Protecting Ohio's Families

Ohio Attorney General's

Insurer Task Force on Opioid Reduction

Report and Recommendations

June 2018

MIKE DEWINE

OHIO ATTORNEY GENERAL

MIKE DEWINE
OHIO ATTORNEY GENERAL

June 12, 2018

Dear Fellow Ohioans,

As Attorney General, my No. 1 priority is protecting Ohio's families. Over the past several years, I have focused my office's efforts on finding innovative ways to combat the opioid crisis. The issue is complex and has to be approached from all sides. Consequently, I have joined with law enforcement, health care providers, community groups, and others to develop new strategies to reduce opioid abuse and connect patients with critical treatment. This partnership with Ohio's health insurers provides an additional avenue for addressing this critical issue.

The opioid epidemic is the worst public health crisis of this generation. Thousands of Ohioans have lost their lives due to opioid overdoses and many others struggle to achieve and maintain sobriety. Federal law generally requires that health insurers who provide substance-abuse treatment do not impose more stringent restrictions or limitations on those benefits than they would on other medical services. However, many Ohioans still struggle to access such treatment.

Last summer, I asked Ohio's insurers to join me in the fight against the opioid epidemic. I recognize that insurers care deeply about the health and well-being of their members and are well-positioned to make meaningful changes that can help stem the tide of the crisis. Even small changes in insurance industry practices can lead to big changes in health care delivery.

I invited Ohio's largest commercial health insurers and its Medicaid Managed Care Organizations to join my Insurer Task Force on Opioid Reduction. The goal of the task force was to study and identify strategic actions that insurers can take to address opioid abuse. In addition, I asked the task force to identify policy, legislative, or regulatory barriers that have hindered their ability to combat the crisis.

Members of the task force are experts in their fields with a wide variety of professional backgrounds and experiences dealing with substance-use disorder. Task force members include behavioral health directors, case managers, pharmacy directors, compliance officers, medical directors, and corporate leaders.

The task force met over the course of seven months to work toward a consensus and the development of the important recommendations contained within this report.

I want to express my sincere appreciation to everyone on the Insurer Task Force on Opioid Reduction for their thoughtful assistance in developing this report and their ongoing commitment to eliminating overdose deaths, helping addicts recover, and preventing substance abuse.

Very respectfully yours,

Mike DeWine
Ohio Attorney General

Table of Contents

Ohio Attorney General Mike DeWine's
Insurer Task Force on Opioid Reduction

Task Force Members

Aetna
Anthem Inc.
Buckeye Health Plan
CareSource
Medical Mutual
Molina Healthcare
Ohio Association of Health Plans
Paramount Health Care
United Healthcare

Attorney General's Office Staff Acknowledgments

Carol Baden
Lloyd Early
Lauren Emery
Paula Farrell
Jonathan Fulkerson
Jermaine Jones
Ara Mekhjian
Mary Mertz
Keesha Mitchell
Alisha Nelson
Randi Ostry
Justin Radic

Special Acknowledgments

Raquel Graham, Department of Administrative Services
Dr. William C. Miller, The Ohio State University
Miranda Motter, Ohio Association of Health Plans

Task Force Meeting Structure and Purpose

The task force first convened on Oct. 4, 2017. At that meeting, task force members had an opportunity to share information with Ohio Attorney General Mike DeWine about their opioid reduction programs and successes. Miranda Motter, president and CEO of the Ohio Association of Health Plans, also gave an overview of the past and ongoing efforts that the insurance industry is making to combat the opioid crisis. Finally, the task force heard a presentation from The Ohio State University's Dr. William C. Miller, M.D., Ph.D., M.P.H., on the costly, long-term medical consequences of opioid abuse including endocarditis, hepatitis B, and hepatitis C. Dr. Miller also proposed ideas for combating the opioid crisis, many of which were later discussed by the task force and are included in these recommendations.[1]

The task force met three additional times over the next six months. Each meeting focused on a different aspect of combating the opioid epidemic: prevention, intervention, and treatment. The meetings began with presentations from task force members on a unique program the member had implemented to address the opioid epidemic. All task force members gave presentations at a task force meeting. The remainder of each meeting focused on group discussion and attempts to develop a consensus around concrete recommendations that could be implemented industrywide.

The fifth and final meeting of the task force was held on April 4, 2018, to finalize the recommendations contained within this report. All task force meetings were open to the public.

The recommendations contained within this report are designed to be aspirational and represent best practices for insurers to strive toward. Task force members have undertaken many proactive measures within their organizations to combat the opioid crisis, and many of the recommendations in this report are modeled after initiatives and pilot programs they have established.

This report recognizes that health insurers are only one part of the puzzle when developing a strategy to combat the opioid epidemic.[2] To be successful, these recommendations will require collaboration and partnership with provider groups, hospital associations, state agencies, and others. The support of employers who provide health insurance to half of Ohioans also will be necessary for success.[3] Insurers and employers must continue to work diligently to assess the long-term costs associated with opioid abuse and explore the benefits of covering nonopioid therapies, opioid-abuse treatment, and other support services.[4]

It will also be important to continue enforcing the protections put in place by the federal mental health parity law. The Mental Health Parity and Addiction Equality Act of 2008 "generally prevents group health plans and health insurance issuers that provide mental-health or substance-use disorder (MH/SUD) benefits from imposing less-favorable benefit limitations on those benefits than on medical/surgical benefits."[5] For example, insurers cannot place more restrictive financial limitations (such as copays, deductibles, and coinsurance) on mental-health and substance-abuse services than they do on other benefits.[6] Vigorous enforcement of this law will ensure that Ohioans struggling with addiction have access to the high-quality treatment services that they need without unnecessary barriers.

Introduction

The opioid epidemic is the most significant public health crisis of our time. Its origins can largely be traced to efforts begun by certain pharmaceutical companies in the mid-1990s to assure the medical community, patients, and regulators that prescription opioids were safe and nonaddictive.[7] Those efforts, along with the irresponsible and improper distribution of prescription opioids by various wholesale distributors, resulted in a near quadrupling of the number of prescription opioids sold to pharmacies, hospitals, and doctors' offices from 1999 to 2010.[8] During this time, in spite of an increased use of opioids, there was no change in the amount of pain that patients reported.[9]

Prescription opioids are, in fact, highly addictive and widely abused or diverted. Twenty-one to 29 percent of patients prescribed an opioid for chronic pain misuse it, and 8 to 12 percent develop an opioid-use disorder.[10] Moreover, abuse of a prescription opioid can also lead to abuse of illicit drugs such as heroin.[11]

According to the Centers for Disease Control and Prevention (CDC), Ohio has the second-highest rate of drug overdose deaths in the country at 39.1 per 100,000.[12] An average of 12 Ohioans die each day from a drug overdose.[13] These figures are heavily driven by opioid overdoses, both prescription and illicit.[14] While the Ohio Department of Health reports that the number of deaths caused by prescription opioids has started to decline, there has been a corresponding increase in the number of deaths caused by heroin, fentanyl, and related drugs.[15]

In addition to the devastation it has caused to families and communities, the opioid epidemic has placed a significant economic burden on the state. Estimates of the aggregate cost to the state from the opioid epidemic have varied greatly, but generally include analyses of: health care and treatment costs; criminal justice costs; lost productivity among current opioid abusers; and lost productivity of drug overdose deaths.[16] After analyzing these figures, OSU's C. William Swank Program in Rural-Urban Policy reached a likely conservative estimate that, in a single year, opioid abuse cost Ohio's economy between $6.6 billion to $8.8 billion.[17] The American Enterprise Institute, on the other hand, estimated the cost at closer to $32 billion, or 5.32 percent of the state's gross domestic product.[18]

Ohio health insurers bear a significant portion of the financial burden of opioid abuse. For example, from 2014 to 2016, the Ohio Department of Medicaid spent $462 million on treatment and counseling services for opioid abusers and more than $110 million on medications used to treat opioid abuse.[19] Similarly, between 2007 and 2014, private health insurance claims from opioid-related diagnoses increased 770 percent.[20] Moreover, since half of Ohioans receive employer-provided health insurance coverage, these are costs also borne by Ohio businesses.[21]

After conducting five meetings, the task force developed the following 15 recommendations.

Recommendations

The task force's work covered many different aspects of the insurance industry's involvement with the opioid crisis. To structure its work, the task force categorized its meetings and recommendations into three categories: prevention, intervention, and treatment.

Prevention Recommendations

Developing successful prevention strategies is essential to reducing the occurrence of opioid-use disorder in the United States. The recommendations below are designed to promote alternatives to opioid-based pain management, to prevent inappropriate prescribing of opioids, and to educate the public about the risks of abusing prescription opioids.

Recommendation 1: Insurers should cover and encourage, where appropriate, the use of both nonopioid pain medications and nonpharmacological treatments for pain.

When treating individuals for pain, providers should determine which treatment provides the greatest benefit to the patient while minimizing the risk of long-term adverse consequences. In many cases, nonopioid medications and nonpharmacological interventions can provide adequate pain relief with less risk than a long-term opioid prescription.[22] However, any alternative treatments should be evidenced-based with demonstrated efficacy.

In order to encourage providers to use nonopioid therapies, insurers should cover and encourage their use, when appropriate. Managed Care Organizations (MCOs) should work with the Department of Medicaid to review their contracts and policies to determine the appropriate coverage for nonopioid therapies.[23] Providing coverage for these services may require a reprioritization or reallocation of current health care spending away from opioids and toward alternative treatments. Nonpharmacological therapies may include: cognitive behavioral therapy, physical therapy, weight loss, massage, meditation, chiropractic services, and acupuncture/acupressure.

In addition, insurers should examine their reimbursement models — which often bundle payment for services — to ensure they are not disincentivizing nonopioid therapies. For example, an insurer may bundle reimbursement for a surgical procedure such that the cost of treating post-surgical pain is deducted from the amount the health care provider would otherwise receive for the procedure. In this way, there is an incentive for providers to treat pain in the cheapest way — like an opioid prescription — rather than exploring a nonopioid medication or therapy.

This recommendation is consistent with new pain assessment and management standards for accredited hospitals issued by the Joint Commission, an independent, not-for-profit organization that accredits and certifies about 21,000 health care organizations and programs in the United States. On Jan. 1, 2018, the Joint Commission issued new standards that include requiring hospitals to "provide at least one nonpharmacologic pain treatment modality" and to "actively engage medical staff and hospital leadership in improving pain assessment and management, including strategies to decrease opioid use and minimize risks associated with opioid use."[24]

Recommendation 2: Insurers should identify and develop targeted education efforts for clinicians who prescribe high volumes of opioids compared with peers in their clinical specialty.

Reducing the overall number of prescriptions written for opioids --- while still ensuring patients receive adequate treatment for pain — is a critical part of combating the epidemic. Thus, educating all prescribers about the risks of opioids and appropriate clinical guidelines is essential. However, targeted efforts should be made for those physicians who prescribe opioids at a rate that is significantly higher than others in their specialty. Insurers have easy access to a large volume of prescription data and are in a position to use that information to address the problem of over-prescribing. Several task force members shared their approach to this issue.

One plan discussed how it sent letters to nearly 1,000 physicians in its nationwide network that were identified as "super-prescribers" of opioids. The letters advised the physicians that they prescribed opioids at a higher rate than their peers.[25] After this effort, the plan saw a 7 percent reduction in the rate of monthly opioid prescriptions, suggesting that even this simple education effort can change prescribing habits.[26] Another plan shared how — in addition to sending letters to high-volume prescribers — it was creating an online, interactive, provider dashboard that would allow physicians to see how their prescribing patterns compare with their peers.

While targeting in-network prescribers is critical, many individuals receive an opioid prescription from emergency room physicians, who are typically not contracted with an insurance company. In order to reach high-volume prescribers in the ER, insurers may need to collaborate with hospital systems. This may also be a helpful strategy for addressing overprescribing in nursing homes and rehabilitation facilities.

Insurers should analyze, where possible, their existing prescription claims data in order to identify high-volume prescribers in their networks. Armed with this information, they should create targeted education efforts and collect data about the program's effect on the number of opioid prescriptions written.

Recommendation 3: Insurers should ensure that providers in their networks are aware of and follow applicable opioid prescribing guidelines, which should be more uniform to reduce the amount of opioids prescribed.

Establishing clear and consistent prescribing guidelines is an essential part of limiting the number of inappropriate opioid prescriptions. However, task force members noted that their providers struggle to stay apprised of competing guidelines.

Federal and state agencies and provider groups have each put forth recommendations regarding when an opioid should be prescribed based on the clinical setting and the cause of the pain. While task force members noted that all Ohio prescribers are generally bound by the base-level guidelines issued by the State Medical Board to maintain licensure, these guidelines are less stringent than others issued in the state and across the country.

For example, Gov. John Kasich's Governor's Cabinet Opiate Action Team has published guidelines on managing acute pain outside of emergency departments;[27] prescribing opioids for treating chronic, nonterminal pain;[28] and prescribing opioids in emergency and acute care settings.[29] In addition, the CDC published guidelines for prescribing opioids for the treatment of chronic pain.[30] Many physician groups also provide their own additional guidance about opioid prescribing.

In order to eliminate the confusion caused by multiple guidelines, the State Medical Board — alongside other state agencies, provider groups, and subject matter experts — should perform a

comprehensive review of existing prescribing guidelines. The group should work toward a standard that is evidenced-based and represents best practices for reducing the number of opioids prescribed. Once uniform prescribing standards are identified or created, insurers should work with the group to disseminate them to their providers and evaluate them over time.

Though the establishment of clear, uniform prescribing guidelines is an important first step in decreasing the number of inappropriate opioid prescriptions, their value is dependent upon provider adherence. America's Health Insurance Plans recently analyzed data regarding commercial health insurance claims and encounters to see how well providers were following some of the CDC's recommendations.[31] On several of the recommendations, providers had significant room for improving compliance. For example, only 1 percent of patients received a urine drug screen before being prescribed an opioid, and less than 15 percent received annual urine drug screens while on chronic opioid therapy.[32]

As noted above, insurers should prioritize the education of providers in their networks regarding applicable prescribing standards. Insurers should also consider performing audits of providers' compliance with these guidelines and incentivizing those who adhere to them.

Recommendation 4: Insurers should develop targeted prevention efforts aimed at reducing the number of opioid prescriptions written for adolescents and young adults who are "opioid-naive."

A recent study found that "adolescents and young adults are in the most likely age groups to abuse prescription medications."[33] In 2016, people younger than 34 accounted for 38 percent of total opioid overdose deaths in Ohio.[34] Since individuals' early exposure to drugs increases their risk of developing an addiction, efforts to decrease a young person's exposure to prescription opioids can help to decrease his or her likelihood of abusing them in the future.[35]

Task force members shared anecdotal evidence that many of the young members covered by their plans had received their first opioid prescription either as the result of a sports injury or an oral surgery. Research has confirmed that youths who participate in interscholastic athletics during high school are at an increased risk of opioid use and misuse.[36] Moreover, an examination of opioid prescriptions by physician specialty found that dentists prescribe 30.8 percent of all opioids to youths ages 10 to 19, and more than 15 percent of all opioids for those ages 20 to 29.[37]

Thus, it was recommended that insurers work with in-network sports medicine physicians and oral surgeons to help to decrease the number of opioid prescriptions written to opioid-naive adolescents and young adults. To its credit, the American Dental Association recently released an opioid policy that supports mandates on prescription limits and continuing education.[38] Insurers should continue to work with these provider groups in order to reduce the number of opioids prescribed to opioid-naive adolescents and young adults.

This partnership could take the form of insurer-created provider education, pilot programs, and supplying educational materials for patients. Collaborating with providers is critical because task force members noted that messages about the risks of opioids may be taken more seriously by patients when they come from a provider the patient knows, rather than from their insurer. Task force members also agreed that communication needed to be clear, concise, and consistent.

Recommendation 5: Insurers should develop targeted "first-fill" education programs.

For many individuals, long-term opioid use begins by receiving an opioid prescription for acute pain.[39] Specifically, a recent CDC study found that "the likelihood of chronic opioid use increased with each additional day of medication supplied starting with the third day, with the sharpest increases in chronic opioid use observed after the fifth and 31st day on therapy."[40] Therefore, patients should be advised upon receipt of their initial opioid prescription of the substantial risks of long-term opioid use.

One task force member shared a presentation on a pilot program it had instituted to educate members upon receipt of their "first-fill" of an opioid prescription. This company sent letters to members about the risks and benefits of opioid use and educated them on how to properly dispose of opioids in order to avoid diversion. In addition, these members were placed in a six-month monitoring program, and members at high risk of abusing opioids received an additional call from a specially trained pharmacist.

Insurers should look to develop similar targeted efforts in order to ensure that patients are educated on the risks of developing long-term dependence on opioids. Moreover, insurers should work collaboratively with pharmacists on this effort to provide education to members at the point of sale.

Recommendation 6: Insurers should work together to develop communication strategies and use easy-to-understand language to educate the public about the risks of opioids.

Task Force members expressed concern that the public often does not understand important terminology about the opioid crisis. For example, the plans agreed that their members often don't understand how their lawful opioid prescription is related to the opioid epidemic. Educating the public is complicated by the fact that individuals receive disparate and uncoordinated messages from a variety of sources including physicians, insurers, pharmacists, and the media.

In order to successfully educate the public about the risks of opioids, insurers should work collaboratively to develop an easy-to-understand, consistent, public education campaign or use other state efforts (such as Take Charge Ohio) to ensure consistent messaging. Prevention experts note that a collaborative approach "leverages the expertise of multiple groups and increases the likelihood that their collective efforts will bring about change."[41] In addition, insurers should collaborate with state agencies (for example, the Ohio Department of Insurance, Ohio Department of Medicaid, the Ohio Department of Mental Health and Addiction Services, etc.) and provider groups whose members interact frequently with patients (for example, the Ohio State Medical Association, Ohio Pharmacists Association, and Ohio Association of Advanced Practice Nurses) to develop clear messaging and consistent language.

Intervention Recommendations

Once an individual has begun misusing opioids, timely and targeted intervention efforts provide the best hope for effective treatment. The recommendations below suggest populations that need targeted intervention efforts and programs that present the greatest likelihood of success for addressing an individual's opioid-use disorder.

Recommendation 7: Insurers should educate prescribers about tapering guidelines for patients who use opioids to treat chronic pain, and encourage prescribers, as appropriate, to reduce a patient's dependence on opioids.

Though opioids are largely effective for treating short-term, acute pain, there is little evidence that they are successful at treating long-term, chronic pain.[42] Moreover, prolonged exposure to opioid medications can lead to dependence and opioid abuse. Task force members emphasized the importance of educating prescribers on how to safely and appropriately reduce the number of opioids patients are taking to treat chronic pain.

In March 2016, the CDC introduced guidelines for tapering opioids for patients with chronic pain.[43] Later that year, the Department of Veterans Affairs released its "Opioid Taper Decision Tool," a publication "designed to assist Primary Care providers in determining if an opioid taper is necessary for a specific patient, in performing the taper, and in providing follow-up and support during the taper."[44] It is important that providers be educated about these guidelines and tools, which can help to reduce their patients' dependence on opioids.

Many task force members are already sharing this information with their providers. For example, one has created a provider education document that includes reasons to taper a patient's opioid prescription; protocols for tapering opioids; symptoms of opioid withdrawal; and tips for using motivational interviewing with patients to encourage patients during tapering.[45] Whether through the use of publications, continuing medical education programs, webinars, or similar programming, all insurers should educate in-network providers about opioid tapering guidelines.

Recommendation 8: Insurers should create, use, and continually refine "lock-in" programs to reduce the practice of doctor or pharmacy "shopping" by patients who are seeking opioids.

An important tool for combating abuse and diversion of prescription opioids is a "lock-in" program. In a lock-in program, an insurer uses predictive analytics to review its prescription claims data and to identify patients who are suspected of overusing or diverting opioids, and limits them to "a single designated provider, pharmacy, or both."[46]

The criteria used to identify an individual for inclusion in a lock-in program vary. However, common criteria include high daily opioid dosage in morphine equivalent doses; the number of prescriptions obtained; the number of prescribers for a patient; and the number of pharmacies dispensing to the patient.[47]

Task force members reported that they have lock-in programs in place in their organizations for many of their service lines. Insurers should expand their use and continually evaluate the strength of these programs, reviewing the selection criteria for members to ensure that they are accurately identifying abuse or diversion of opioids.

Recommendation 9: Insurers should use multidisciplinary teams, when appropriate, to coordinate care for members with opioid-use disorder.

Several task force members spoke about programs that use interdisciplinary teams of professionals to coordinate care for members with opioid-use disorder. The teams may include social workers, pharmacists, physicians, mental-health professionals, and other specialists as appropriate. This model addresses historical barriers between physical and mental health providers with the goal of providing holistic and coordinated care for the member. Moreover, this model acknowledges that addressing the member's physical, psychological, and social needs is an essential step in helping him or her to achieve and maintain sobriety. The interdisciplinary team can help with things such as scheduling follow-up appointments, coordinating transportation, connecting the member with a peer support group, or assisting with job search resources.

Recognizing that this service cannot be provided to all members, and that it may not be appropriate for everyone, insurers should analyze their data and develop criteria to identify high-risk members with opioid-use disorder who would benefit most from this intense care-coordination model.

Recommendation 10: Insurers should direct obstetricians and gynecologists in their network to screen pregnant patients for opioid use throughout pregnancy.

Opioid-use disorder in pregnant women presents risks to both the mother and the unborn child. Opioid abuse during pregnancy is associated with serious complications including stunted growth, preterm labor, fetal convulsions, and fetal death.[48] In addition, children born to mothers who use opioids are at risk for developing neonatal abstinence syndrome (NAS), in which the infant becomes dependent on the drugs used by the mother during pregnancy.[49]

Early identification and prompt treatment of pregnant women who use opioids is essential to improve health outcomes for both the mother and infant. Children born to women who receive treatment for opioid-use disorder during pregnancy experience significantly better outcomes than those whose mothers did not receive treatment.[50] Among other things, women who received treatment during pregnancy had children with a lower risk of NAS; less severe NAS; shorter treatment time; and higher gestational age, weight, and head circumference at birth.[51]

The American College of Obstetricians and Gynecologists recommends performing early screening for substance use at the first prenatal appointment as part of comprehensive obstetric care.[52] More specifically, it recommends using validated screening questionnaires for all pregnant patients, rather than just for those patients with certain risk factors — such as poor adherence to prenatal care — in order to avoid missing cases or causing stereotyping and stigma.[53]

The task force supports these strong guidelines, and further recommends continued screening throughout a woman's pregnancy. Opioid use is dangerous throughout all stages of pregnancy, and OB-GYNs should remain vigilant for signs of opioid-use disorder in their patients. In order to quickly identify pregnant women who use opioids, and to more efficiently connect them with highly effective treatment, insurers should direct OB-GYNs in their network to routinely screen pregnant women for opioid use. Insurers should review their policies and ensure that they offer adequate coverage and reimbursement for these screenings. Finally, insurers should consider incentivizing OB-GYNs in their network to pursue additional training on how to identify and treat pregnant women with substance-use disorder.

Recommendation 11: Insurers should accept a standard authorization form for disclosure and use of protected health information to better coordinate the care of its members.

Task force members identified the need to have a standard release form (or forms) that would allow for the sharing of a patient's protected health information. Currently, a provider of substance-abuse treatment services cannot share information about a patient's opioid abuse with the patient's other medical providers unless the patient executes a release authorizing the sharing of that information. Without this release, for example, a substance-abuse treatment provider could not warn the patient's primary care provider to refrain from prescribing opioids to the patient.

In order to most effectively treat a patient's opioid addiction, it is essential that all members of the patient's care team have the most accurate information about the patient's medical history. Patients therefore should be encouraged to execute releases that ease the sharing of medical information with a patient's various providers.

The lack of standardized release forms has made it more difficult for providers to share information with those who may be instrumental in the patient's care or payment for the patient's care. Insurers should work with others, such as the Ohio Department of Medicaid, the Ohio Department of Insurance, or industry groups to develop a standard authorization form for disclosure and use of protected health information. Once complete, insurers should educate in-network providers and members about how executing these forms can eliminate barriers and better coordinate care.

Recommendation 12: Insurers should help government partners to coordinate substance-use treatment for members who are preparing to re-enter the community after a period of incarceration.

According to the U.S. Department of Justice, more than half (58 percent) of state prisoners and two-thirds (63 percent) of sentenced jail inmates meet the clinical criteria for drug dependence or abuse.[54] Unfortunately, opioid-use disorder is often largely untreated or poorly treated during incarceration, and many individuals resume opioid use upon release.[55] Consequently, a former inmate's risk of death within two weeks of release is 12 times that of other individuals.[56] In addition, "untreated opioid-use disorders contribute to a return to criminal activity, reincarceration, and risky behavior contributing to the spread of HIV and hepatitis B and C infections."[57]

One barrier to providing opioid-abuse treatment to incarcerated individuals is that federal law prohibits the use of Medicaid funds to cover medical services for inmates unless the service is provided outside of the institution (as through a hospital or nursing home).[58] However, there are still things that Managed Care Organizations (MCOs) can do to ensure that Medicaid-eligible incarcerated individuals get the care they need after release.

First, the task force notes that it is no longer necessary to terminate Medicaid for those who are incarcerated. Incarcerated individuals are able to remain on Medicaid with limited coverage, and their full benefits return following release. To reduce the possibility of treatment delays or interruptions upon an inmate's release, the Ohio Department of Medicaid and county Job and Family Service workers should not list incarcerated members in terminated status.[59]

Second, for Medicaid-eligible incarcerated individuals who are not enrolled in Medicaid, the task force recommends that MCOs continue to take advantage of the Medicaid Pre-Release Enrollment Program and help get individuals registered for Medicaid.[60] Getting an individual enrolled in Medicaid prior to release will eliminate unnecessary disruptions in care upon release and ease care coordination.

Finally, insurers should coordinate with representatives of local jails and prisons, drug courts, probation officers, and others to provide education about the types of services they can provide to incarcerated individuals who are nearing release. In particular, task force members noted the importance of working with county drug courts, which are supposed to (but frequently do not) reach out to MCOs when the courts come in contact with MCO members.

Recommendation 13: The General Assembly should amend state statute so that commercial insurance companies have access to prescription information contained in the Ohio Automated Rx Reporting System.

The Ohio Automated Rx Reporting System (OARRS) was established in 2006 and collects information on all outpatient prescriptions for controlled substances dispensed by Ohio-licensed pharmacies and furnished by licensed prescribers. A primary goal of OARRS is to identify prescription drug diversion and abuse.

Ohio Revised Code 4729.80 identifies the entities with which the Board of Pharmacy is authorized to share OARRS data. Among others, prescribers and pharmacists (or their delegates), law enforcement, health care licensing boards, and MCOs may access OARRS data.

All insurers have data regarding prescription claims that their members submit for reimbursement. However, this data does not reflect any prescriptions that a member pays for in cash or chooses not to submit to their insurer for reimbursement. Since many individuals who abuse prescription drugs may pay for them in cash, commercial insurers have no knowledge about transactions that may have a significant impact on their members' physical and mental health. Without OARRS access, a commercial insurer's ability to engage a member in a lock-in program or develop appropriate intervention strategies is limited.

MCOs, through access to OARRS data, have the benefit of a more complete picture of their members' use of prescription drugs. The task force believes that revising the statute to give commercial insurers access to OARRS data would allow them to better coordinate care for their members and identify signs of potential fraud or diversion.

Treatment Recommendations

The American Society of Addiction Medicine recommends treating opioid-use disorder with a combination of medication and psychosocial treatment, often called Medication Assisted Treatment (MAT).[61] Participation in MAT is associated with improved patient survival; increased retention in treatment; decreased illicit opiate use and other criminal activity; increased ability of the individual to gain and keep employment; and improved birth outcomes for pregnant women with substance-use disorders.[62]

Federal parity law requires that insurers who offer substance-abuse treatment benefits, such as MAT, do not impose less-favorable limitations on those benefits than they would on other medical or surgical benefits. Nonetheless, other barriers persist that prevent an individual from effectively accessing MAT. The recommendations below are focused on increasing access to MAT.

Recommendation 14: Insurers should eliminate or expedite prior authorizations for accessing Medication Assisted Treatment (MAT).

A prior authorization is a requirement that a clinician receive approval from a health insurer before prescribing a medication or procedure for their patient. Prior authorizations have been criticized as being primarily a tool for insurers to control their costs. However, they are also a way for insurers to coordinate a member's care by ensuring that a member is getting necessary wraparound services.

While prior authorizations are an important tool for insurers, clinicians report that they are often a barrier for getting patients into substance-abuse treatment quickly at critical junctures. Specifically, when a patient is attempting to initiate drug treatment — often referred to as the "induction" window — any significant delay presents an opportunity for the individual to resume substance use or to overdose.

In February 2017, the American Medical Association sent a letter to the National Association of Attorneys General urging all attorneys general to work with insurers to eliminate prior authorizations on MAT.[63] In a survey conducted by the American Medical Association, 90 percent of physicians reported that "prior authorization delays access to necessary care."[64]

Due to the risks presented when a member is not timely enrolled in MAT, insurers should work to eliminate or streamline prior authorizations and expedite a member's enrollment in treatment. This may take the form of eliminating prior authorizations for certain approved formularies or eliminating prior authorizations for a short supply of medication during the critical induction window. In general, insurers should review their prior authorization procedures and ensure that they are not more burdensome than necessary and that they may be resolved quickly in order to get members access to treatment. Moreover, those insurers maintaining prior authorizations for MAT should document how they are used for coordinating wraparound services such as drug screens and counseling.

Recommendation 15: Insurers should increase reimbursement rates to adequately cover the cost of providing substance-use disorder treatment.

Clinicians who provide substance-abuse treatment, including MAT, report that they are reimbursed at rates that "are typically lower than those for other health conditions."[65] This trend is consistent in both inpatient and outpatient settings.[66] As a consequence, some clinicians are reluctant to provide substance-abuse treatment, and insurers report that they struggle to find quality providers.

In addition to questioning the low reimbursement rates, providers also express concerns with serving those with substance-use disorder diagnoses because of their increased behavioral, social, and care

coordination needs. This problem is particularly pronounced for the Medicaid population, with several task force members reporting that they struggle to find providers who are willing to see Medicaid patients. Together, these issues result in diminished access to care even when there may be sufficient provider capacity.

In order to encourage clinicians to provide MAT and increase access to care for their members, insurers should increase the rates at which they reimburse for substance-abuse treatment services so that they are commensurate with reimbursement for other medical conditions. The Ohio Department of Medicaid should proactively work with MCOs to determine the appropriate reimbursement of these services. However, it is critical that any increases in reimbursement be tied to the quality of the care delivered and improved outcomes for patients. For example, increased reimbursement may be tied to reduced use of emergency rooms or decrease in length of inpatient stays.

Conclusion

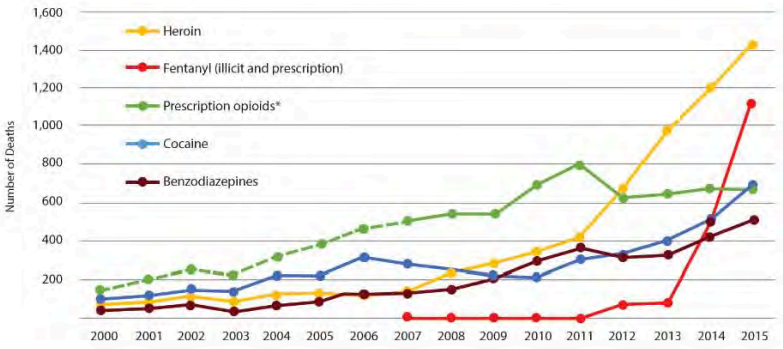
These 15 recommendations are a starting point for how health insurers may work to combat the opioid epidemic. It is the hope of this task force that these recommendations will result in meaningful conversations among insurers, providers, regulators, and the public about how to stem the tide of the opioid crisis. More than that, the task force hopes that these recommendations will result in meaningful action, innovation, and improvement in the outcomes of those with opioid-use disorder.

Appendix

Opioid (overdose) Crisis in Ohio

Bill Miller
Division of Epidemiology
OSU

Unintentional overdose deaths in Ohio, 2000-2015



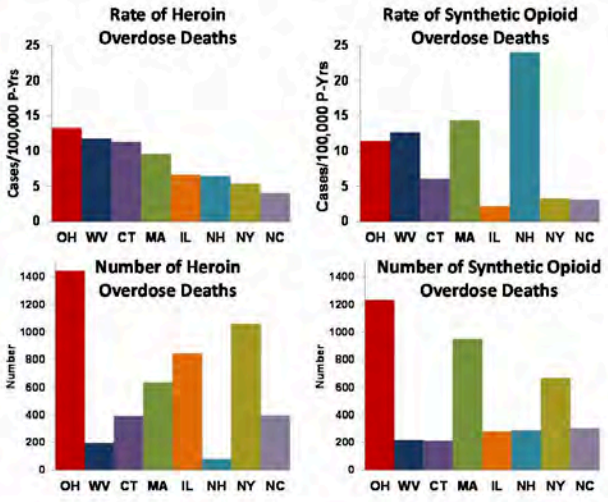
Age-adjusted rates (per 100,000 person-years) of drug overdose deaths by county in Ohio, 2010-2015.

Appalachian counties are east and south of red line.

Age-adjusted rates & number of heroin and synthetic opioid* overdose deaths, 2015

States selected to capture leaders in each category

* (including fentanyl, excluding methadone; right)



Medical consequences of opioid use

Depression/mental health issues (reciprocal)

Cellulitis/skin abscesses

Endocarditis & its consequences

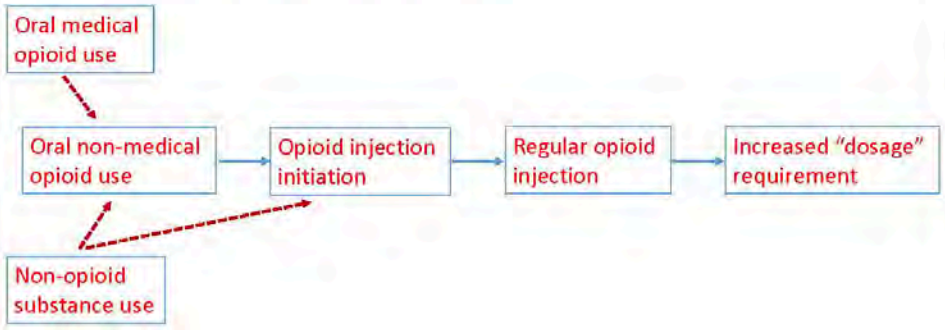
Hepatitis B

Hepatitis C → hepatocellular carcinoma

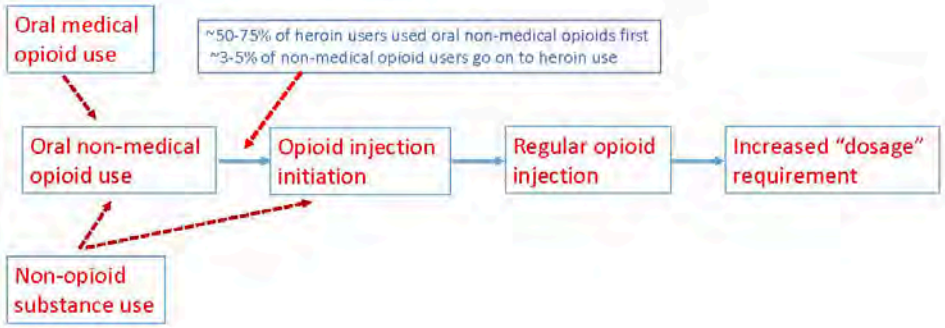
- HCV increased by 1000% between 2011 and 2015 in Ohio

Neonatal abstinence syndrome

Opioid use - transitions



Opioid use - transitions



Evidence-based tools

Syringe service programs/needle exchange programs (SSP)

- Ohio has 7 SSP

Medication-assisted treatment

- Adjunct to counseling
- Methadone
- Buprenorphine, including long-acting implant (Probuphine)
- Buprenorphine/naloxone (Suboxone)
- Extended release injectable naltrexone (Vivitrol)

Naloxone for overdose recovery

What could insurance companies do?

Prevention

Medication therapy management (MTM): reimburse pharmacists & other health professionals to monitor and manage medications, including opioids

- Include patient education with opioid subscriptions

Incentivize alternatives to opioids for chronic pain, including non-drug treatments

Monitor opioid use and flag patients for possible intervention

Monitor physician prescribing

Addiction is a chronic disease - Treatment

Facilitate MAT (costs/access) and counseling

Facilitate mental health services

- Reduce co-pay?

Incentivize primary care providers to become certified for MAT and prescribe after certification.

Facilitate naloxone availability

Cover post-primary treatment, including recovery coaching/case management

HCV: AASLD/IDSA Recommendations for Testing, Managing, and Treating Hepatitis C

"the panel continues to recommend treatment for all patients with chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV treatment, liver transplantation, or another directed therapy."

"...testing and linkage to care combined with treatment of HCV infection with potent interferon-free regimens has the potential to dramatically decrease HCV incidence and prevalence."

"Scaling up HCV treatment in persons who inject drugs is necessary to positively impact the HCV epidemic in the US and globally."

HCV

Encourage reflex HCV RNA PCR testing of positive HCV antibody screening tests

Reduce restrictions on HCV treatment, such as fibrosis scores

Reduce restrictions on need for ID physician or hepatologist to prescribe treatment for HCV

Data

Facilitate data sharing, raw and/or composite, with local authorities

Increase data access/use: share with state public health authorities and/or academics

Deidentified prescription (opioids, MAT) and diagnosis (overdose, substance use disorder, HCV, NAS) data could provide useful information for targeted services

Support trainees (graduate students, postdoctoral fellows) to focus on the issue

[1] Dr. Miller's PowerPoint presentation is included in the Appendix of this report.

[2] The mission and purpose of the Task Force was intentionally sharply focused. The group was tasked with identifying potential changes to industry policies, programs, and practices that have promise for reducing opioid addiction and promoting treatment and recovery. The Task Force was not intended to replace the need for similar conversations and efforts within the provider community or with other stakeholders.

[3] Kaiser Family Foundation, *Health Insurance Coverage of the Total Population* (2016), https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed Mar. 1, 2018).

[4] A recent Kaiser Family Foundation study revealed that the cost to employers of treating opioid overdose and addiction has increased eight-fold since 2004 to $2.6 billion in 2016. Kaiser Family Foundation, *Analysis: Cost of Treating Opioid Addiction Rose Rapidly for Large Employers as the Number of Prescriptions Has Declined* (Apr. 5, 2018), https://www.kff.org/health-costs/press-release/analysis-cost-of-treating-opioid-addiction-rose-rapidly-for-large-employers-as-the-number-of-prescriptions-has-declined.

[5] Centers for Medicare & Medicaid Services, *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.

[6] Ohio Department of Insurance, *Understanding Your Mental Health and Substance Abuse Disorder Benefits*, https://insurance.ohio.gov/Consumer/Documents/MentalHealthParity_infographic.pdf.

[7] National Institute on Drug Abuse, *Opioid Overdose Crisis* (Feb. 2018), https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis (accessed Feb. 20, 2018).

[8] Centers for Disease Control and Prevention, *Understanding the Epidemic* (Aug. 30, 2017), https://www.cdc.gov/drugoverdose/epidemic/index.html (accessed February 26, 2018).

[9] Hsien-Yen Chang, et al., *Prevalence and Treatment of Pain in EDs in the United States, 2000 to 2010*, 32 Am. J. Emergency Med. 421–31 (2014).

[10] *Opioid Overdose Crisis*, supra at Note 7.

[11] *Id.*

[12] Centers for Disease Control and Prevention, *Drug Overdose Death Data* (Dec. 19, 2017), https://www.cdc.gov/drugoverdose/data/statedeaths.html (accessed Feb. 26, 2018).

[13] Centers for Disease Control and Prevention: National Center for Health Statistics, *Provisional Drug Overdose Death Counts* (Feb. 9, 2018), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

[14] Ohio Department of Health, *2016 Ohio Drug Overdose Data: General Findings* (Aug. 30, 2017), https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/health/injury-prevention/2016-Ohio-Drug-Overdose-Report-FINAL.pdf?la=en (accessed Feb. 26, 2018).

[15] *Id.*

[16] *See* Mark Rembert, et al., *Taking Measure of Ohio's Opioid Crisis*, C. William Swank Program in Rural-Urban Policy (Oct. 2017), http://u.osu.edu/betz.40/files/2017/10/SWANK-Taking-Measure-of-Ohios-Opioid-Crisis-1vtx548.pdf. *See also* American Enterprise Institute, *New State-Level Estimates of the Economic Burden of the Opioid Epidemic* (Jan. 16, 2018), https://www.aei.org/publication/new-state-level-estimates-of-the-economic-burden-of-the-opioid-epidemic.

[17] *Taking Measure of Ohio's Opioid Crisis*, supra at Note 12.

[18] *New State-Level Estimates*, supra at Note 16.

[19] Rachel Dissell, Cleveland Plain Dealer, *Ohio's Spending on Opioid Addiction Treatment Drugs Vivitrol and Suboxone Spikes, Spurs Debate on What Treatments Work* (May 1, 2018), http://www.cleveland.com/metro/index.ssf/2017/04/ohios_spending_on_opioid_addiction_treatment_drugs_like_vivitrol_and_suboxone_spikes_spurs_debate_what_treatments_work.html.

[20] FAIR Health, *The Growing Opioid Crisis: Spotlight on Ohio Private Claims Data* (May 2017), https://www.fairhealth.org/publications/publishedresearch (accessed Mar. 1, 2018).

[21] *See* Kaiser Family Foundation, supra at Note 4.

[22] Centers for Disease Control and Prevention, *Non Opioid Treatments for Chronic Pain* (Apr. 27, 2016), https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf (accessed Feb. 27, 2018). Note, recommendations for nonopioid treatment of chronic pain do not apply in the case of active cancer treatment, palliative care, and end-of-life care.

[23] Throughout this report, recommendations regarding increased or expanded coverage for healthcare services should not be understood as a mandate that the Ohio Department of Medicaid increase spending. Increased coverage for certain services may be achieved through a reprioritization of current healthcare spending or by redirecting spending away from opioids and toward less addictive alternatives.

[24] The Joint Commission, *Pain Management* (Jan. 1, 2018), https://www.jointcommission.org/topics/pain_management.aspx.

[25] Aetna, *Aetna Sees Opioid Prescriptions Decrease* (Jan. 31, 2018), https://news.aetna.com/2017/05/aetna-sees-opioid-prescriptions-decrease (accessed Mar. 1, 2018).

[26] *Id.*

[27] Governor's Cabinet Opiate Action Team, *Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments* (Jan. 2016), http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Acute-Pain-20160119.pdf (accessed Mar. 1, 2018).

[28] Governor's Cabinet Opiate Action Team, *Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain 80 mg of a Morphine Equivalent Daily Dose (MED) "Trigger Point"* (Oct. 2013), http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Chronic-Pain.pdf (accessed Mar. 1, 2018).

[29] Governor's Cabinet Opiate Action Team, *Ohio Guidelines for Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCS) Prescribing* (Jan. 2014), http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-ED-Acute-Care.pdf (accessed Mar. 1, 2018).

[30] Centers for Disease Control and Prevention, *CDC Guideline for Prescribing Opioids for Chronic Pain— United States, 2016* (Mar. 18, 2016), https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm (accessed Mar. 1, 2018).

[31] America's Health Insurance Plans, *The STOP Measure: Safe and Transparent Opioid Prescribing to Promote Patient Safety and Reduced Risk of Opioid Misuse* (Feb. 2018), https://www.ahip.org/wp-content/uploads/2018/02/AHIP_STOPMethodology_FINAL-FINAL.pdf (accessed Mar. 1, 2018).

[32] *Id.*

[33] Robert J. Fortuna, et al., *Prescribing of Controlled Medications to Adolescents and Young Adults in the United States*, 126 Pediatrics 1108–16 (2010).

[34] Kaiser Family Foundation, *Opioid Overdose Deaths by Age Group*, https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group (accessed Feb. 28, 2018).

[35] National Institute on Drug Abuse, *Drugs Brains, and Behavior: The Science of Addiction* (July 2014), https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (accessed Feb. 28, 2018).

[36] Philip Veliz, et al., *Opioid Use Among Interscholastic Sports Participants: An Exploratory Study from a Sample of College Students*, Research Quarterly for Exercise and Sport (Dec. 16, 2014), https://www.tandfonline.com/doi/full/10.1080/02701367.2014.983219.

[37] Nora D. Volkow, et al., *Characteristics of Opioid Prescriptions in 2009*, 305 JAMA: J. Am. Med. Ass'n 1299–1301 (2011).

[38] American Dental Association, *American Dental Association Announces New Policy to Combat Opioid Epidemic* (Mar. 26, 2018), https://www.ada.org/en/press-room/news-releases/2018-archives/march/american-dental-association-announces-new-policy-to-combat-opioid-epidemic.

[39] Centers for Disease Control and Prevention, *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use—United States, 2006–2015* (Mar. 17, 2017), https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm (accessed Mar. 1, 2018).

[40] *Id.*

[41] Substance Abuse and Mental Health Services Administration, *Prevention Approaches* (July 21, 2016), https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-approaches (accessed Feb. 28, 2018).

[42] Erin E. Krebs, et al., *Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients with Chronic Back Pain or Hip or Knee Osteoarthritis Pain*, 319 JAMA: J. Am. Med. Ass'n 872–82 (2018).

[43] Centers for Disease Control, *Pocket Guide: Tapering Opioids for Chronic Pain* (2016), https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf.

[44] U.S. Department of Veterans Affairs, *Opioid Taper Decision Tool* (Oct. 2016), https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf.

[45] United Healthcare, *Opioid Tapering Recommendations* (2018), https://www.uhcprovider.com/content/dam/provider/docs/public/resources/pharmacy/opioid-tapering-recommendations.pdf.

[46] Centers for Disease Control and Prevention, *Patient Review & Restriction Programs: Lessons Learned from State Medicaid Programs* (Aug. 2012), https://www.cdc.gov/drugoverdose/pdf/pdo_patient_review_meeting-a.pdf (accessed Mar. 1, 2018).

[47] *Id.*

[48] National Institute on Drug Abuse, *Treating Opioid Use Disorder During Pregnancy* (July 2017), https://www.drugabuse.gov/publications/treating-opioid-use-disorder-during-pregnancy/treating-opioid-use-disorder-during-pregnancy (accessed Feb. 26, 2018).

[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] The American College of Obstetricians and Gynecologists, *ACOG Committee Opinion Number 711: Opioid Use and Opioid Use Disorder in Pregnancy* (Aug. 2017), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy (accessed Feb. 26, 2018).

[53] *Id.*

[54] U.S. Department of Justice, Bureau of Justice Statistics, *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007–2009* (June 2017), https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf (accessed Feb. 26, 2018).

[55] National Institute on Drug Abuse, *Treatment of Opioid Use Disorder in the Criminal Justice System* (Jan. 2018), https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/treatment-opioid-use-disorder-in-criminal-justice-system (accessed Feb. 26, 2018)

[56] *Id.*

[57] *Id.*

[58] The Pew Charitable Trusts, *How and When Medicaid Covers People Under Correctional Supervision* (Aug. 2, 2016), http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision.

[59] Ohio Department of Medicaid, *Medicaid Changes and Implications for the Jail Population* (2016), https://www.mhrsbssw.org/wp-content/uploads/2017/01/2016-Medicaid-Jail-Population.pdf.

[60] U.S. Department of Medicaid, *The Coverage Learning Collaborative: Medicaid and Justice-Involved Populations* (Aug. 17, 2017), https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/justice-involved-populations.pdf.

[61] American Society of Addiction Medicine, *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (Jun. 1, 2015), https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf (accessed Mar. 2, 2018)

[62] Substance Abuse and Mental Health Services Administration, *Medication and Counseling Treatment* (Sept. 28, 2015) https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat (accessed Feb. 27, 2018).

[63] Troy Parks, *AGs Called on to Help Stop Prior Authorization for MAT*, AMA Wire (Feb. 8, 2017) https://wire.ama-assn.org/ama-news/ags-called-help-stop-prior-authorization-mat (accessed Feb. 27, 2018).

[64] *Id.*

[65] The President's Commission on Combating Drug Addiction and the Opioid Crisis, at 70 (Nov. 1, 2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf (accessed Feb. 27, 2018).

[66] *Id.*

Ohio Attorney General's

Insurer Task Force on Opioid Reduction

Report and Recommendations

MIKE DEWINE
OHIO ATTORNEY GENERAL

www.OhioAttorneyGeneral.gov