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LAN SUMMIT

Health Care Payment Learning & Action Network

105 Panel: Addressing the Opioid Crisis: Pain Management, Addiction Treatment, and Recovery in the Context of APMs

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

Welcome

Bill Hazel

Former Secretary, Health and Human Resources,

Commonwealth of Virginia

Panel Speakers

Mary Applegate

Medical Director, Ohio Department of Medicaid

Martin Rosenzweig

Senior Behavioral Medical Director, Optum

Andrey Ostrovsky

CEO, Concerted Care Group

J. Alice Thompson

Social Science Researcher, Center for Medicare and Medicaid Innovation

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Three Ways APMs Can Help Combat the Opioid Epidemic

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

Welcome

Mary S. Applegate, MD, FAAP, FACP

Medicaid Medical Director

Ohio Department of Medicaid

Ohio's goal: 80-90% in APMs within 5 years

Progress to date

Comprehensive Primary Care (CPCs)	Episodes	Behavioral Health Care Coord. (BHCCs)
▪ 1M+ patients ▪ 145 CPC practices ▪ ~10,000 primary care practitioners	▪ 1M+ patients ▪ 43 episodes ▪ 13,000+ providers (PAPs)	*In design: delegating care coordination to qualified BH entities*

3 ways APMs can address the opioid epidemic

I **Metrics:** include opioids-related quality metrics linked to payment

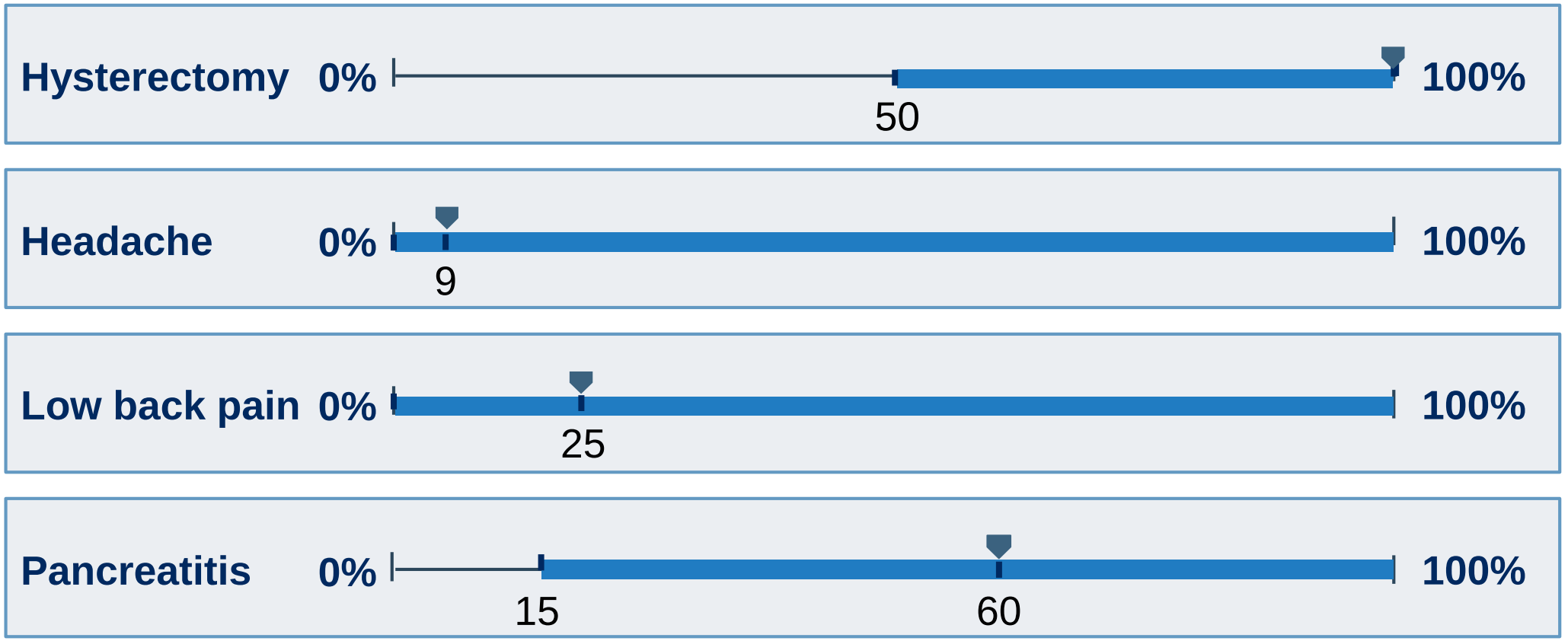
II **Reporting:** increase transparency and provide actionable insights

III **Predictive Analytics:** for earlier identification and intervention

Safer opioid prescriptions tied to incentives

Min Median Max

Variation in new opioid prescrip-tion (fill) rate



Source: Ohio claims data. Episodes ending in 2014

I Include OUD care metrics in APMs

Examples of OUD care metrics under consideration

- % members with OUD not receiving any treatment
- Opioid-related ED / IP visits per 1,000 member months
- % patients receiving > 80mg MED
- % members with # urine drug screens per month while receiving MAT
- % members not screened for Hepatitis B or C

Hospital-level change through APMs:
Care Innovation and Community Improvement Program (CICIP)

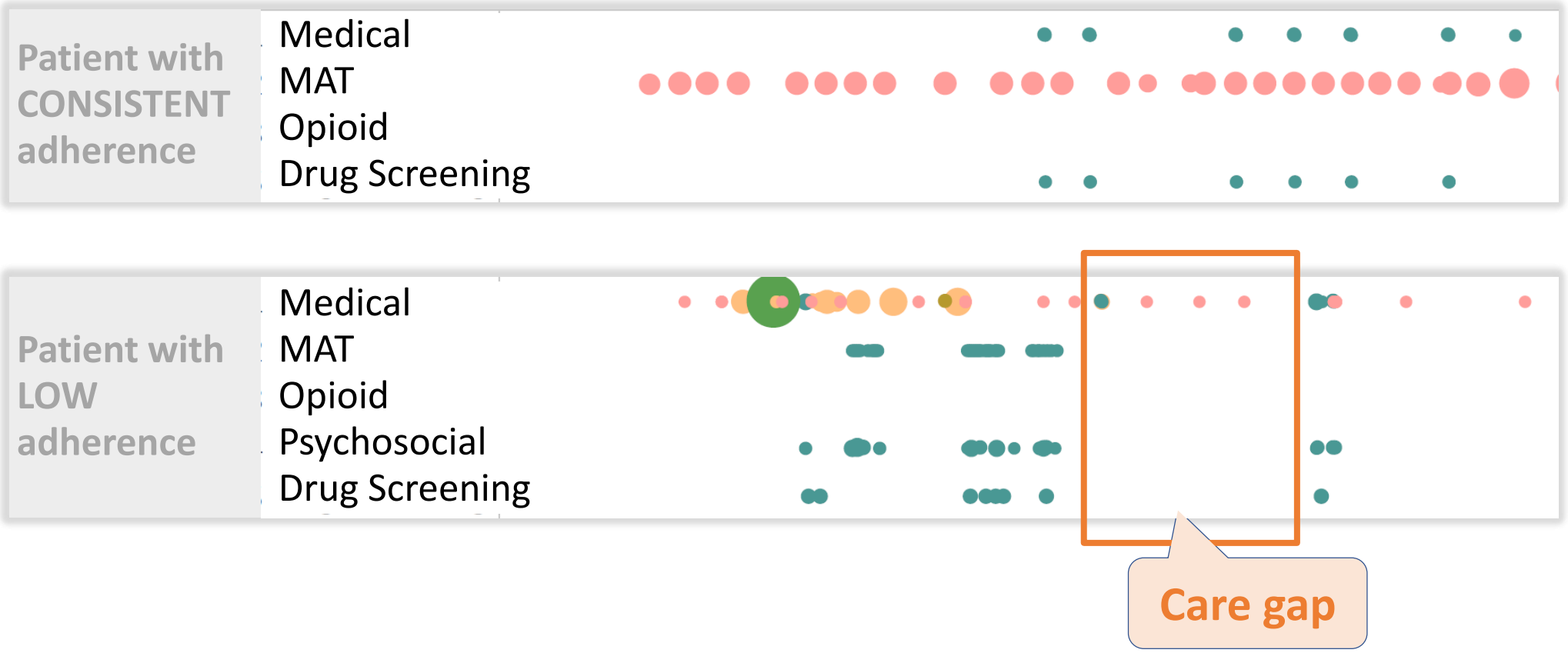
- Additional upside payment to hospitals through managed care plans
- Conditional to specific opioid-related quality metrics
- To align quality improvement strategies

Examples of CICIP measures:

- % patients on opioids AND benzodiazepine
- % patients receiving > 80mg MED
- Follow-up after inpatient mental health stay
- Improvement of maternity measures
- ED utilization reduction

II Reporting for Insight and Action

Patient journey dashboard



II Reporting for Insight and Action

Referral reports may drive improved quality and costs of care

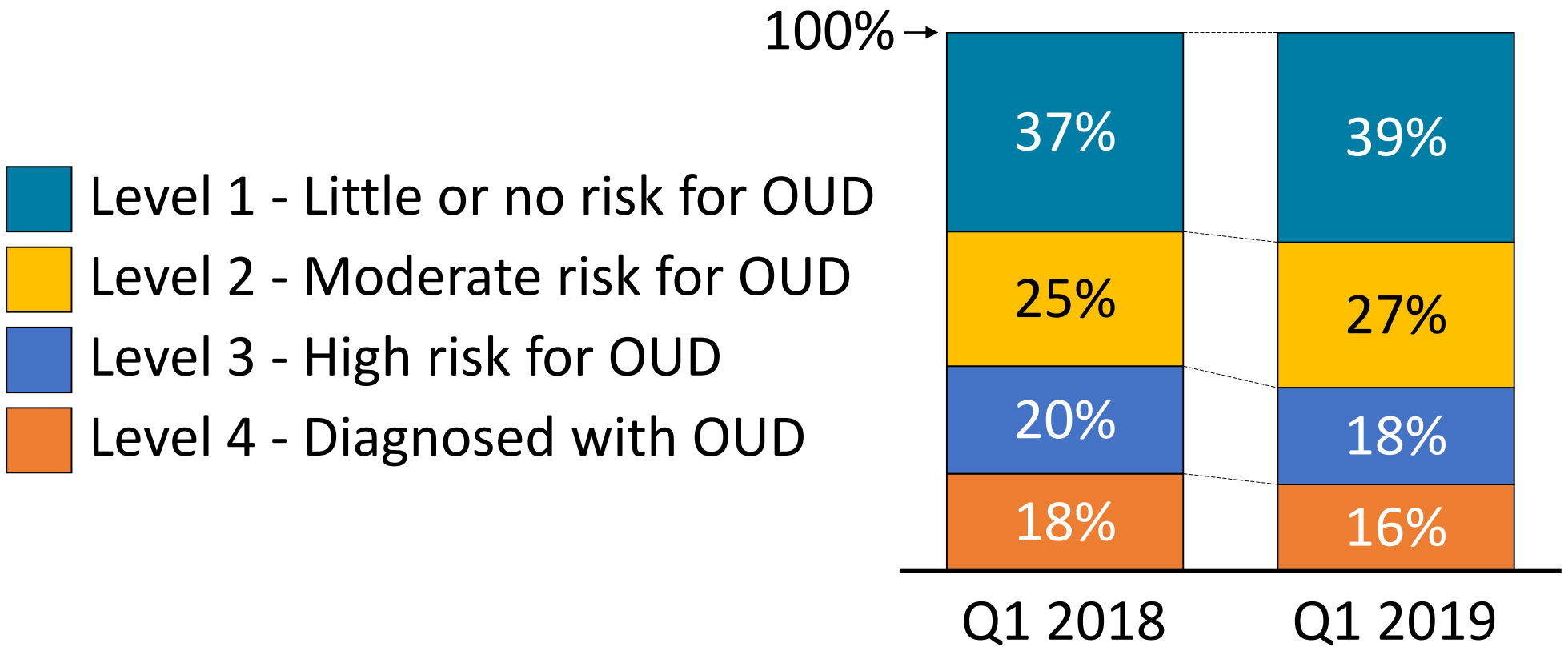
ASTHMA EXARCERBATION – REFERRAL REPORT

Provider (PAP)	Risk-adj. cost	Meets quality standards	# of episodes from your patients	% of your episodes
Provider 1	$	✓	18	15%
Provider 2	$$	✗	15	13%
Provider 3	$$$$	✓	11	9%

III Predictive modeling: population health insights

OUD risk in your panel

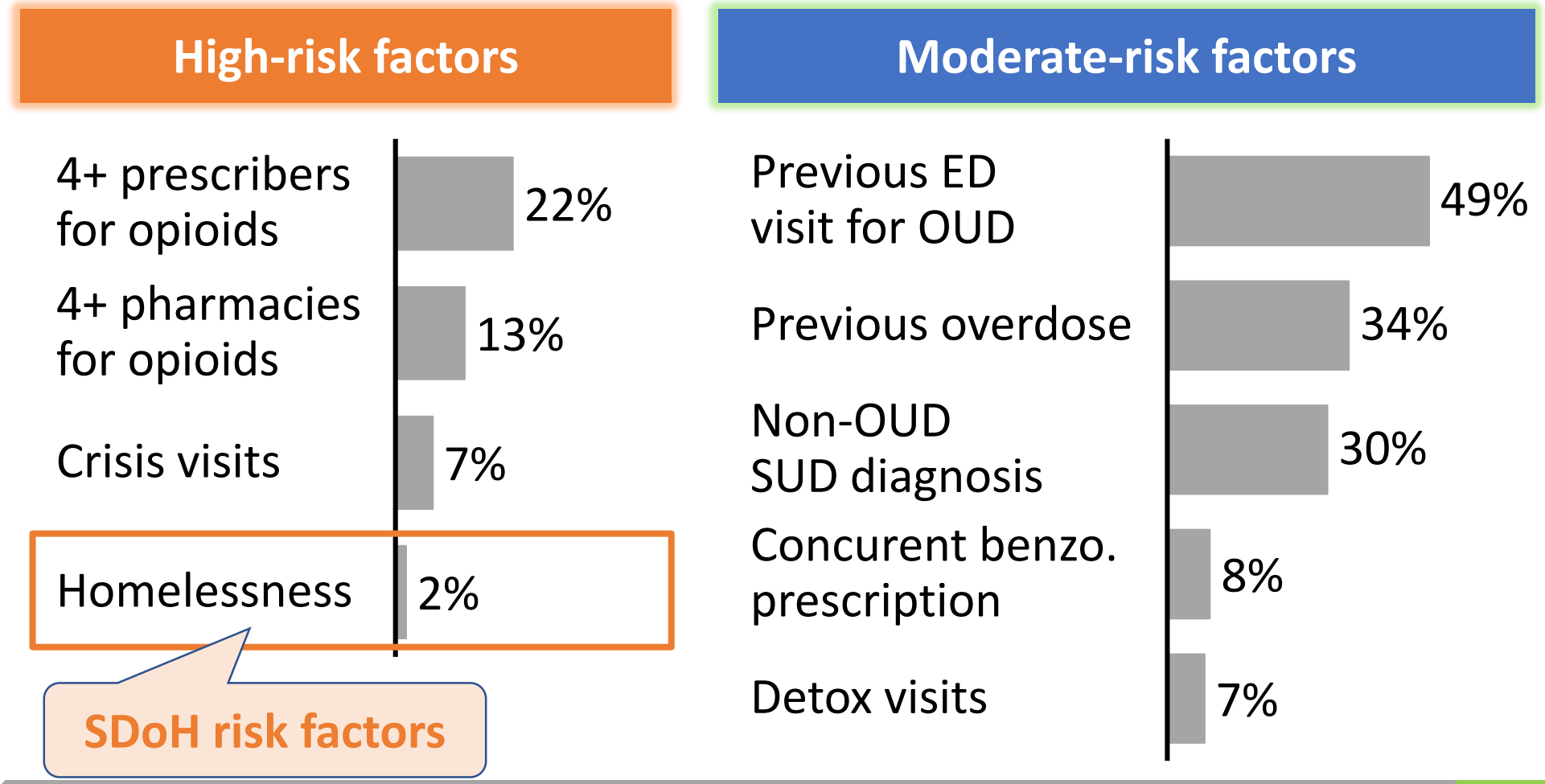
% of members



III Predictive modeling: population health insights

Risk factor prevalence in OUD-diagnosed population

% members



Additional Considerations

Prevention

- **School-based health** incentives for CPCs
- Further leverage & evolve **predictive modelling**
- Link opioids-specific metrics to payment in **more episodes, CPC,** aligning with PDMP
- Opportunities with 100% **e-prescribing**
- Expand models to **include pain management** avoid unintended consequences for chronic pain patients

Treatment

- Link payment to **retention in care** **(**referrals, pain management
- Further leverage CPC with long-acting MATs
- HCC program to refer to highest **quality OUD treatment providers**

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Implementing Evidence-based Addiction Treatment in the Context of Upstream Barriers to Health

Andrey Ostrovsky MD | *CEO* | *Concerted Care Group* | *@andreyostrovsky*

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

Welcome

Andrey Ostrovsky

CEO, Concerted Care Group

Faculty Disclosure

Andrey Ostrovsky, MD

Source: socialinnovationventures.co

Catharsis at the front line

- **Vision:** Eliminate addiction in all American communities
- **Mission:** Empower every individual with the ability to improve the quality of their life through comprehensive, integrated, and evidence-based addiction treatment.
- **True North Goals:**
  - Improve clinical outcomes
  - Become financially sustainable
  - Increase joy at work

CCG
CONCERTED CARE GROUP

4 pillars of MAT

- Medication (methadone, buprenorphine, or naltrexone)
- Primary care
- Addictions counseling and mental health therapy
- Social supports

Source: https://www.samhsa.gov/medication-assisted-treatment/treatment

OTP vs OBOT

- Opioid Treatment Program (OTP)
  - SAMHSA-licensed via CARF or Joint Commission to administer methadone for opioid use disorder
  - Can administer methadone, buprenorphine and naltrexone as well
  - Sometimes referred to as “methadone clinic”
- OBOT (Office-based Outpatient Treatment)
  - Individual providers need to have a DATA 2000 waiver
  - Can administer buprenorphine and naltrexone, but not methadone

Source: https://www.samhsa.gov/medication-assisted-treatment/treatment

Dispelling Myths about MAT

MAT JUST TRADES ONE ADDICTION FOR ANOTHER: MAT bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat SUDs and help sustain recovery. (10)

MAT IS ONLY FOR THE SHORT TERM: Research shows that patients on MAT for at least 1-2 years have the greatest rates of long-term success. There is currently no evidence to support benefits from stopping MAT. (11)

MY PATIENT'S CONDITION IS NOT SEVERE ENOUGH TO REQUIRE MAT: MAT utilizes a multitude of different medication options (agonists, partial agonists and antagonists) that can be tailored to fit the unique needs of the patient (2).

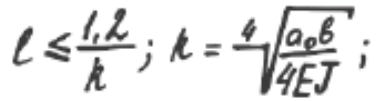
Source: TheNationalCouncil.org

Dispelling Myths about MAT

MAT INCREASES THE RISK FOR OVERDOSE IN PATIENTS: MAT helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (14)

PROVIDING MAT WILL ONLY DISRUPT AND HINDER A PATIENT'S RECOVERY PROCESS:

MAT has been shown to assist patients in recovery by improving quality of life, level of functioning and the ability to handle stress. Above all, MAT helps reduce mortality while patients begin recovery.



THERE ISN'T ANY PROOF THAT MAT IS BETTER THAN ABSTINENCE: MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and

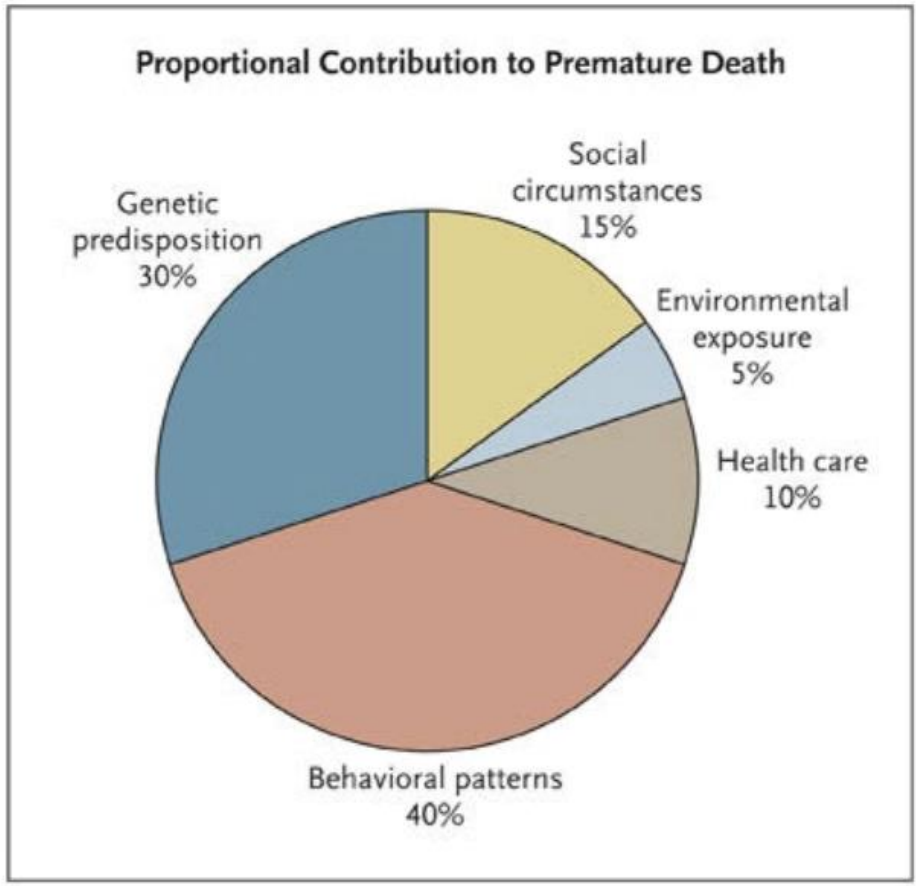
Source: TheNationalCouncil.org

Dispelling Myths about MAT

MOST INSURANCE PLANS DON'T COVER MAT: As of May 2013, 31 state Medicaid FFS programs covered methadone maintenance treatment provided in outpatient programs (4). State Medicaid agencies vary as to whether buprenorphine is listed on the Preferred Drug List (PDL), and whether prior authorization is required (a distinction often made based on the specific buprenorphine medication type). Extended-release naltrexone is listed on the Medicaid PDL in over 60 percent of states. (5)

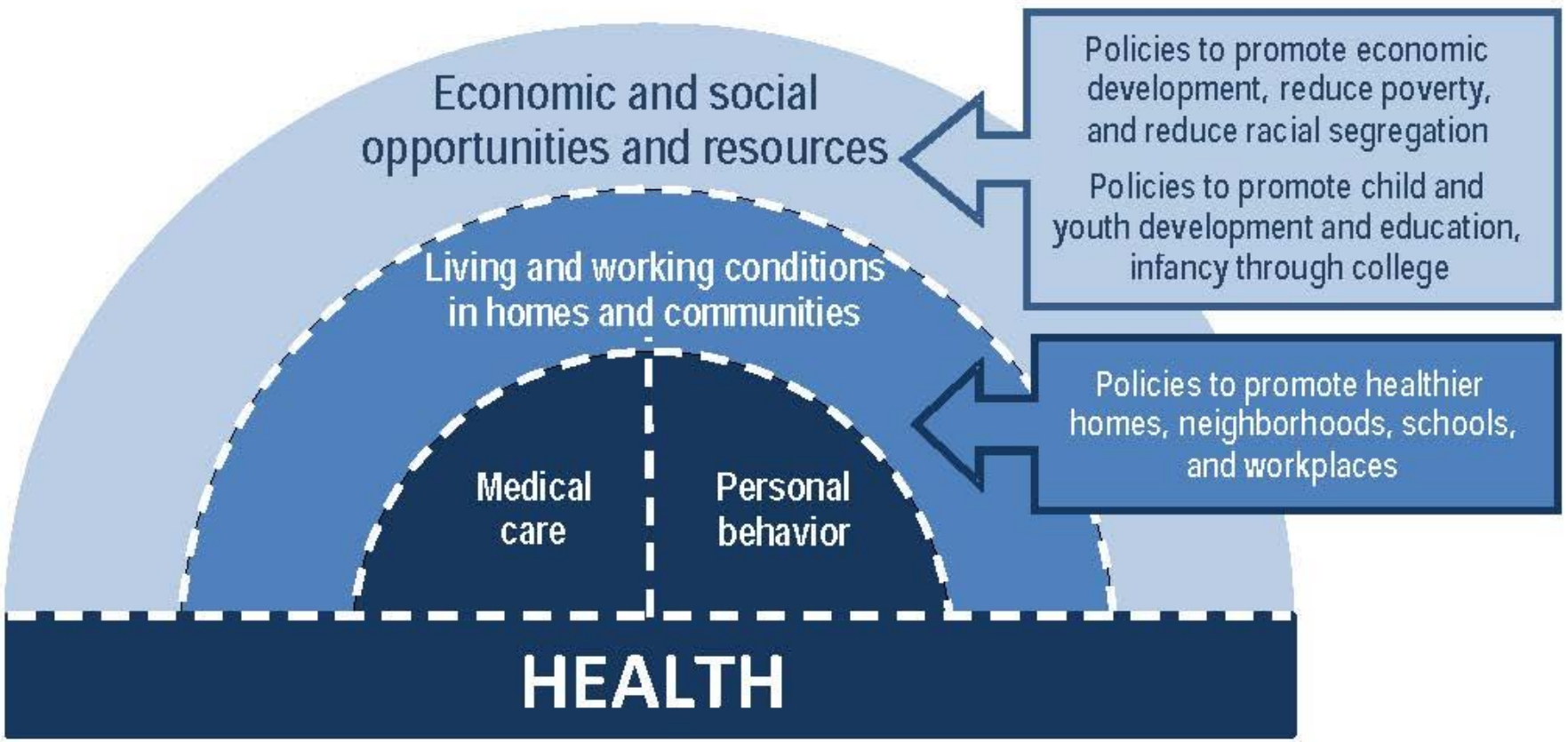
Source: TheNationalCouncil.org

Role of Non-Healthcare Determinants



Source: Schroeder. NEJM. 2007. Adapted from McGinnis et al.

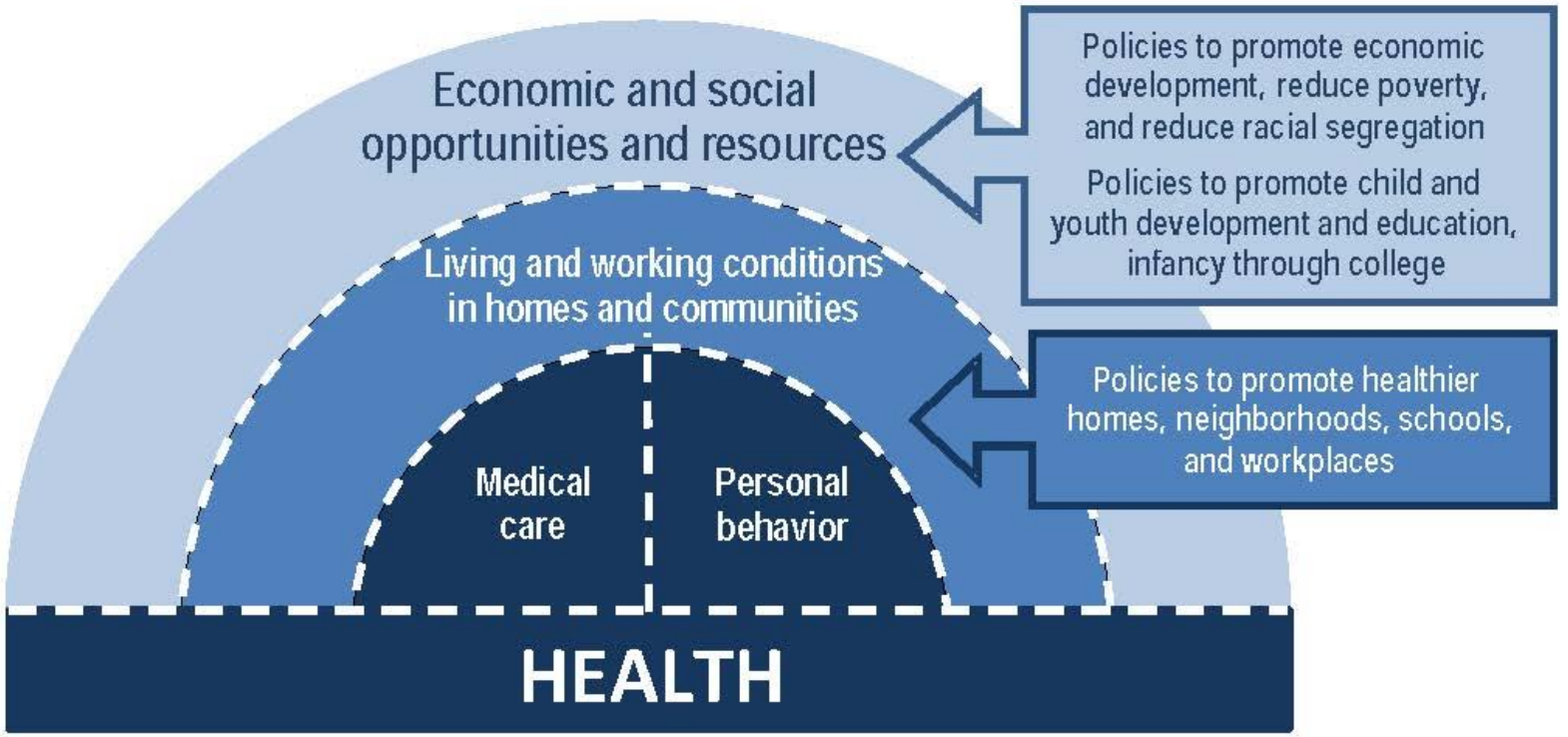
Role of Social Determinants of Health



Source: Braverman P et al. Broadening the Focus: The Need to Address the Social Determinants of Health. AJPM. 2011. 40(1):1.

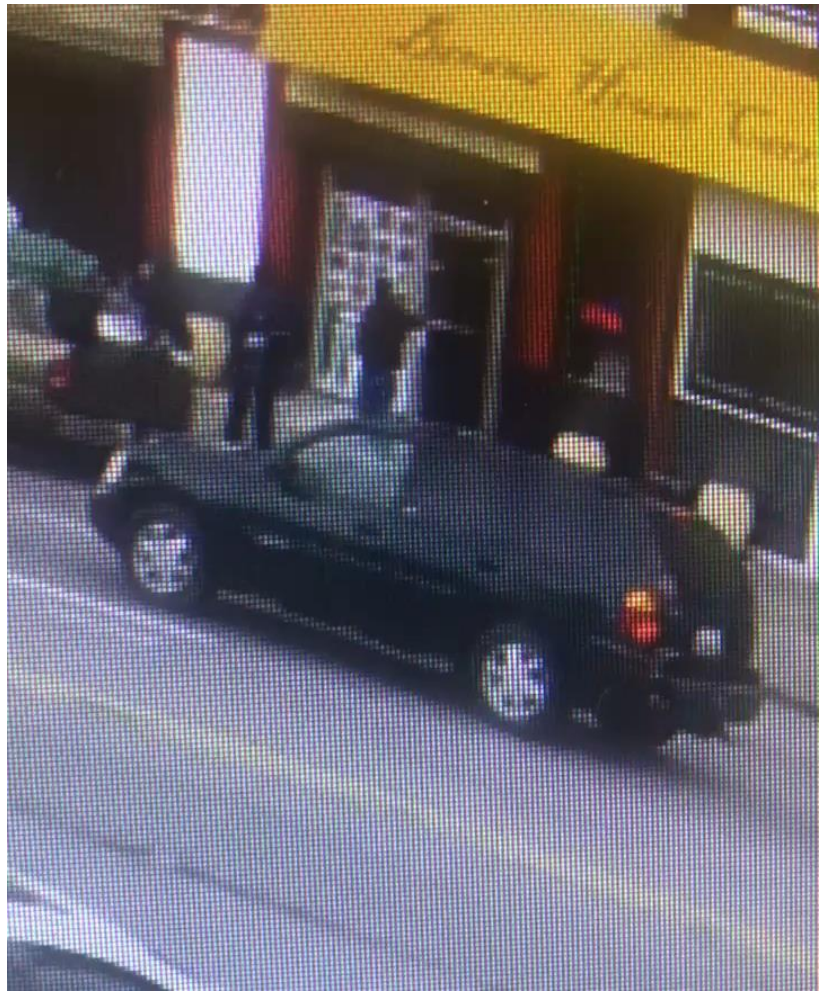
Role of Social Determinants of Health

Stigma



Source: Braverman P et al. Broadening the Focus: The Need to Address the Social Determinants of Health. AJPM. 2011. 40(1):1.

Role of Social Determinants of Health



Pathways to OUD

- Pathway 1: Inadequately controlled chronic physical pain leads to misuse (17%)
- Pathway 2: Some individuals are vulnerable to opioid dependence even after brief opioid exposure (12%)
- Pathway 3: Prior substance use problems and introduction of prescribed opioids (15%)
- Pathway 4: Relief from emotional distress reinforces misuse or abuse (21%)
- Pathway 5: Recreational initiation or non-medically supervised use of opioids (40%)

Source: Stumbo et al. Patient-reported PATHWAYS to opioid use disorders and pain-related barriers to treatment engagement. Journal of Substance Abuse Treatment 73 (2017) 47–54.

“Gas and go” vs Comprehensive care vs “Abstinence”

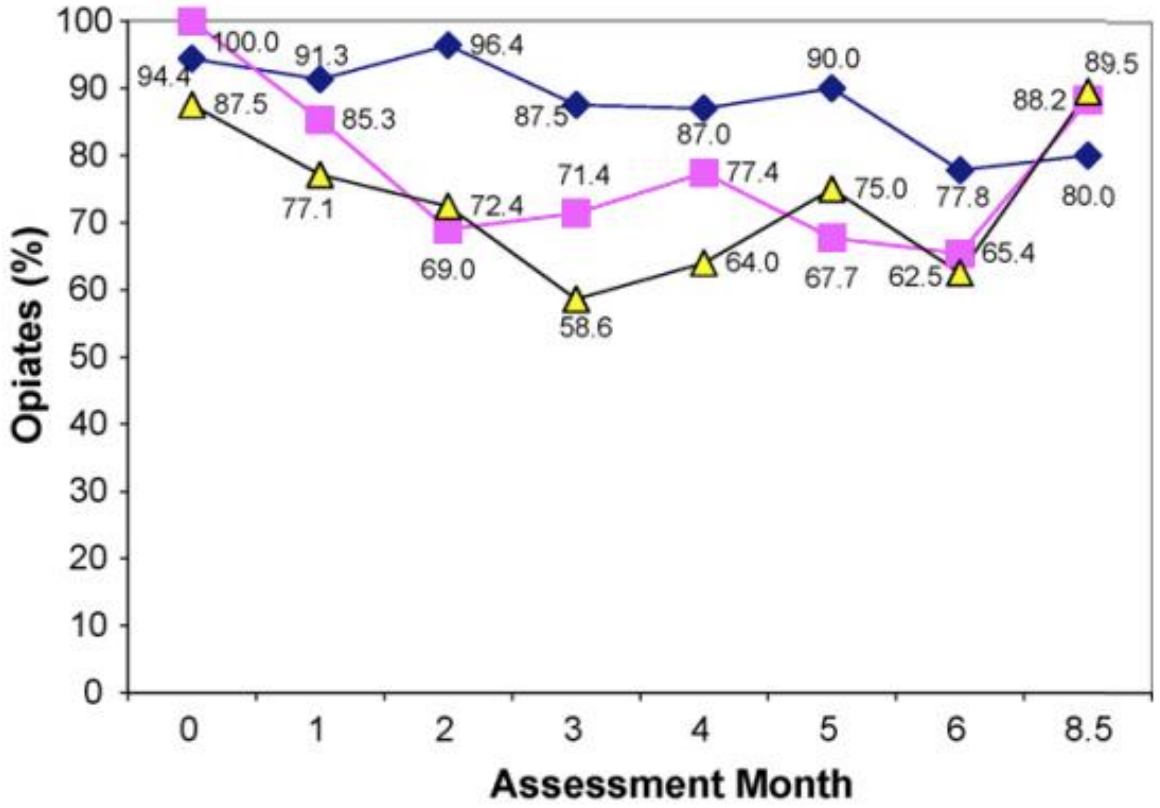
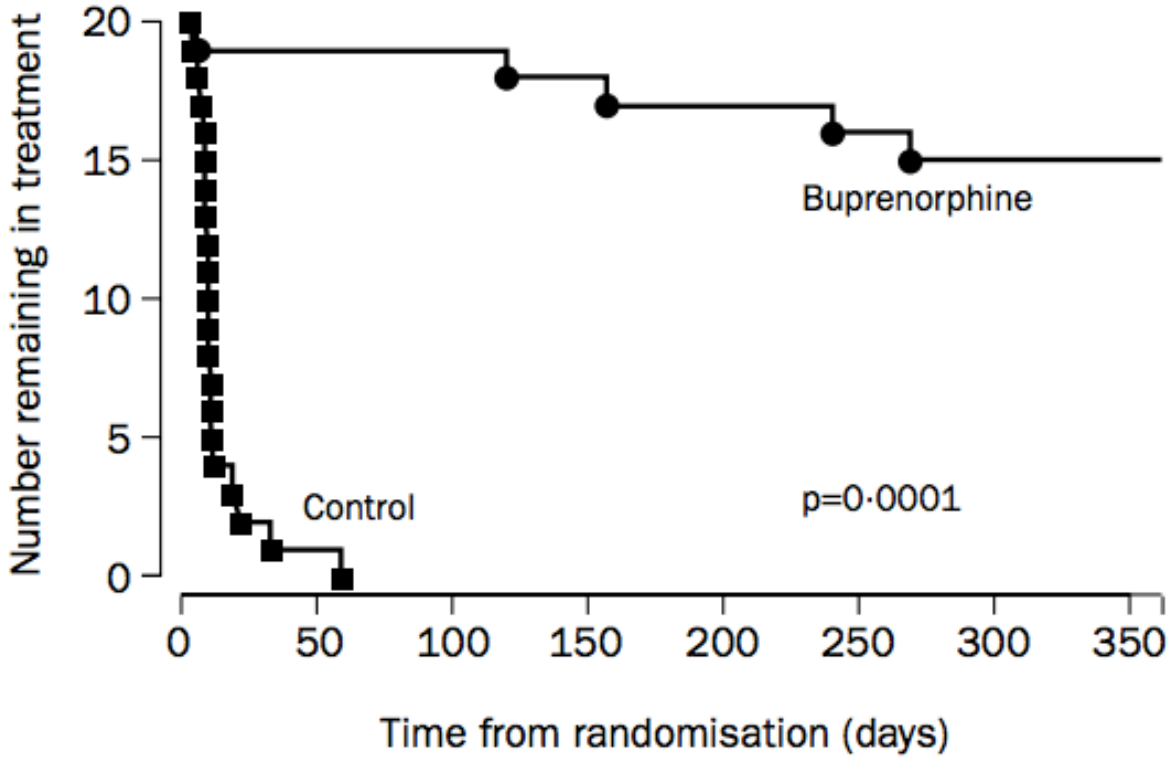


Fig. 1. Percent urine tests positive for opiates by assessment month and treatment condition. (♦, 21-day methadone detoxification; ■, 6-month methadone maintenance with minimal counseling; △, 6-month methadone maintenance with standard counseling) Although the standard errors of some of the proportions may overlap [SEP = $p(1-p)/n$], the combined difference was statistically significant. Opiate positive urine tests months 1–6: Minimal MM vs. Detox $p = .0302$. Opiate positive urine tests months 1–8.5: Minimal MM vs. Detox $p = .0149$.

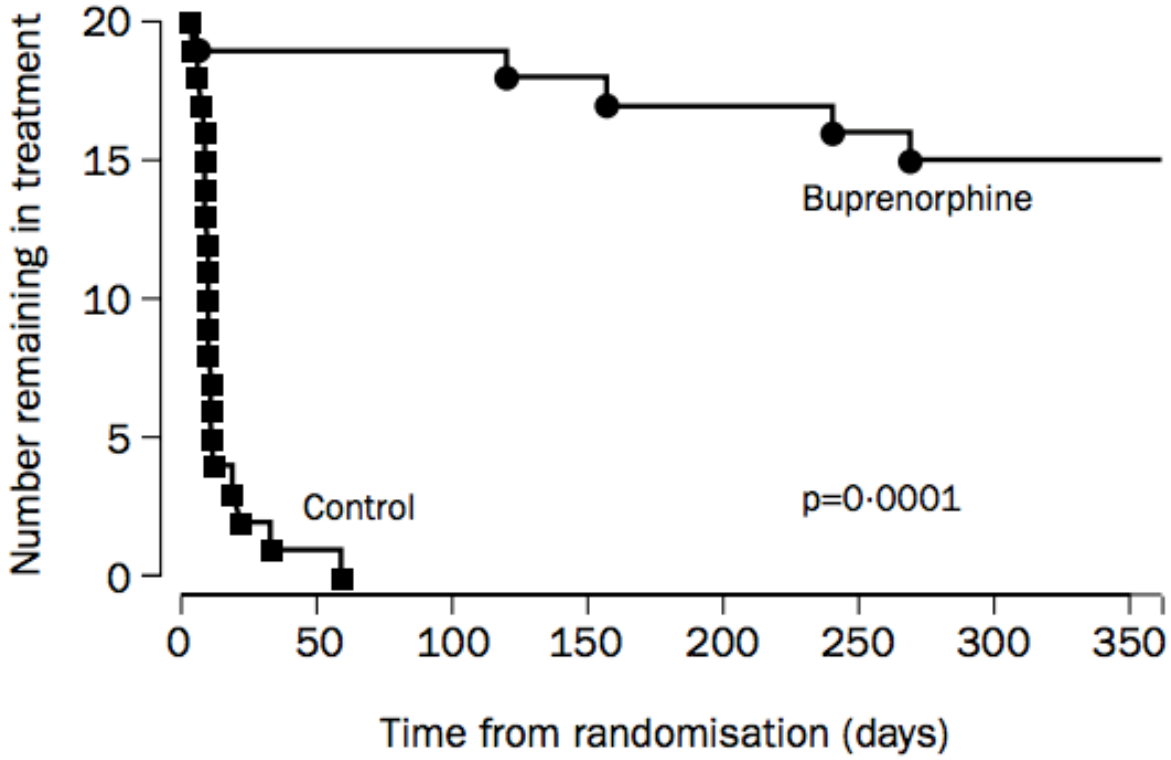
Source: Gruber et al. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug and Alcoh Dependence. April 1, 2008. Volume 94, Issues 1-3, Pages 199–206.

“Gas and go” vs Comprehensive care vs “Abstinence”



Source: Kakko et al. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. Lancet 361 (9358). 2003. P662-668.

“Gas and go” vs Comprehensive care vs “Abstinence”



4 out of 20 people died in the placebo arm versus none in the buprenorphine group (p = 0.015)

Source: Kakko et al. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. Lancet 361 (9358). 2003. P662-668.

Care needs to be individualized

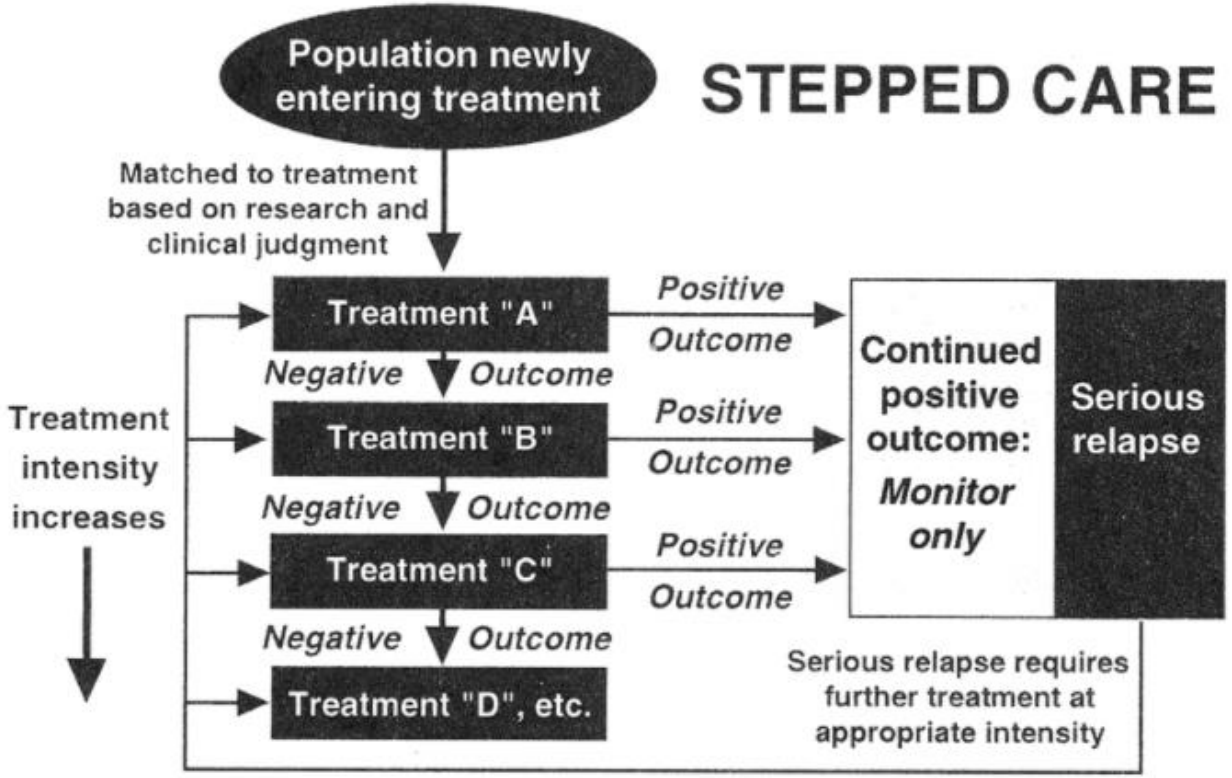
Opinion

Addiction Doesn't Always Last a Lifetime

In fact, most people recover, often on their own. Here are some of their stories.

Source: Szalavitz M. NYT. Aug 2018.

How to manage patients not adhering to treatment



A stepped care approach to the delivery of health care services. From Addictive Behaviors Across the Lifespan: Prevention, Treatment, and Policy Issues (p. 150), by J. S. Baer, G. A. Marlatt, & R. J. McMahon (Eds.), 1993, Beverly Hills, CA: Sage. Copyright 1993 by M. B. Sobell and L. C. Sobell. Adapted with permission.

How to manage patients not adhering to treatment

Phases of Recovery	Criteria	Treatment
Orange Phase: Induction Phase / or IOP	First 4 weeks Assessment / getting to know each other	• 1 counseling session per week • 1 group per week – to include Orientation group & overdose prevention group • 2 MD/NP meetings • Weekly urinalysis
	(Step Up! Step Down! With changing needs)	
Yellow Phase: Intensive Phase	Current struggle with maintaining abstinence	• 1 counseling session per week • 2 groups per week • 2 MD/NP meetings per month • Weekly urinalysis
Green Phase: Moderate Phase	Some use may continue now & then. Earning some take homes or working towards earning take homes, moderately engaged in treatment.	• 2 counseling sessions per month • 1 group per week • 1 MD/NP meetings per month • Monthly urinalysis
Blue Phase: Maintenance Phase	Abstinence from all substances maintained. Receiving take homes.	• 1 60 minute counseling session per month • 1 MD/NP visit every 3 months • Monthly urinalysis

Red Phase: Harm Reduction	Non-adherence to treatment plan	• Non-preferential dosing times • Weekly urinalysis

How to manage patients not adhering to treatment

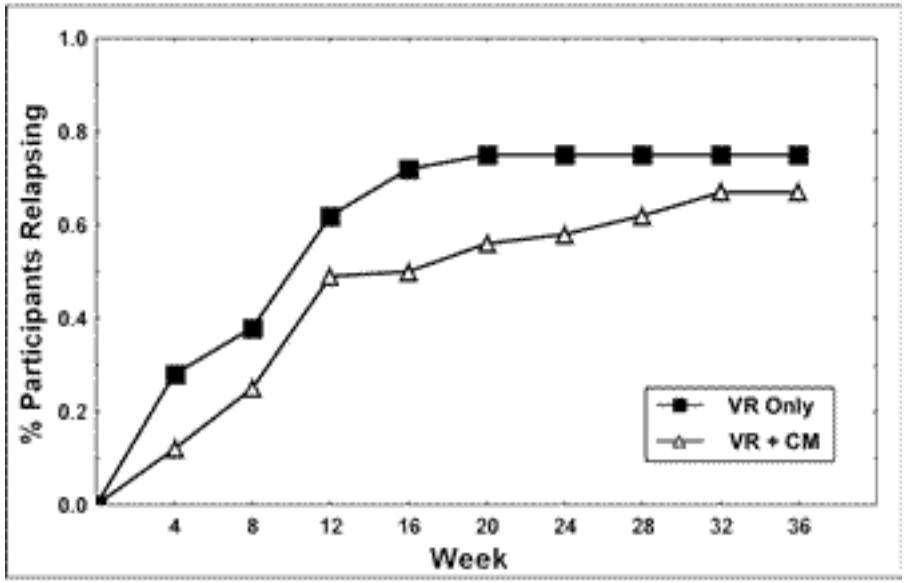


Figure 3.
Time to relapse during 9 months of follow-up; vocational rehabilitation (VR) only versus VR plus contingency management (CM). Note: Sobriety incentives were available weeks 1–16 only.

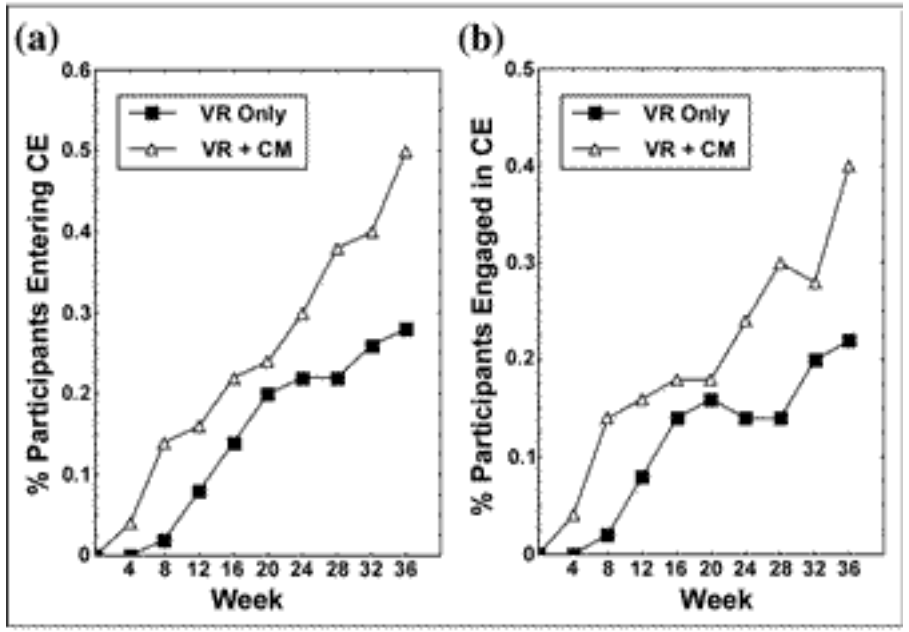


Figure 1.
Vocational rehabilitation (VR) only versus VR plus contingency management (CM) during 36 weeks of follow-up (n = 100, 50 each group): **(a)** time to competitive employment (CE) and **(b)** percentage engaged in CE.

Source: Drebing CE et al. Adding contingency management intervention to vocational rehabilitation: Outcomes for dually diagnosed veterans. JRRD. 2007. 44(6)

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CMS Innovation Center Opioid Strategy and Current Efforts

J. Alice Thompson
Center for Medicare & Medicaid Innovation (CMMI)
Centers for Medicare & Medicaid Services (CMS)

Welcome

J. Alice Thompson

Social Science Researcher, Center for Medicare and Medicaid Innovation

The CMS Innovation Center Statute

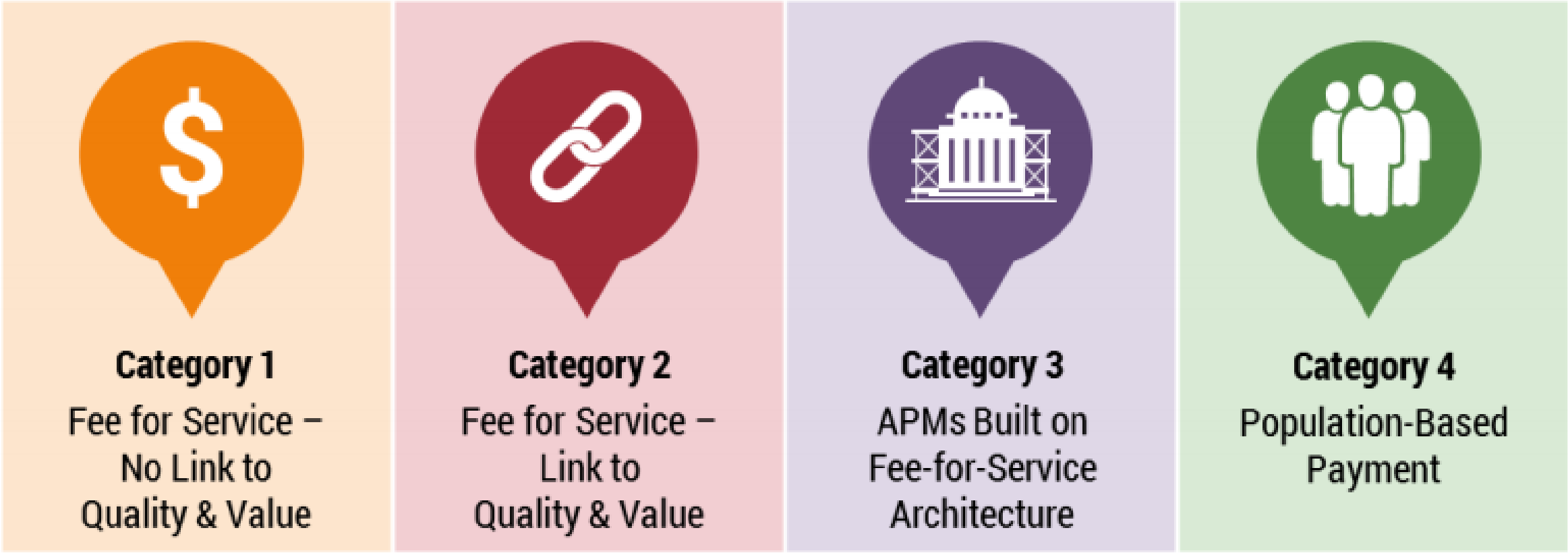
"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles."

Three scenarios for success from Statute:

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

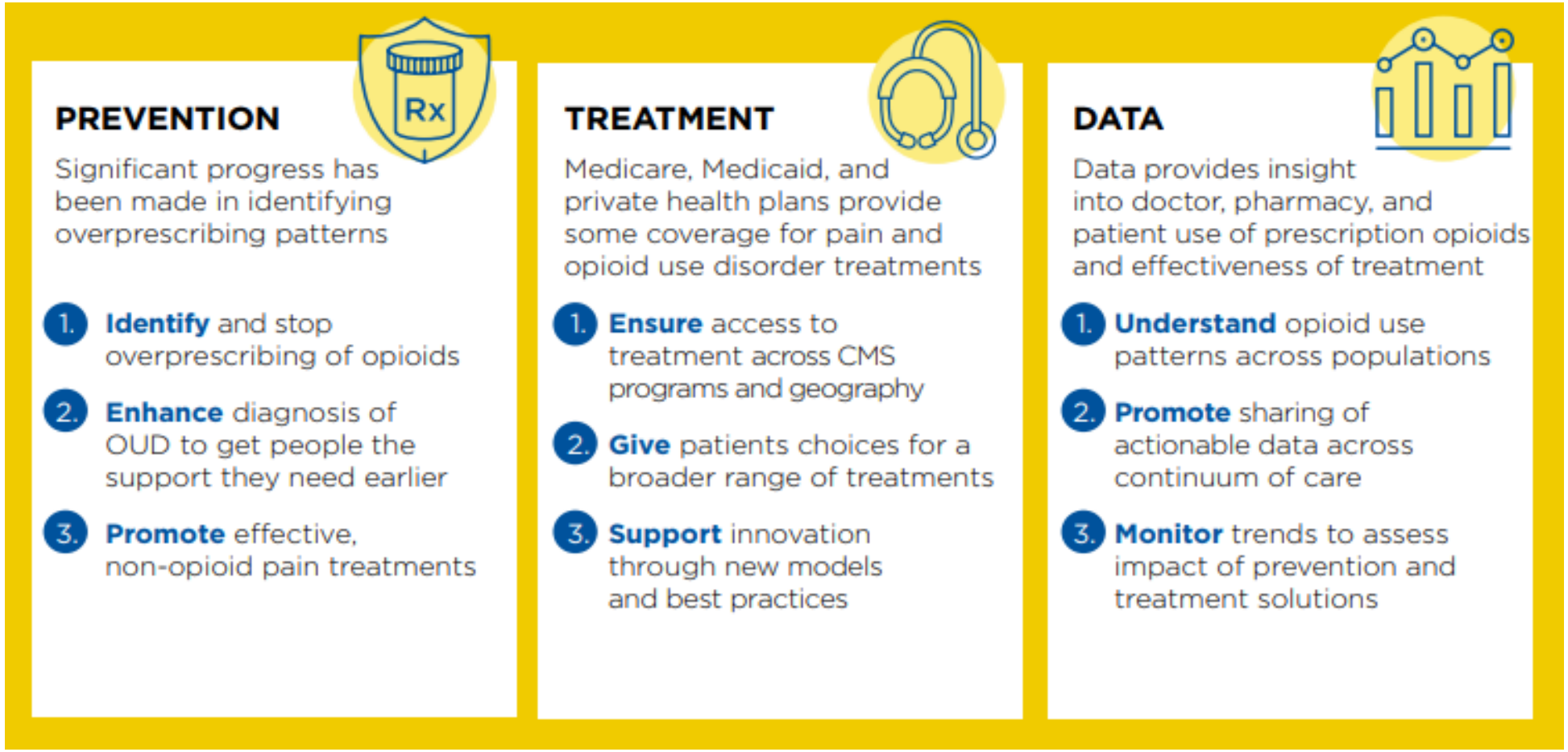
If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

CMS Value-Based Payment Framework



https://hcp-lan.org/workproducts/apm-whitepaper.pdf

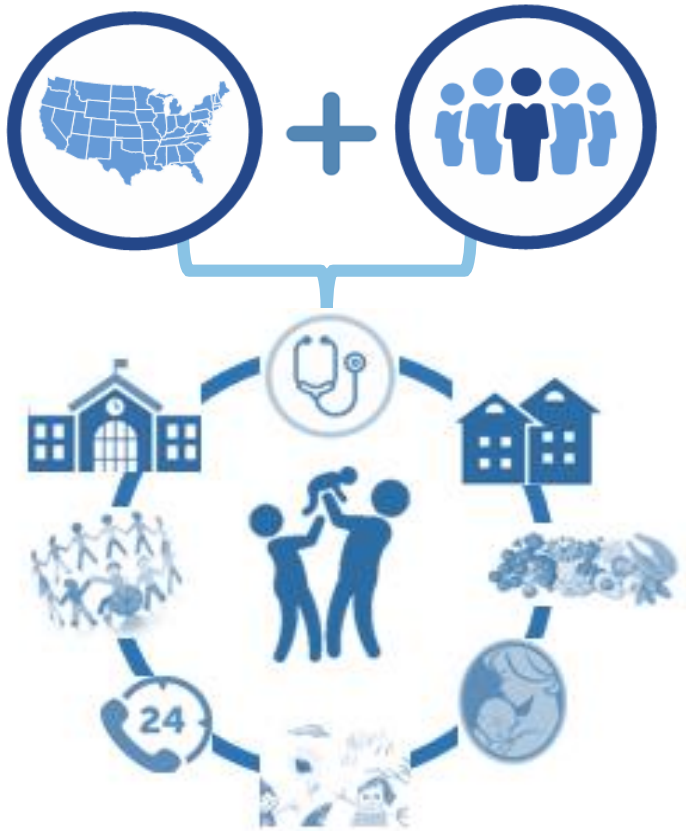
CMS Roadmap to Address the Opioid Crisis



https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

Integrated Care for Kids (InCK) Model

The **Integrated Care for Kids (InCK) Model** is a child-centered *local service delivery* and *state payment model* aimed at **reducing expenditures** and **improving the quality of care** for children covered by Medicaid and CHIP, especially those with or at-risk for developing significant health needs.



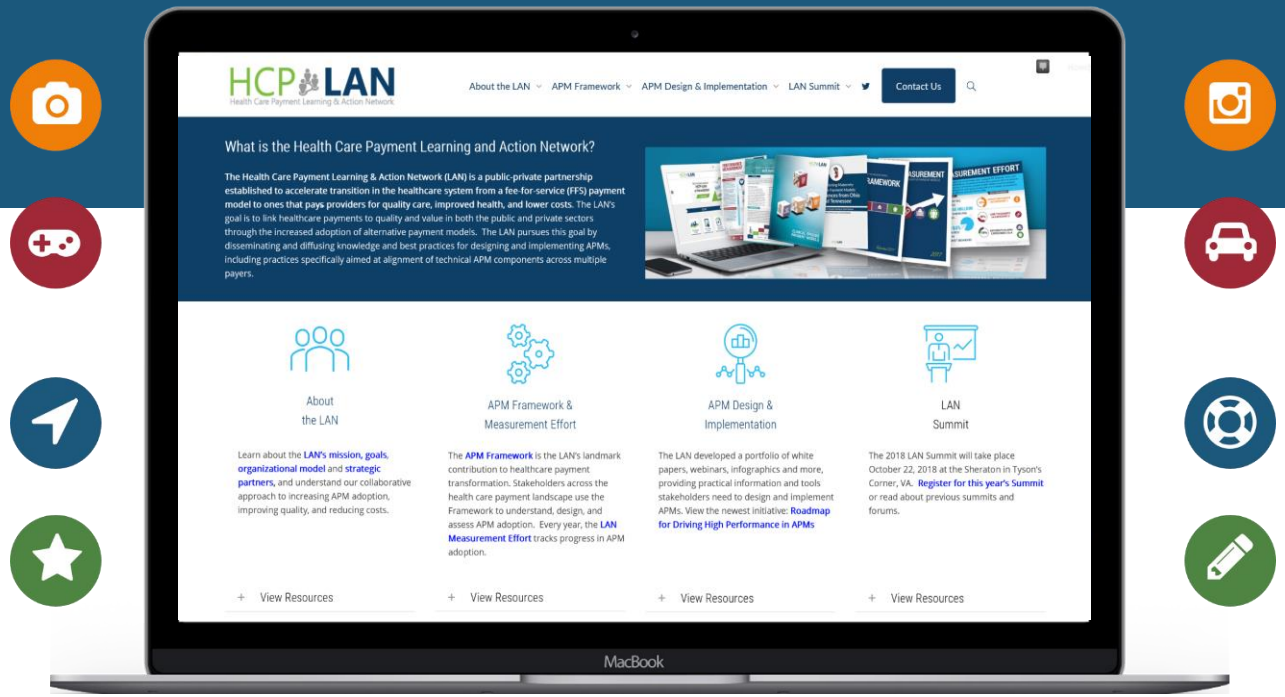
Up to 8 cooperative agreement awards anticipated Summer 2019

Goals:

1. **Improving performance on priority measures of child health**
2. **Reducing avoidable inpatient stays and out-of-home placements**
3. **Creation of sustainable Alternative Payment Models (APMs)**

Visit the LAN Website for our Resources

https://hcp-lan.org/



Exit Survey

We want to know what you think!

Please take a moment to complete the exit survey so we can continue to improve and enrich the LAN. Use the link in ***Guidebook*** for this session to provide us your feedback.

Contact Us

We want to hear from you!

www.hcp-lan.org

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PaymentNetwork@mitre.org

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Thank You!