers to MAT

Insurance authorization policies can present major obstacles for patients and providers, according to a 2014 New England Journal of Medicine article. These obstacles include limits on prescribed dosages, annual or lifetime medication limits, initial authorization and reauthorization requirements, inadequate coverage of counseling services, and “fail-first” criteria requiring that other therapies be attempted prior to MAT (e.g., requirements for initial trial of taper or detox, or failure of other medication). A 2016 Urban Institute study that included health plans available in six cities (Los Angeles included) showed that prescription drug coverage was less restrictive for treatments targeted to individuals with alcohol use disorders compared to treatment for those with opioid use disorders. Buprenorphine was also more often subject to quantity or prior authorization limits, while oral naltrexone was not subject to the same level of authorization limits.

A 2017 California Society of Addiction Medicine (CSAM) survey of its membership showed significant concern about the administrative barriers created by authorization requirements. In particular, survey participants were concerned about step therapy, dose limitations, the burdens of proving counseling attendance, and the requirement for negative drug screens for ongoing therapy. Fifty-six percent of respondents found it difficult to access MAT for patients new to treatment due to insurance barriers, and 46% had difficulty getting approval for maintenance treatment. Only 35% of physicians found that authorization processes “went smoothly,” with 41% experiencing situations where patients went without treatment due to authorization delays. Eleven percent of the surveyed physicians reported that they stopped prescribing medications for OUD and 12% reported witnessing other colleagues who stopped prescribing. Often one to two hours of employee time was required per patient to collect documentation for clinical justifications, drug screens, and counseling, and to call the health plan (which was required more than half the time). Over 38% of respondents reported that insurance companies required treatments proven ineffective (e.g., failure of short-term detox) before approving buprenorphine or methadone.

Patient cost-sharing requirements also hinder access to MAT; some plans have copayments as high as $60 or $75 per outpatient visit and $2,500 per inpatient stay. When patients are starting buprenorphine, recommended practice is for them to initially receive a day or a week of medications at any one time, leading to much higher pharmacy copay burden compared to monthly prescriptions. Co-insurance costs can be even higher, and difficult for consumers to understand when comparing and shopping for plans. Consumers can have difficulty understanding drug formularies and cost-sharing requirements, which can make it difficult to choose a plan that provides affordable treatment.
Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction

Expanding Networks

In interviews, leaders discussed challenges on the provider supply side, including the limited number of physicians treating addiction and willing to participate in insurance networks. Since addiction treatment as an essential health benefit has only been in place since the 2014 implementation of the Affordable Care Act, a substantial number of opioid treatment programs are outside of insurance networks, and plans have difficulty identifying them as potential network providers. One commercial health plan leader noted that some clinicians who prescribe MAT “can keep their practices busy by not working with insurance companies” and that it is difficult to identify such providers and practices.

To increase MAT use, health plan leaders said they are working with providers to streamline internal reporting paperwork between primary care providers and the health plan, incentivize providers to start patients on buprenorphine by increasing reimbursement to reflect the additional time spent with patients, and encouraging physicians to use team-base models that allow licensed clinical social workers, nurses, or medical assistants to take on some of the administrative, educational, and care coordination functions to relieve the physician’s burden of prescribing MAT. Some plans have undertaken efforts to identify and contract with opioid treatment programs, as well as telehealth providers of buprenorphine. One commercial plan created a code for providers to bill for induction visits separately so that the provider would be reimbursed at a higher rate due to the increased complexity of the office visit. Some health plan leaders stated that pilot programs in expanded reimbursement, pay-for-performance, and training have extended buprenorphine access points in their network, and they plan to continue these programs.

In areas of the country particularly hard-hit by the epidemic, some health plans are using innovative payment approaches to expand treatment networks.

For example, Medicaid and commercial health plans in Vermont participate in a hub-and-spoke bundled payment model supporting opioid treatment programs (hubs) and primary care and other outpatient offices (spokes) to deliver MAT services. The model aims to create primary care and specialty mutual referral relationships for opioid use disorder treatment, with standardized protocols guiding referrals of complex patients to the hubs and stable

HEALTH PLAN STRATEGIES

- Remove authorization requirements for MAT.
- Remove or reduce copays for MAT (including pharmacy, medical, and behavioral health services).
- Remove authorization requirements and copays for naloxone.
patients back to the spoke for ongoing buprenorphine maintenance treatment. In mid-2017, California launched a federally funded, statewide hub-and-spoke program modeled after Vermont’s. While Medi-Cal will reimburse treatment services, relationships with commercial health plans are yet to be determined as of publication.

**HEALTH PLAN STRATEGIES**

- Estimate opioid use disorder prevalence in membership; determine the volume of opioid treatment programs (“methadone clinics”) and buprenorphine prescribers needed to meet the demand in each region.
- Identify and contract with opioid treatment programs in every region (to remove travel barriers).
- Work with local coalitions to identify new MAT access strategies, including new access points in emergency departments, jails, primary care, and specialties.
- Contract with MAT telehealth providers.
- Build hub-and-spoke networks, where opioid treatment programs are hubs that manage inductions and complex patients, and spokes are primary care providers treating milder addiction and providing maintenance.

**Patient Identification, Engagement, and Care Management**

Emergency department (ED) and inpatient admissions for complications from opioid use (including near overdose deaths) present a crucial opportunity for health plans to alert primary care providers, engage members in treatment, and reduce the incidence of future overdoses. Research shows that the weeks immediately following an overdose episode are characterized by extremely high risk of death. In a landmark Yale study, treating patients with a dose of buprenorphine during their emergency department stay doubled the retention rate in treatment at 30 days. This model has been replicated in emergency departments across Rhode Island, combined with peer recovery coaches to facilitate entry into treatment. According to a 2016 SAMHSA report, only about 11% of privately insured patients received the recommended combination of both medication and therapeutic services within the 30 days following an opioid-related hospitalization. In addition, hospitalizations for diagnoses related to IV drug use (e.g., endocarditis and osteomyelitis) are often missed opportunities to start MAT. A New England Journal of Medicine article described a group of infectious disease specialists learning to prescribe buprenorphine to inpatients to treat addiction and prevent readmission due to recurring IV drug use.

Some plans are making efforts to identify overdose events in the ED and follow up with patients to make sure they are linked to treatment, rather than simply restarted on the same dose of opioid, as is often the case. Partnership HealthPlan of California launched a pilot to send information obtained from inpatient utilization management to the primary care provider. Since opioid overdose does not require public health reporting, and many hospitals do not have systems in place to notify prescribers, health plans can play an important role in ensuring overdoses do not recur by alerting prescribers after an overdose, and recommending either referring patients into treatment (if they have addiction) or tapering them to a safer dose (if taking opioids for chronic pain).

To overcome challenges with patient identification (since admission diagnoses often are inaccurate and may not include underlying addiction as the reason for admission), some plans are using real-time notification vendors to identify patients and connect them with case management, and then even enabling case management and providers to collaborate on shared plans of care. These tools create interfaces with electronic health records in all hospitals in a region, apply analytics, and then deploy alerts summarizing critical information and a care plan that can be used in real time by ED physicians, health plans, and primary care practices. Health plans can identify high-priority populations, such as patients seeking frequent or early opioid refills, or those using multiple pharmacies or providers, to help connect these patients with care management and steer them into addiction treatment.

“Lock-in” programs are increasingly used by Medicaid and commercial health plans to identify patients using multiple providers and pharmacies, both to limit access to one provider and/or one pharmacy, and to refer to addiction treatment when appropriate.

Finally, some plans are actively providing case management for patients admitted to emergency departments or detox facilities. Blue Cross Blue Shield of Massachusetts hired social workers to contact plan members admitted
Why Health Plans Should Go to the “MAT” in the Fight Against Opioid Addiction

to detox facilities to help them figure out next steps for treatment. Aetna launched a Behavioral Health Medication Assistance Program where nurses and psychologists worked with physicians to counsel and manage the care of patients with addiction. According to Aetna, this program resulted in a 30% increase in opioid abstinence rates, a 35% reduction in hospital admissions, and a 40% decrease in total medical costs. Rhode Island launched a model where patients admitted to the ED with addiction or after an overdose are assigned to a recovery coach who meets with the patient over the next month and helps facilitate connections to treatment. While health plans have yet to cover these ED visits (paid from state and federal funding), they cover some of the ongoing counseling visits. A New York commercial health plan (not named in the publication) assigned members using multiple pharmacies for opioids to a certified addiction counselor who contacted the prescribers to alert them about the issue, and contacted the members to screen them for addiction and discuss treatment options. As a result, the use of multiple prescribers and pharmacies dropped significantly.

**HEALTH PLAN STRATEGIES**

- Contract with vendor to ensure notification of ED or hospital admissions for overdose; provide care management and treatment referral; notify prescribers.
- Start direct or delegated care management program for addiction; identify patients through pharmacy or utilization data, pharmacy benefits manager (PBM) analytic programs, or through lock-in programs.
- Work with hospitalists to start buprenorphine or methadone treatment with inpatients hospitalized with addiction-related diagnoses (e.g., endocarditis or osteomyelitis).
- Place peer coaches or care navigators in emergency departments to guide patients to treatment.
- Develop data dashboards to compare delegated medical groups and contracted providers on standardized measures of opioid prescribing and MAT utilization.
- Identify outlier and/or fraudulent prescribers; ensure patients are transferred to needed care if these practices close down.

**Data Sources and Measuring Success**

Health plans track MAT use and impact through pharmacy data (prescriptions filled) and utilization data (behavioral health visits, primary care visits, ED and hospital rates), although accurate inpatient data are elusive since the admission diagnoses may not mention SUD. Research studies tend to define MAT success as lack of illicit drug use in addition to retention and treatment, and avoidance of morbidity (HIV, hepatitis) and mortality (overdose). These outcomes can be difficult for health plans to measure. Therefore, plans often struggle to identify process and outcomes measures to define whether access to MAT is sufficient, and to know if new programs are meeting goals.

Multiple health plans promote clinical practice guidelines identified by the American Psychological Association and the American Society of Addiction Medicine (ASAM) as the standard for services and care delivery. Another leader described a study in progress, showing improved outcomes for patients using MAT: an increase in the number of people receiving MAT correlated with decreased ED admissions. The plan will soon publish an internal study that compared maintenance treatment with traditional treatment. The study found that “by increasing the coordination [between case managers, primary care providers, and the health plan] to offer comprehensive and evidence-based treatments, there are better outcomes.” The same health plan leader reflected, “We have a task force that looks at MAT from a variety of angles. We have lots of resources pointing to MAT.”

Interviewees noted that a lack of clear success metrics and data points for health plans makes comparison and outcome measure identification difficult between specific subsections of health plan membership.

“Where I work, clinicians from other specialties do not step forward and prescribe it due to perceived insurance problems.”

— CSAM Member
HEALTH PLAN STRATEGIES

» Create dashboard to measure health plan success: opioid prescriptions and morphine milligram equivalents (MME) pmpm, multiple prescribers/pharmacies, high-dose use, buprenorphine prescriptions pmpm, members on MAT compared to members with SUD diagnoses.

» Promote clinical practice guidelines for safer prescribing and MAT.

Mitigating Buprenorphine Diversion

Health plan leaders are concerned about the risk of buprenorphine diversion (prescribed medications being sold or distributed to others) based on published reports, data from emergency departments, and information from law enforcement. However, some leaders expressed that the risk of inadequate access to treatment outweighed the risk of inappropriate use, and that this calculation weighed into decisions to remove authorization requirements from buprenorphine and buprenorphine/naloxone products. One plan noted that 95% of buprenorphine authorization requests were approved, and most denied requests were due to lack of information, leading them to decide the authorization process was not adding value. Another plan leader stated that while authorization requirements were removed from buprenorphine products in general, these requirements will be kept in place for prescribers with outlier and unsubstantiated prescription patterns.

Return on Investment: The Financial Case for MAT

Cost factors in MAT were also examined as part of this research. Evidence summarized below shows that addiction treatment decreases health costs — largely due to avoided emergency department and inpatient stays. One study found that treating injection drug users lowers the incidence of expensive complications including endocarditis, abscesses, HIV, and hepatitis C. Treating addiction also lowers the ED and hospital costs associated with reversed opioid overdose events; some of these studies are described below.

HEALTH PLAN STRATEGIES TO INCREASENALOXONE DISTRIBUTION

» Offer or support training on naloxone co-prescribing (routine naloxone prescriptions with all — or high-risk — chronic opioid prescriptions).

» Incentivize or train local pharmacies to furnish naloxone without a prescription.

» Work with local coalitions to increase dispensing of naloxone in community settings (e.g., needle exchanges) under standing orders.

Alternate Views on Diversion

While minimizing diversion is a legitimate plan concern, some studies have shown that diverted buprenorphine is typically used for its intended purpose — reducing cravings and coping with withdrawal symptoms — as opposed to providing euphoria. A study documented that people in treatment with historical illicit use of buprenorphine were twice as likely to stay in treatment as those with no prior experience. In 1995, recognizing a spike in heroin deaths, the French government systematically removed all barriers to buprenorphine treatment by allowing all physicians to prescribe, maximizing reimbursements, and minimizing coverage barriers. As a result, 20% of French general practitioners prescribe buprenorphine, overdose deaths have dropped by 79%, and diversion, while present, is described as minimal.

A 2014 study looked at the costs of care in commercial integrated health systems and found that patients with buprenorphine plus counseling had less use of general medical services and lower total health care costs compared to those with little or no addiction treatment. Specifically, annual health care costs with buprenorphine treatment were $13,578, while average health care costs with no addiction treatment were $31,055. Other studies have shown that access to therapeutic doses of buprenorphine/naloxone are associated with a longer treatment period, with resources used and lower total medical costs despite higher pharmacy acquisition costs.

A study looking at methadone maintenance and costs of care in a commercial plan demonstrated that costs were 50% lower compared to two or more drug-free treatment visits, and 62% lower when compared to one or zero
drug-free treatment visits. A 2014 study on buprenorphine maintenance demonstrated higher pharmacy charges but lower outpatient, inpatient, ED, and total health care charges ($28,458 vs. $49,051) for patients adherent to buprenorphine.

In another study of methadone treatment, a commercial health plan’s costs for members receiving methadone maintenance were 50% lower ($7,163) than those with two or more outpatient addiction treatment visits without methadone ($14,157), and 62% lower than those with one or zero outpatient addiction treatment visits without methadone ($18,694).

### HEALTH PLAN STRATEGIES

- Work with addiction treatment and OB community to increase access to buprenorphine and methadone treatment for pregnant members.
- Work with hospitals to increase their capacity to manage neonatal abstinence syndrome and decrease the number of infants requiring NICU care, including promotion of evidence-based practices such as rooming in, breastfeeding, and use of buprenorphine in the treatment of infants.

### MAT and Neonatal Abstinence Syndrome

Health plans are seeing increasingly long lengths of stay for neonatal abstinence syndrome (NAS). The National Institute for Drug Abuse estimates the average cost of treatment for NAS as $66,700 per infant, compared to $3,500 without NAS. While evidence supports minimizing stimulation by rooming-in (as opposed to a bright, overstimulating neonatal intensive care environment), breastfeeding (in the absence of HIV), promotion of nonpharmacological soothing techniques, and use of standardized scoring tools to assess when medication is needed, many hospitals feel ill-equipped to manage infants and thus transfer them to neonatal intensive care units, often leading to separation of mother and infant at a time when bonding is a critical motivating factor for women’s retention in treatment.

While MAT in pregnancy has been shown to increase retention in treatment and prevent relapse, many pregnant women, especially in rural areas, have no local access to care, and many fear seeking treatment due to the risk of losing custody. While attitudes are slowing changing, many child protection workers and judges continue to view MAT as a sign of continuing addiction and deny custody if women are taking methadone or buprenorphine. Buprenorphine in pregnancy can lower the risk of NAS and long lengths of stay compared to morphine treatment. One study showed the mean dose of morphine required for infants exposed to buprenorphine in utero was 1/10th the dose compared to methadone, with length of stay decreasing by 75%.

While neonatal outcomes improved, retention in treatment for buprenorphine was lower (67%) compared to methadone (88%), potentially due to the additional counseling and case management services offered in methadone maintenance. Studies have not found problems in childhood development due to treatment of addiction with buprenorphine or methadone in pregnancy.

While morphine has been considered the standard of care for NAS treatment, a 2017 *New England Journal of Medicine* randomized study showed treating neonatal abstinence syndrome with buprenorphine cut lengths of stay in half (15 vs. 28 days) compared to morphine, with no difference in the rate of adverse events.

In summary, the opioid epidemic continues to drive up health care costs for plans, consumers, and the public, with costs of care due to opioid misuse and addiction rising to $31 billion for the insurance industry nationwide. This creates a pressing business case for plans to work actively to prevent new cases of addiction through changing prescribing practices, and to ensure their networks have adequate treatment resources for people with addiction, including pregnant women, and for infants with NAS.

### Legislation Related to Health Plans and MAT

#### Federal Parity Laws

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 prohibits insurers from applying cost-sharing and benefit limits to treatments for SUD that are more restrictive than those placed on other medical services. Prior to the ACA, MHPAEA did not apply to Medicaid beneficiaries or Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and state Children’s Health Insurance Program plans. The ACA also...
requires insurers to cover substance use and behavioral health treatment as an essential health benefit.

A 2016 federal parity task force issued a report91,92 (see Appendix A) stating that a plan may not require prior authorization for buprenorphine based on safety risks associated with the drug if prior authorization is not required for prescription drugs with similar safety risks to treat medical or surgical conditions.93 MHPAEA also prohibits fail-first requirements if such requirements are not equivalent to the medical benefit. Finally, 30-day limitations to buprenorphine could be inconsistent with authorization practices for chronic medical and surgical conditions, since authorization for prescription drugs used for chronic medical conditions is typically approved for 6 or 12 months. See Appendix A for federal questions and answers on these requirements.94

The Centers for Medicare & Medicaid Services (CMS) Opioid Misuse Strategy Report 2016 recommended that health plans promote naloxone access and coverage among private payers, strengthen messaging, and accelerate widespread adoption of MAT by collaborating with SAMHSA and other Health and Human Services agencies.95 The report includes plans for CMS to evaluate health plan coverage laws, including SUD treatment network adequacy, among other priorities.

It should be noted that federal negotiations on legislation to weaken the ACA continue at the time of this report’s publication. Even without repeal, the essential health benefit definitions could be altered or eroded by administrative actions. In June 2017, the Robert Wood Johnson Foundation and Urban Institute released an analysis concluding that repealing and replacing the ACA could significantly reduce access to mental health and SUD treatment and parity protections.96

Actions in the States
At the state level, some policymakers are looking to legislative solutions to increase access to MAT. In 2014, Massachusetts enacted legislation to increase SUD treatment access by prohibiting prior authorization for substance use disorder and mandating coverage of 14 days of inpatient substance use treatment.97 It also created a commission to look at the feasibility of requiring insurance providers to monitor and limit the use of opioids. The commission will also investigate models for limiting the overprescription of opioids without limiting patients’ access to necessary pain medication.98

In Rhode Island, 2016 legislation required health insurers to provide SUD treatment to explicitly cover MAT services including buprenorphine, naltrexone, and other clinically appropriate medications.99 Commercial health plans must provide coverage for at least one generic opioid antagonist and device approved to treat opioid overdose (e.g., naloxone). Health plans may require prior authorization for nongeneric versions. Coverage includes naloxone prescribed or dispensed via standing order or through a collaborative practice agreement, allowing it to be dispensed to family members or friends of people at risk of overdose.

In 2016, the New York Attorney General Eric Schneiderman initiated an investigation into Cigna and Anthem’s MAT policies, alleging that authorization policies delayed treatment and unnecessarily put patients at risk. These investigations were part of a law that was passed in 2011 enabling doctors and pharmacists to report and track controlled opioids in real time. This law led to many prosecutions of health care providers who illegally prescribed and diverted opioids.100

In 2016, New York passed legislation limiting the use of prior authorizations for MAT, as well as limiting opioid prescriptions to seven days and requiring mandatory prescriber education on pain management.101 This comprehensive legislation followed a final report and recommendations released by the Governor’s Heroin and Opioid Task Force.102 In February 2017, the American Medical Association sent a letter to the National Association of Attorneys General to raise awareness about the consequences of insurance plan requirements for prior authorization for MAT, urging “all attorneys general to carefully review and consider taking similar action to the policies of New York Attorney General Eric Schneiderman.”103 In 2017, Cigna, Aetna, and Anthem announced they would end prior authorization for MAT across the US.104

New York State’s FY 2017 budget invested nearly $200 million to combat the heroin and opioid epidemic — an 82% increase in state spending since 2011. This figure included $38 million to fund MAT programs that serve approximately 12,000 clients in residential or outpatient settings.105 Governor Cuomo states that he plans to eliminate prior authorization requirements and to increase access to buprenorphine by recruiting health care providers to become prescribers.106
Medicaid Managed Care and MAT in California

In 32 states including California, Medicaid pays for addiction treatment in a separately funded payment and delivery system, or “carve-out.” Medicaid managed care plans cover medical care, counties cover care for serious mental illness, and addiction treatment is managed through a separate state program. As of 2016, 27 out of California’s 58 counties did not have opioid treatment programs (OTPs), and few clinicians are stepping up to provide buprenorphine access in these counties. Only one Medicaid beneficiary receives buprenorphine for every four patients who receive methadone.107

In recent years, California has made a concerted effort to increase addiction treatment access in safety-net settings:

- In 2015, the California Department of Health Care Services (DHCS) removed the authorization requirement for buprenorphine in Medi-Cal (California’s Medicaid); buprenorphine claims doubled between 2015 and 2016.108

- In 2016, DHCS received approval for a Medi-Cal waiver authorizing participating county governments to serve as managed care plans responsible for covering all SUD treatments for Medi-Cal enrollees. While most counties are participating, small rural counties do not have the resources to do so. In response, Partnership HealthPlan, a public Medi-Cal managed care plan, is planning to manage the addiction treatment network on behalf of eight of their counties, essentially “carving” SUD services back into managed care in their region.

- In 2017, DHCS received an $89 million SAMHSA grant109 for a MAT expansion project, replicating a hub-and-spoke model proven successful in Vermont.110 This model uses OTPs as specialty centers (hubs) where more complex patients can be managed, and primary care sites (spokes) where clinicians manage stable patients and milder addiction. While the grant will serve all of California, tribal and rural communities will receive special attention, since only 2.2% of American physicians have obtained the waivers required to prescribe buprenorphine to treat opioid use disorders, and 90.4% of these physicians are practicing in urban counties.

To address the “not in my backyard” challenges of local resistance to building addiction treatment resources, the state public health department partnered with the California Health Care Foundation (CHCF) to expand access to MAT by supporting locally-led community coalitions. Coalitions identify treatment gaps in their counties and work to increase access to MAT through provider trainings, launching induction clinics (allowing patients to be initiated in treatment and then transferred to primary care providers when stable), starting MAT telehealth programs, and integrating addiction treatment into community health centers. These coalitions also work actively to change opioid overprescribing practices and increase access to naloxone.111 In related work, 25 community health centers across California joined a CHCF-funded learning collaborative to receive training and technical assistance to start MAT practices in their clinics,112 and eight hospitals are participating in a related collaborative to start MAT-initiation programs in their emergency departments.113

While substance use treatment services are carved out of Medi-Cal managed care plan contracts, some local Medi-Cal managed care plans launched MAT expansion projects in their networks, recognizing that promotion of MAT is a way to improve health and safety in their membership while lowering ED and inpatient services associated with untreated addiction. Examples include sponsoring buprenorphine waiver trainings, pay-for-performance programs that incentivize physicians to become waivered and to accept new patients,114 and fee-for-service payments on top of capitation.115 Such incentives recognize the additional time required to start patients on treatment.
Conclusion: Next Steps for Health Plans

Health plans, as payers both for prescription opioids and the medical consequences of untreated OUD, are well-positioned to address the public health crisis through increasing access to addiction treatment and safer pain management options, and many are taking steps to do so. Health plan leaders interviewed for this research emphasized the importance of health plans taking a leading role in addressing both the roots of the crisis (through plan-wide efforts to ensure safer prescribing practices) and its consequences (by ensuring streamlined addiction treatment access, and safer management of opioid-dependent patients with chronic pain).

The literature review and interviews with health plan leaders indicate that plans are working to increase treatment access through multiple coordinated approaches:

▶ **Pharmacy benefit.** Changing formularies to promote safer opioid prescribing; eliminating prior authorization requirements and copays for MAT and naloxone; starting lock-in programs; incentivizing or training local pharmacies to furnish naloxone without a prescription.

▶ **Provider network.** Assessing OUD prevalence and ensuring sufficient MAT access in all regions; promoting new MAT access points in primary care, emergency departments, inpatient settings, and corrections by supporting trainings, increased reimbursement, P4P programs, or grants; contracting with telehealth providers; training providers to offer co-prescriptions of naloxone; incentivizing behavioral health integration through P4P or direct grants; working to increase access to MAT for pregnant women; and working with hospitals to ensure evidence-based treatment of neonatal abstinence syndrome.

▶ **Medical management.** Providing data analytics to identify patients at risk for addiction; training case managers to guide members to treatment; starting care management programs for addiction; notifying prescribers for ED and hospital overdose admissions; supporting peer navigators in emergency departments; and minimizing copays for addiction treatment (medications, prescriber visits, and behavioral health).

▶ **Data analytics.** Creating dashboards to measure progress on opioid prescribing and MAT access, and sharing them with providers and delegated medical groups; identifying outlier prescribers to provide education and (when appropriate) refer for fraud; identifying outlier members to refer to case management.

▶ **Community engagement.** Working with local opioid safety coalitions to adopt community prescribing guidelines and ensure adequate access to MAT and naloxone (for example, over 35 of California’s 58 counties have active opioid safety coalitions; see www.chcf.org/oscn).

Both commercial and Medicaid health plan leaders focused on the need to counteract bias against medication-assisted addiction treatment by focusing on the evidence — lowered overdose rates and increased retention in treatment — and to directly address the stigma associated with MAT that still prevents many medical communities from stepping up to expand access. Some leaders called for aggressive action on network access for addiction similar to that used for any other specialty in high demand and low supply.

In terms of return on investment, the research shows that paying for OUD saves insurers costs in the long run. MAT reduces expensive ED visits and hospitalizations due to overdose and other opioid-related morbidities. Further, the costs associated with ineffective treatment go beyond relapse and can include higher risks for infectious disease due to IV drug use.

While plans have a clear business case for change, the health plan leaders stressed that their commitment went beyond return on investment. Plans are poised to play a critical role in a systemwide effort to turn the epidemic around: to prevent a new generation of people dependent on or addicted to opioids, to safely treat those with chronic pain at risk due to long-term opioid use, and to ensure that all members with addiction have easy access to effective treatment. Plans cannot do this alone, but the epidemic won’t end unless they take action.

FOR MORE TOOLS, GO TO SMART CARE CALIFORNIA
Appendix A. FAQ on Implementation of ACA and Parity Act

A frequently asked questions document released to clarify the 2016 final report of the federal parity task force specifically addressing prior authorization for buprenorphine as a potential parity violation.118

Q. My plan requires prior authorization from the plan’s utilization reviewer that buprenorphine is medically necessary for the treatment of my opioid use disorder. . . . Although there are prescription drugs to treat medical/surgical conditions that have similar safety risks, my plan does not impose similar prior authorization requirements on those drugs. Is this permissible?

A. No. A plan may impose an NQTL [non-quantitative treatment limit], including a prior authorization requirement for buprenorphine, if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to buprenorphine to treat an opioid use disorder are comparable to, and applied no more stringently than, those used in applying its prior authorization requirement with respect to medical/surgical benefits in the prescription drug classification under MHPAEA [Mental Health Parity and Addiction Equity Act].

In this scenario, the plan imposes the prior authorization requirement due to stated safety concerns. However, the prior authorization requirement is applied more stringently to buprenorphine when used to treat opioid use disorder than it is applied to prescription drugs with similar safety risks to treat medical/surgical conditions. Accordingly, the plan’s prior authorization requirement on buprenorphine does not comply with the MHPAEA.

Q. My plan requires that I meet specific nonpharmacological fail-first requirements (for example, that I have tried counseling alone, failed at recovery, and resumed substance use) before it will authorize coverage for buprenorphine to treat my opioid use disorder. While comparable evidentiary standards and other factors indicate that similar fail-first requirements could be imposed on certain prescription drugs covered by my plan for medical/surgical conditions, the plan does not impose fail-first requirements in these instances. Is this permissible?

A. No. A fail-first requirement is an NQTL that must comply with the requirements of MHPAEA. A plan or issuer cannot impose a fail-first requirement on coverage for buprenorphine for opioid use disorder unless, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in designing and imposing this fail-first requirement are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying fail-first requirements to medical/surgical benefits in the prescription drug classification under MHPAEA.
In this case, the plan is imposing a nonpharmacological requirement that the individual fail first at recovery with counseling alone before the plan will authorize coverage of benefits for buprenorphine. While comparable evidentiary standards and other factors indicate that similar fail-first requirements could be appropriate before authorizing coverage for certain other prescription drugs covered by the plan’s first requirement that applies for medical/surgical conditions, the plan does not in fact impose fail-first requirements in any of these instances. Accordingly, the fail-first requirement imposed on buprenorphine is an NQTL that the plan applies more stringently to a substance use disorder condition than medical/surgical conditions. This disparity violates MHPAEA.

Q. My group health plan states that it follows nationally recognized treatment guidelines for setting prior authorization requirements for prescription drugs, but requires prior authorization for my buprenorphine/naloxone combination at each refill (every 30 days) for my opioid use disorder, which is not consistent with nationally-recognized treatment guidelines. Is this permissible?

A. No. In setting the NQTL of prior authorization for the substance use disorder medication, buprenorphine/naloxone, a plan or issuer must apply comparable processes, strategies, evidentiary standards, and other factors no more stringently to buprenorphine/naloxone than those applied to medical/surgical medications. The plan states that it follows nationally-recognized guidelines. However, these guidelines, such as the American Society of Addiction Medicine (ASAM) national practice guidelines, do not support 30-day authorization practices for buprenorphine/naloxone. Furthermore, the plan does not deviate from nationally-recognized treatment guidelines when establishing prior authorization requirements for any prescription drugs to treat medical/surgical conditions. Accordingly, although the plan asserts that its process of setting the NQTL of prior authorization — following nationally-recognized treatment guidelines — is comparable as written, in operation, the plan’s process departs from and provides less coverage than recommended under nationally-recognized treatment guidelines for buprenorphine/naloxone, in violation of MHPAEA.

However, as an alternative to simply mirroring nationally-recognized treatment guidelines, many plans and issuers use Pharmacy and Therapeutics (P&T) committees in deciding how to cover prescription drugs and evaluating whether to follow or deviate from nationally-recognized treatment guidelines for setting the prior authorization requirements. The Departments note that while the use of P&T committees to inform prior authorization requirements for prescription drugs in this manner may not violate MHPAEA per se, these processes must also comply with MHPAEA’s NQTL standard in operation. For example, if the plan deviates from nationally-recognized treatment guidelines for buprenorphine/naloxone based on P&T committee reports, then use of the P&T committee would be evaluated for compliance with MHPAEA’s NQTL requirements (for example, by evaluating whether the P&T committee is comprised of comparable experts for MH/SUD conditions, as compared to the experts for medical/surgical conditions, and how such experts evaluated nationally-recognized treatment guidelines in setting prior authorization for medications for both MH/SUD and medical/surgical conditions).
Appendix B. Alkermes Registry Data, VICTORY Trial

Most published studies reviewing the effectiveness of injectable naltrexone (Vivitrol) in opioid use disorder are short: two to six months in duration. The best available data on 12-month retention in treatment are from the Alkermes VICTORY (Vivitrol’s Cost and Treatment Outcomes Registry) registry. While these data were not published, they were presented in a presentation at the American Society of Addiction Medicine Conference, April 13, 2014.

<table>
<thead>
<tr>
<th>REASONS FOR DISCONTINUATION PRIOR TO 12 MONTHS</th>
<th>n</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost to follow up</td>
<td>199</td>
<td>49.4%</td>
</tr>
<tr>
<td>Withdrawal by patient</td>
<td>60</td>
<td>14.9%</td>
</tr>
<tr>
<td>Study terminated by sponsor</td>
<td>30</td>
<td>7.4%</td>
</tr>
<tr>
<td>Patient feels treatment goal met</td>
<td>22</td>
<td>5.5%</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>5.2%</td>
</tr>
<tr>
<td>Physician intended planned course of treatment met</td>
<td>12</td>
<td>3.0%</td>
</tr>
<tr>
<td>Insurance loss or loss of coverage for Vivitrol™</td>
<td>11</td>
<td>2.7%</td>
</tr>
<tr>
<td>Lack of efficacy by patient</td>
<td>10</td>
<td>2.5%</td>
</tr>
<tr>
<td>Noncompliance</td>
<td>10</td>
<td>2.5%</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>9</td>
<td>2.2%</td>
</tr>
<tr>
<td>Relocated</td>
<td>9</td>
<td>2.2%</td>
</tr>
<tr>
<td>Death</td>
<td>5</td>
<td>1.2%*</td>
</tr>
<tr>
<td>Time constraints</td>
<td>3</td>
<td>0.7%</td>
</tr>
<tr>
<td>Withdrawal symptoms or re-entered detox</td>
<td>2</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

*Three ODs: 21, 55, and 115 days post last dose; one drowning: 28 days post last dose; one suicide: 34 days post last dose.

Endnotes


2. These data include heroin.


6. These data include heroin.


10. Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths, Health and Human Services, March 26, 2015, aspe.hhs.gov.

11. TI-17-014 MAT Expansion Project, California Opioid Maintenance Providers, 2016, californiamethadone.org (PDF).


20. Fullerton et al., “Medication-Assisted Treatment.”


22. Fullerton et al., “Medication-Assisted Treatment.”


27. “Treatment Improvement Protocol (TIP) Series (No. 49, 2009),” Substance Abuse and Mental Health Services Administration, www.ncbi.nlm.nih.gov. Compared with using placebo, short-term naltrexone treatment (less than or equal to 12 weeks) significantly improves relapse rates during active treatment and is linked with a lower percentage of drinking days, fewer drinks per drinking day, longer times to relapse, more days of abstinence, and lower total alcohol consumption during treatment.


32. American Society of Addiction Medicine presentation by Frank J Vocci PhD, Jacquelin Zummo MPH, MBA, Asli Memisoglu ScD, David R Gastfriend MD, Bernard L Silverman MD, reviewing results of VICTORY trial (Vivitrol’s Cost and Treatment Outcomes Registry), representing experience in US with 403 patients, funded by Alkermes (Vivitrol manufacturer). 10% of patients discontinued due to treatment goals met. 9% of patients discontinued due to study termination or insurance loss (therefore unable to determine efficacy).


42. Advocates for Human Potential, Promising Practices.


44. Advocates for Human Potential, Promising Practices.


52. Peters and Wengle, Coverage.


57. Burns, “Policies Related.”


60. Justin Johnson and Lawrence Miller, Report on Integration of Substance Abuse Payment and Care Coordination with Physical and Mental Health, Vermont Legislature, January 15, 2016, hcr.vermont.gov (PDF).


66. M. R. Larochelle et al., “Opioid Prescribing After Nonfatal Overdose and Association with Repeated Overdose: A Cohort Study,” Annals of Internal Medicine 164 (January 5, 2016): 1-9, doi:10.7326/M15-0038. A 2016 study from the Annals of Internal Medicine showed that even for people who have previously overdosed, it is common for patients to be prescribed the same opioid dosage. Using the Optum database of claims for a large national insurer, the authors found that among 2,848 patients who survived an overdose on opioids prescribed for chronic noncancer pain, 91% continued to receive opioid prescriptions.


68. Livingston, “Insurers Slowly Removing Barriers.”


75. Auriacombe et al., “French Field.”


79. McCarty et al., “Methadone Maintenance.”

80. Tkacz et al., “Relationship.”

81. McCarty et al., “Methadone Maintenance.”


90. Livingston, “Insurers Slowly Removing Barriers.”


92. FAQs About Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation, US Department of Labor, October 27, 2016, [www.dol.gov](http://www.dol.gov) (PDF).

93. New FAQ Guidance on Mental Health Parity Requirements, PricewaterhouseCoopers, November 8, 2016, [www.pwc.com](http://www.pwc.com) (PDF).

94. Department of Labor, FAQs.


98. Under Section 28, a commission is to study and examine the feasibility of requiring insurance providers in the commonwealth, including MassHealth, to monitor and limit the use of opiates. The commission shall investigate the public benefit to mandating that insurance providers monitor and limit policyholders’ use of Schedule II and Schedule III opiates. Under Section 30, the Center for Health Information and Analysis (CHIA) has the authority to conduct a review of the accessibility of substance use disorder treatment and the adequacy of insurance coverage in Massachusetts. Under Section 32, CHIA can conduct a mandated benefit review to ensure that insurance companies reimburse providers for MAT. Insurance companies must also reimburse providers for mental health and substance use disorder screening when a primary care physician deems it necessary.

99. Alexander Perry and Brandon Goldner Act, 2016 RI Pub Laws 172, [webserver.rilin.state.ri.us](http://webserver.rilin.state.ri.us); Act of June 28, 2016, 2016 RI Pub Laws 189, [webserver.rilin.state.ri.us](http://webserver.rilin.state.ri.us).


107. T1-17-014 MAT Expansion Project, californiamethadone.org (PDF).


111. For more information, see CHCF’s “California Opioid Safety Coalitions Network,” www.chcf.org/oscn.


115. Central California Alliance for Health created a fee-for-service payment program on top of capitation to encourage primary care providers to prescribe buprenorphine, as well as developing incentive payments for PCPs obtaining a buprenorphine waiver.

116. Livingston, “Insurers Slowly Removing Barriers.”

117. Livingston, “Insurers Slowly Removing Barriers.”

CVS Health announced Thursday that it was limiting the amount and strength of prescription opioid painkillers it provides to patients taking the drugs for the first time, a step intended to help curb opioid abuse.

Through its pharmacy benefit manager, CVS Caremark, which has 90 million plan members, the company will introduce three new policies, effective in February. First, patients new to opioids will only get seven days’ worth of medication. The program will also limit daily dosages and require that immediate-release formulations of drugs be given before extended-release versions are prescribed.

Doctors can ask for exemptions for certain patients, CVS said, and employers and insurers can opt out of the program.

CVS said the new rules will bring the company in line with prescribing guidelines\(^1\) issued by the Centers for Disease Control and Prevention last year. In a Health Affairs blog post\(^2\), CVS officials estimated that 61 people at a company of 100,000 employees would avoid becoming addicted to opioids in a given year if those guidelines were followed. The estimate, they said, was based on commercial insurance data.
“The CDC Guideline should become the default approach to prescribing opiates, a scenario in which physicians would have to seek exceptions for those patients who need more medication or longer duration of therapy,” the officials wrote. “What is more, pharmacy benefit managers are better placed than others in the pharmacy supply chain to put this approach to the CDC Guideline into practice,” as opposed to medication wholesalers or retail pharmacists.

Based on the CDC’s recommendations, CVS’s new daily dosage limit is 90 morphine milligram equivalents, or MMEs, a measure of the strength of a painkiller.

As part of the new effort, CVS Pharmacy sites will also offer enhanced counseling and education campaigns about opioid safety and addiction.

The move by CVS could fuel the debate about whether doctors, PBMs, and pharmacies are reacting too stringently to the opioid epidemic, tightening access to prescription opioids so that patients with legitimate pain problems cannot get the treatment they feel they need. Another large PBM, Express Scripts, previously announced it was planning to limit the supply and dosage of opioids for first-time patients, a move the American Medical Association warned was a “blunt, one-size-fits-all approach” that took treatment decisions away from the doctor and patient.

Increasingly, heroin and the illicit use of synthetic opioids like fentanyl are responsible for fatal opioid overdoses, but many cases of addiction begin with prescription painkillers. In some cases, people will start taking leftover medicine originally prescribed to someone else.

CVS also announced Thursday it was adding another 750 medication disposal kiosks at its pharmacies around the country, roughly doubling the number that CVS has helped open as of now.

The roots of the opioid epidemic are multifaceted, but pharmacies and PBMs have been accused of allowing painkillers to flow into communities with few limitations. Earlier this year, Cherokee Nation sued CVS and other companies, alleging they helped fuel an addiction crisis in the tribal community.

About the Author

Andrew Joseph
General Assignment Reporter
Andrew Joseph is a general assignment reporter at STAT.

Tags

Links


Topic 2: C-Section for Low-Risk First-Time Births
Meeting Materials
Multi-Lever Model for Change

Reduce NTSV C-section

- Data/Transparency
- Purchaser Requirements
- Workforce
- Quality Improvement (QI)/Clinician Interventions
- Consumer Engagement
- Public Policy
- Payment
# Potential Ways to Address C-section Levers

<table>
<thead>
<tr>
<th>Category</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data/ Transparency</strong></td>
<td>• Public Reporting on <a href="#">Cal Hospital Compare</a> of maternity metrics (NTSV, Episiotomy, VBAC, Breast Feeding)</td>
</tr>
<tr>
<td></td>
<td>• Smart Care CA <a href="#">Hospital Honor Roll</a></td>
</tr>
<tr>
<td></td>
<td>• Strong Data Infrastructure: Hospitals can submit data to CMQCC’s <a href="#">Maternal Data Center’s</a> online tool that generates rapid-cycle performance metrics on maternity care services for hospital participants</td>
</tr>
<tr>
<td><strong>QI/Clinician Interventions</strong></td>
<td>• Implement <a href="#">CMQCC Provider Toolkit to Support Vaginal Birth and Reduce Primary Cesareans</a></td>
</tr>
<tr>
<td></td>
<td>• Hospital participation in CMQCC QI Collaborative to Support Vaginal Birth and Reduce Primary Cesareans</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>• Adopt blended case rate payment for both professional fees and facility fees to remove financial incentive for C-section (see <a href="#">PBGH Maternity Pilot Project</a>)</td>
</tr>
<tr>
<td></td>
<td>• Pay less for scheduled C-sections without trial of labor and without clear medical indication</td>
</tr>
<tr>
<td></td>
<td>• Pay-for-performance incentives for meeting NTSV C-section goals</td>
</tr>
<tr>
<td><strong>Purchaser Requirements</strong></td>
<td>• Contract language that holds health plans accountable for variation and requires payment reform that removes incentive for operative delivery</td>
</tr>
<tr>
<td></td>
<td>• Exclusion of hospitals who do not meet Healthy People 2020 goal of 23.9% for NTSV C-section from network, or require low performers to document a performance improvement plan</td>
</tr>
<tr>
<td></td>
<td>• Contract requirements for hospitals to submit data to Maternal Data Center and participate in QI activities</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>• Train more certified nurse midwives</td>
</tr>
<tr>
<td></td>
<td>• Encourage use of doulas</td>
</tr>
<tr>
<td></td>
<td>• Change attitudes of current and new L&amp;D providers that birth is a natural process</td>
</tr>
<tr>
<td><strong>Consumer Engagement</strong></td>
<td>• Distribute CHCF, CMQCC, Consumer Reports jointly created materials on engaging consumers to reduce unnecessary C-sections</td>
</tr>
<tr>
<td></td>
<td>• Encourage consumers to look at public reporting of maternity metrics on Yelp Hospital Pages (forthcoming)</td>
</tr>
<tr>
<td><strong>Public Policy</strong></td>
<td>• Support legislation that permits greater use of CNMs</td>
</tr>
</tbody>
</table>
BACKGROUND

SCC requested help in developing public education materials to unify message and approach.

Materials would sync with CMQCC provider toolkit providers.

Materials would need to be suited for wide distribution — including SCC leadership, membership, and beyond.

Need both video and print content, for online and offline distribution.
GOALS

To develop consumer education materials (video and print) about C-section for wide distribution that will:

• Educate women about C-sections
• Motivate consumer action to reduce the likelihood of unnecessary surgery
• Encourage informed, shared decision-making between pregnant women and their providers

PARTNERS

CMQCC
California Maternal Quality Care Collaborative

CR Consumer Reports

California Health Care Foundation
**AUDIENCES**

**Primary**

- First-time, low-risk pregnant women in CA
- Across income, racial, ethnic, and geographic segments (oversampled Black, Latina and Medi-Cal)

**Secondary**

- Providers (hospitals, physicians, L&D nurses, midwives) key to making consumer education work

**RESEARCH TO DATE**

24 individual provider interviews (OBs, family practitioners, labor nurses, nurse-midwives) *(Spring, 2017)*

9 focus groups, with total of 78 consumers, to develop messages and approach *(Early Summer, 2017)*

- Medi-Cal and private insurance
- English and Spanish
- Locations: Fresno, L.A., Oakland
- African-American, Latino, white

27 individual interviews with consumers (19 Medi-Cal, 8 commercial) to test video prototypes *(Late Summer, 2017)*
KEY INSIGHTS FROM RESEARCH & TESTING

INSIGHT #1: Self-care is a challenge

Women are often family caregivers.

Self-care is a luxury they don’t often get to practice.

Need to speak to them as caregivers while also giving self-care greater urgency.
**INSIGHT #2: C-sections are scary**

Women are AFRAID to have to a C-section.

Fear is a strong motivator that can be used to connect with women, but don’t overdo it.

*Top statement we tested in focus groups:*

> Because a C-section is a major surgery, it takes longer to heal and there is a possibility of more complications compared to a vaginal birth. The most common complications include infection, heavy blood loss, and a blood clot in the legs or lungs.

**INSIGHT #3: Shocked by too many C-sections**

Target women are SURPRISED to learn about increase, hospital variation.

This motivates them to take action.

It also prompts them to ask WHY this is happening.
INSIGHT #4: Empowerment message is effective

Health care system is intimidating.
Medi-Cal woman often lack sense of agency or ability.

Our job is to build confidence!

Top empowerment statement we tested:

Your voice matters — for you and your baby!

INSIGHT #5: Behavior change should be meaningful and practical

Recommended behaviors to target based on literature, and our research (provider and consumer feedback):

1. Mindset to avoid C-section
2. Educate yourself about how to avoid C-section
3. Talk with your doctor (and nurse and family)
KEY MESSENGERS

• labor and delivery nurse
• new mom

FORMAT: Why use animation?

• Distinctive look and feel
• More practical and cost effective compared to live video
• Communicates complex ideas in less time
• Age and ethnicity can be more ambiguous, and that helps audiences generalize.
• Ability to create print products in same visual style
NEXT STEPS

Get input from SCC and other key stakeholders (early/mid October)

Develop rough cut of video and print versions (late October)

Test rough cut and print versions via 1:1 interviews with target moms (early November)

Conduct webinar with broader group of stakeholder groups (early November)

Secret shopper testing (December)

Finalize video and print products (December)

Dissemination (early 2018)

QUESTIONS/COMMENTS?
Aligning Birth Payment to Reduce Unnecessary C-section: A Menu of Options

ABOUT SMART CARE CALIFORNIA

Smart Care California is a public-private partnership working to promote safe, affordable health care in California. The group currently focuses on reducing the overuse of inappropriate care in three areas: C-sections, opioid prescriptions and low back pain. Smart Care California is co-chaired by the state’s leading health care purchasers: The Department of Health Care Services (DHCS), Covered California, and CalPERS. Collectively, Smart Care California participants purchase or manage care for more than 16 million Californians—or 40 percent of the state.

PURPOSE OF THE MENU

The following menu presents a set of strategies that payers in California should consider for adoption in order to align payment strategies and contract language with the goal of providing only medically warranted C-sections for women who are low-risk, first time mothers. This menu is intended for payers including purchasers and health plans, as well as provider groups taking on increasing financial risk, such as medical groups, IPAs, and ACOs. Although payers will choose the strategies that work best for their respective organizations, there is substantial value in having every payer in California address the same quality issue through the implementation of an aligned payment strategy that Reinforces a consistent business model that ensures provider revenue supports achieving the same quality target.

BACKGROUND ON CEASEAREAN DELIVERIES (C-SECTIONS)

Cesarean deliveries can be life-saving procedures in certain circumstances. However, significant numbers of healthy women, specifically first-time mothers at low risk for complications, are undergoing these surgical procedures when they may not be medically indicated. C-sections are performed with the goal of improving maternity outcomes. But the evidence documents that the rise in C-sections for low risk pregnancies has actually resulted in a higher rate of complications for mothers and babies. Complications for mothers include hemorrhage, transfusions, infection and blood clots, while babies have higher rates of infection, respiratory complications and neonatal intensive care unit (NICU) admission. Furthermore, approximately 90% of women with a prior cesarean have subsequent deliveries by cesarean, leading to higher risks of additional complications including placenta previa or accreta and uterine rupture (all of which can lead to massive hemorrhage, hysterectomy and even death). With more than 500,000 births every year in California, there is a compelling need to reduce unnecessary cesarean deliveries among low-risk, first time births (also known as NTSV C-section) and to provide appropriate, evidence-based care.

AN OPPORTUNITY FOR IMPROVEMENT

There have been multiple efforts in California to improve maternity care and they are starting to yield positive results as low-risk, first birth C-section rates have declined from 27.3 percent in 2013 to 25.6 percent in 2015. While California is close to meeting the federal Healthy People 2020 goal of 23.9 percent for low-risk, first birth C-sections, significant overuse of this surgical procedure persists. More importantly, there remains a wide degree of unwarranted variation across the state, and sometimes even within a single county. Only 40% of maternity
hospitals met the 23.9 percent goal in 2015 and NTSV C-section rates for maternity hospitals in California ranged from 11% to 77% in 2015.\textsuperscript{i} The evidence suggests that a woman’s chance of having a C-section depends largely on the hospital where she delivers and the practices of her clinical team. There are also significant cost implications for high C-section rates because Cesarean deliveries are more costly than vaginal deliveries ($12,739 versus $9,048 for private health insurers in 2010).\textsuperscript{vii} Potential complications from a C-section are also costly. Reducing medically unnecessary C-sections for low-risk, first time mothers, which support better health outcomes, could therefore save money for patients, consumers, purchasers and taxpayers.

**PAYMENT IS ONE LEVER TO PROMOTE CHANGE**

Smart Care California is leveraging the work of California Maternal Quality Care Collaborative (CMQCC), the California Health Care Foundation (CHCF) the Pacific Business Group on Health (PBGH), and Covered California to create greater alignment across the state regarding the importance of reducing NTSV C-section rates and the need to implement value-based payment approaches that eliminate perverse financial incentives for C-section deliveries. To move the Smart Care California workgroup participants from concept to action, Smart Care California leadership drafted the following menu which highlights value-based payment and contracting strategies to improve alignment of reimbursement strategies with the need to provide revenue to support evidence-based maternity care.

This menu is not an exhaustive list of approaches and there is not a one size fits all solution. However, this menu provides payers some specificity in regards to existing payment mechanisms and contract language that align with the desired outcome of providing cesareans among low-risk, first time births only when medically indicated. It is the hope of Smart Care California leadership that as many payers as possible in California will elect to implement strategies aligned with this menu, thereby leveraging their collective power to reduce harm and waste in the health care system related to births. Aligning payment with desired birth outcomes is critical not only to improve care initially, but to maintain improvements over time.

**ENDNOTES**

\textsuperscript{i} The Centers for Disease Control and Prevention defines a low-risk cesarean delivery as a C-section among women giving birth for the first time (nulliparous) who are at term (37 or more completed weeks of gestation), singleton (one fetus), and vertex (head first). This is also known as NTSV (Nulliparous, Term, Singleton, Vertex) C-Section.


\textsuperscript{iv} Cal Hospital Compare, \url{http://calhospitalcompare.org/}.

\textsuperscript{v} Soumya Karlamangla and Ryan Menezes, “Find your hospital’s C-section rate,” Los Angeles Times, March 8, 2016, \url{http://spreadsheets.latimes.com/c-section-rates/}.

\textsuperscript{vi} Soumya Karlamangla and Ryan Menezes, “Find your hospital’s C-section rate,” Los Angeles Times, March 8, 2016, \url{http://spreadsheets.latimes.com/c-section-rates/}.

\textsuperscript{vii} Katy Backes Kozhimannil, Michael R. Law and Beth A. Virnig, “Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues”, Health Aff March 2013 vol. 32 no. 3 527-535.
# Payer Payment Strategies to Align Payment with Medically Necessary Use of C-sections

<table>
<thead>
<tr>
<th>Option</th>
<th>How would this work?</th>
<th>Rationale for Implementing</th>
</tr>
</thead>
</table>
| **1) Adopt a blended case rate payment for both physicians AND hospitals** | • A blended case rate reimburses physicians and hospitals, separately, the same flat rate regardless of cesarean or vaginal delivery  
• The blended rate would fall in between the current vaginal and C-section payment rates  
• A blended case rate covers costs associated with labor and delivery, which can be greater when supporting a prolonged labor than it is for a scheduled C-section.  
• It does not apply to prenatal or postpartum care (Bundled, or episode payment, covers the entire episode from pregnancy to post-delivery) | • Paying the same rate for delivery shifts some revenue to support vaginal delivery and removes financial incentives to perform a C-section for physicians and hospitals  
• Incentives for birth must be aligned for both physicians and hospital concurrently |
| **2) Pay less for C-sections without active trial of labor and without medical indication** | • For mothers who have a C-section without an active trial of labor, and without clear medical indication, reimburse for birth according to the following:  
  o If plan pays different rates for C-section and vaginal birth, reimburse at vaginal rate  
  o If plans pay a blended rate, reimburse at lower than the equalized rate  
• Implementing this strategy will require adequate coding to indicate if a woman went into active labor (e.g. a code to indicate cervical dilation between 4 and 6 cm) | • Dis-incentivizes scheduling of C-sections that are not medically necessary |
| **3) Include NTSV-section in existing hospital and physician quality incentive programs** | • Provide quality bonuses for physicians and hospitals that attain a NTSV C-section rate goal or make improvements in reducing NTSV  
• Plans would determine the attainment and improvement thresholds within the context of the national target of 23.9 percent | • Inclusion of NTSV as a quality metric signals the importance of both attaining and sustaining an NTSV C-section rate at or below the national target of 23.9%  
• Incentives can pay for the structural changes needed at the physician organization or hospital level to drive and sustain improvement |
| **4) Adopt population-based payment models, such as ACO like arrangements** | • In the simplest form of population based payment, payers would contract with a network of doctors and hospitals (the ACO) who are held accountable for the quality and cost of the entire continuum of care for an attributed population of patients.  
• The contract would establish specific quality and cost thresholds. If the quality threshold is met and the cost of care delivered is less than the targeted amount, both the payer and the ACO share in the savings.  
• A more mature model of population based payment would involve payers paying the provider network a fixed per-member per-month payment that adequately covers the cost of care for the group of patients. | • Population-based payment models, like ACO arrangements, help optimize care by providing financial incentives for the health care delivery system to more effectively coordinate care to improve quality while reducing costs.  
• Provider quality benchmarks for NTSV C-section in the ACO contract are vital to properly incentivizing evidence-based care |
### Payer Contracting Strategies to Align Payment with Medically Necessary Use of C-sections

<table>
<thead>
<tr>
<th>Option</th>
<th>How would this work?</th>
<th>Rationale for Implementing</th>
</tr>
</thead>
</table>
| **1) Require or incent hospital participation in CMQCC’s Maternal Data Center (MDC)** | - In hospital contracts, explicitly require or incent hospitals to submit data to CMQCC’s MDC | - MDC can generate rapid-cycle OB quality metrics for QI at the hospital and physician level in a way that substantially minimizes data collection burden on hospitals  
- Hospitals can benchmark against others  
- Annual member fee waived for 2017 for newly-joining hospitals |
| **2) Implement network quality improvement requirements with a deadline** | - Establish that hospitals and providers achieve a specified NTSV C-section goal by a certain date and require annual reports of their rate  
- For hospitals and providers who do not meet the goal by the deadline, require excluding low performers from the network OR require documentation for an improvement plan to meet NTSV goals  
- One example of an improvement plan could be encouraging hospitals with high rates to join the CMQCC quality collaborative for supporting vaginal birth and reducing primary cesareans | - Signals the importance of reducing NTSV C-section |
Topic 3: Low Back Pain
Meeting Materials
Multi-Lever Model for Change

Reduce inappropriate care for low back pain

- Data/Transparency
- Purchaser Requirements
- Workforce
- Payment
- Public Policy
- Consumer Engagement
- Quality Improvement (QI)/Clinician Interventions
### Potential Ways to Address Low Back Pain Levers

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Interventions</th>
</tr>
</thead>
</table>
| Data/Transparency         | • Existing measures: HEDIS imaging from IHA, back surgery rates from OSPHD, work-related lower back hospitalizations from CDPH  
                           • Potential new measures: Use of Oswetry Disability Index (ODI) to monitor patient function; use of validated screening (stratification) tool |
| QI/Clinician Interventions| • Use validated screening tool to stratify patients at risk of chronic pain and disability and match to appropriate treatment plan (e.g. Stanford CERC Identification, Coordination, and Enhanced-Decision Making [ICE] model)  
                           • Adopt CDS to reduce inappropriate imaging  
                           • Guidelines for acute low back pain: ACP 2017 guidelines, ICSI currently revising guidelines, Kaiser WA  
                           • CTAF and ICER review of cognitive and mind-body interventions to treat chronic low back and neck pain |
| Payment                   | • Value-based insurance design (e.g. bundle multiple PT visits for one copay)  
                           • Increase access for alternative therapies and multidisciplinary care |
| Purchaser Requirements    | • Promote adoption of stratification tools and tools to measure patient function  
                           • Tiered/preferred networks of providers who use evidence-based practices |
| Workforce                 | • Use of multidisciplinary teams  
                           • Train individuals to serves as back coaches to provide self-management (from Stanford CERC ICE model) |
| Consumer Engagement       | • Distribute Consumer Reports materials on low back pain to patients |
| Public Policy             | • Develop public policies regarding prescribing of opioid drugs for low back pain |
## Existing Resources to Address Low Back Pain Levers

| Data/ Transparency | • Existing measures: [HEDIS imaging](https://www.hedis.org), [back surgery rates](https://www.ahrq.gov), [work-related lower back hospitalizations](https://www.shawnmorial.com)  
  • Potential new measures: [ODI](https://www.ohiospine.org), [STarT Back Screening (Stratification) Tool](https://www.startback.org) |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------### In WA State, a public-private partnership created by the WA State legislature released a report of spine/low back pain best practice recommendations for clinicians, health plans, and purchasers. 
  • IHA has catalogued 9 CDS companies that target clinicians and have EMR integration including [Stanson Health](https://www.stansonhealth.com), [Grand Round Table](https://www.grandroundtable.com), and [MedCurrent](https://www.medicurrent.com)  
  • Guidelines for acute low back pain: [ACP 2017, ICSI, Kaiser WA](https://www.acponline.org)  
  • Clinical trials underway at Stanford and Kaiser WA. |
| QI/Clinician Interventions | • [Bree Collaborative](https://www.breecollaborative.org) in WA State, a public-private partnership created by the WA State legislature released a report of spine/low back pain best practice recommendations for clinicians, health plans, and purchasers  
  • IHA has catalogued 9 CDS companies that target clinicians and have EMR integration including [Stanson Health](https://www.stansonhealth.com), [Grand Round Table](https://www.grandroundtable.com), and [MedCurrent](https://www.medicurrent.com)  
  • Guidelines for acute low back pain: [ACP 2017, ICSI, Kaiser WA](https://www.acponline.org)  
  • Clinical trials underway at Stanford and Kaiser WA. |
| Payment | • [Geisinger Health Plan](https://www.geisinger.org) bundled 5 physical therapy visits for one co-pay  
  • [Oregon Health Authority (OHA)](https://www.oha.oregon.gov) has established a Health Evidence Review Commission (HERC) which provides coverage guidance for low back pain treatments |
| Purchaser Requirements | • [WA State Healthcare Authority](https://www.hca.wa.gov), which manages WA’s Medicaid and public employee benefits, has adopted Bree Collaborative recommendations into health plan contracts  
  • [Virginia Mason Spine Clinic](https://www.vm.org) was redesigned due to pressure from employers like Starbucks, Intel, and Boeing |
| Workforce | • [Cochrane review](https://www.cochranelibrary.com) found patients experienced less pain and disability with multidisciplinary biopsychosocial rehabilitation |
| Consumer Engagement | • [Consumer Reports consumer facing materials](https://www.consumerreports.org) |
| Public Policy | • Develop public policies regarding prescribing of opioid drugs for low back pain |
Smart Care CA Next Steps for Low Back Pain

SCC will focus on patients with acute back pain, consistent with the Choosing Wisely advice on use of imaging, aiming to prevent progression to chronic pain and disability. In previous meetings, the group decided to focus on 3 general approaches for low back pain: 1) patient education; 2) provider resources, and 3) clinical decision support.

<table>
<thead>
<tr>
<th>Focus</th>
<th>What Activities Can SCC Promote (related to the focus)</th>
<th>Next Steps</th>
<th>Thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase speed to the correct modality (such as PT)</td>
<td>Encourage rapid access to PT within 24 hours of referral</td>
<td>• Explore value-based payment for PT and alternative therapies (e.g. Geisinger Health Plan used VBID approach and bundled 5 PT treatments for one co-pay)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Encourage use of alternative therapies such as exercise, yoga, massage, acupuncture</td>
<td>• Work with health plans to expand benefit design or remove PA for use of alternative modalities</td>
<td></td>
</tr>
<tr>
<td>Agree upon outcome measure(s)</td>
<td>Encourage use of functional status assessment tool as an outcomes measure of low back pain</td>
<td>• Agree on which functional status assessment tool to use (Oswestry Disability Index seems most widely used) • Encourage health plans and purchasers to promote use of functional status assessment tool</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify other outcome indicators of low back pain</td>
<td>• See &quot;Potential Measures&quot; on next page</td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Developer (Measure ID)</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Use of imaging studies for low back pain</strong>: % of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis</td>
<td>NCQA (NCQA: 0052)</td>
<td>Currently used for PRIME, Medicare Physician QRS, Medicaid Adult Core, and IHA VBP4P. Currently reported as an inverse rate (appropriate imaging) statewide by IHA</td>
<td></td>
</tr>
<tr>
<td><strong>Imaging efficiency</strong>: % of MRI of the lumbar spine studies with a diagnosis of low back pain on the imaging claim and for which the patient did not have prior claims-based evidence of antecedent conservative therapy.</td>
<td>CMS (NQMC: 010435)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laminectomy or spinal fusion: laminectomy or spinal fusion area rate</td>
<td>AHRQ (NQMC 005550)</td>
<td>CA has this data by county but there is no ideal rate yet. Data from OSHPD.</td>
<td></td>
</tr>
<tr>
<td>Adult acute and subacute low back pain: % of patients with low back pain diagnosis who are prescribed opioids.</td>
<td>ICSI (NQMC: 007518)</td>
<td>Oregon Health Care Quality Corporation has used this measure in an analysis of LBP utilization</td>
<td></td>
</tr>
<tr>
<td>Adult acute and subacute low back pain: % of patients with low back pain diagnosis who have their functional status assessed using the Oswestry Disability Questionnaire or other assessment tool.</td>
<td>ICSI (NQMC: 007519)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spinal surgery</strong>: average change between lumbar spinal fusion pre-operative and one year (9 to 15 months) post-operative functional status as measured with the Oswestry Disability Index, version 2.1a</td>
<td>MN Comm Measurement (NQMC: 010404)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lumbar functional status</strong>: mean change score in lumbar functional status for patients with lumbar impairments receiving physical rehabilitation.</td>
<td>FOTO Inc (NQMC: 002632)</td>
<td>Lumbar Functional Status measure uses items from various back pain scales</td>
<td></td>
</tr>
<tr>
<td>Adult acute and subacute low back pain: % of patients with non-specific low back pain diagnosis who have had collaborative decision-making with regards to referral to a specialist.</td>
<td>ICSI (NQMC: 007521)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult acute and subacute low back pain: % of patients who were advised on maintenance or resumption of activities, against bed rest, use of heat, education on importance of active lifestyle and exercise, and recommendation to take anti-inflammatory or analgesic medication in the first six weeks of pain onset in the absence of &quot;red flags.&quot;</td>
<td>ICSI (NQMC: 008333)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Indicates NQF Endorsed Measure
## Smart Care CA Draft Low Back Pain Dashboard Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Developer (Measure ID)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Use of imaging studies for low back pain:</strong> % of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis</td>
<td>NCQA (NCQA: 0052)</td>
<td>Currently used for PRIME, Medicare Physician QRS, Medicaid Adult Core, and IHA VBP4P. Currently reported as an inverse rate (appropriate imaging) statewide by IHA</td>
</tr>
<tr>
<td>2. <strong>Adult acute and subacute low back pain:</strong> % of patients with low back pain diagnosis who are prescribed opioids.</td>
<td>ICSI (NQMC: 007518)</td>
<td>Oregon Health Care Quality Corporation has used this measure in an analysis of LBP utilization. Low back pain is a common diagnosis with chronic opioid use, but no data support its chronic use.</td>
</tr>
<tr>
<td>3. <strong>Timely access to physical therapy:</strong> Using administrative claims data, for patients with diagnosis of low back pain, identify the number of days between date of request for physical therapy and date of claim for physical therapy.</td>
<td>n/a</td>
<td>Access to physical therapy is a marker of alternative therapies offered in a timely way. Stanford CERC and Virginia Mason include rapid access to physical therapy (within 24 hours) as an evidence-based best practice. At minimum, health plans and health systems should meet Department of Managed Health Care (DMHC) Timely Access regulations requiring managed care plans to provide ancillary services within 15 days of call.</td>
</tr>
</tbody>
</table>