

Toby Douglas, Senior Vice President, Medicaid Solutions, Centene Corporation
Testimony on Combatting the Opioid Crisis

Good morning. My name is Toby Douglas and I am the Senior Vice President for Medicaid Solutions at Centene Corporation. Centene is the largest Medicaid Managed Care plan in the country serving 7.1 million Medicaid members in 25 states. I am also a Commissioner on the Medicaid and CHIP Payment and Access Commission known as MACPAC, and a board member on the Medicaid Health Plans of America (MHPA) Association. Previously, I was a long standing Medicaid Director and behavioral health official in California serving as the Director of the California Department of Health Care Services. My testimony today is based on my experience in all these positions as well as my interactions with colleagues in these various states and MCOs who are all working together to combat this epidemic.

Centene, other Medicaid MCOs, and states are taking a comprehensive approach of prevention, treatment and recovery, working with members and providers to:

- Prevent addiction from occurring by curbing excessive prescribing patterns,
- Prevent overdose, and
- Facilitate treatment and recovery in chronic opioid users.

In order to address and end the crisis, Congress must enact policies that further state and Medicaid Managed Care Organizations' (MCOs) ability to take a comprehensive approach to prevention and treatment. Congress should invest in initiatives that advance the following:

- The adoption of best practices in ensuring appropriate prescribing and utilization patterns and increased member and provider education

- The development of continuum of treatment modalities including the use of Medicaid Assisted Treatment and ASAM criteria.
- The elimination of the Medicaid payment restriction on residential treatment (IMDs) for substance use in order to ensure there is a full continuum of treatment modalities.
- State adoption of Prescription Drug Monitoring Programs (PDMP) and the use of strategies to ensure all appropriate entities, including Medicaid agencies, health systems, managed care entities, and providers, have efficient access to PDMP data.
- The reform of 42 CFR Part 2 to align SUD privacy protections with HIPAA, while maintaining appropriate protections for patient SUD information, in order to advance physical and behavioral health integrated care approaches.
- Investment in Medicaid state officials and MCOs that can effectively implement the continuum of approaches to addressing this epidemic and future public health epidemics.

Background

The opioid epidemic disproportionately affects Medicaid beneficiaries. For example:

- Medicaid beneficiaries age 18–64 have a higher rate of opioid use disorder than privately insured individuals, comprising about 12 percent of all civilian, non-institutionalized adults in this age group but about one-quarter of those with an opioid use disorder. Opioid addiction is estimated to be 10 times as high in Medicaid as in commercial populations.

- Medicaid beneficiaries are prescribed pain relievers at higher rates than those with other sources of insurance. Medicaid beneficiaries are prescribed opioids at twice as often as individuals with private health insurance
- They also have a higher risk of overdose and other negative outcomes, from both prescription opioids and illegal opioids such as heroin and illicitly manufactured fentanyl. For example they have higher rates of hospitalization and emergency department use for drug poisoning and six times the risk of overdose death.
- But, it is the case, that Medicaid beneficiaries with an opioid use disorder have higher treatment rates than privately insured adults with the same condition.

State Medicaid programs and Medicaid MCOs are responding to the opioid crisis by preventing addiction from occurring, curbing excessive prescribing patterns, and facilitating treatment and recovery of chronic opioid users.

Preventing Addiction from Occurring by Curbing Excessive Prescribing Practices

The first area I would like to address is the focus on curbing excessive prescribing practices of opioids to reduce overuse and overdose.

- States and MCOs are taking several actions related to improved formulary management: MCOs and states are removing medications from the formulary that could have a greater potential for misuse. They are limiting early refills and prescription quantities and duration. Finally, some plans, including Centene, and states are using prescription data to lock in high-risk individuals to one prescriber for all opioids and/or one pharmacy to fill opioid prescriptions.

- At Centene, we are implementing clinical policies to help prevent opioid dependency from ever occurring
 - limit supplies to seven days for certain types of patients (limit is less than seven days when desired by states)
 - limit daily dosage based upon strength of the opioid
 - require use of immediate-release formulations before extended-release opioids are dispensed. Exceptions to this approach exist as dictated by state specific mandates.
 - exceptions for special populations such as oncology, sickle cell, and palliative care
- MCOs and states are also focusing on provider education. For example, one California plan initiated a campaign to educate providers about the risks of high dose prescribing and authorization review requirements. State and MCOs have also offered trainings on evidence based practice guideless, pain management toolkits, practice design tools.
- At Centene, we offer complementary CME detailing best practices in opioid prescribing, addiction treatment and chronic pain management. We have also implemented prescriber profiling as a way of educating providers. This includes prescriber comparisons to their peers, highlighting opioid utilization and dosing profiles, and dangerous drug combinations such as opioid + benzodiazepine.
- States are also including Opioid safety as part of their delivery system reform 1115 waivers. Providers, in many states, are participating in projects that aim to

increase evidence based strategies for the treatment of chronic pain, and include increasing multi-modal therapies as the standard of care.

- A new approach that states and MCOs are taking is using Project ECHO, (Extension for Community Healthcare Outcomes), a tele-mentoring approach, to train evidence based models of pain management. This offers remote and / or face-to-face training and technical assistance to increase prescriber skills. In California, the ECHO is being used as a collaborative model for serving underserved American Indian population in order to:
 - Link front-line clinicians to resources and supports to help them to improve care quality and accessibility.
 - Improve Medication Assisted Treatment access for Tribal and Urban Indian communities
- One of the most useful tools available for monitoring prescribing rates across providers and improving appropriate rates is a state's Prescription Drug Monitoring Program (PDMP). Best practices in this areas include:
 - Strategies to ensure all appropriate entities, including Medicaid, health systems, managed care entities, and providers, have access to PDMP data. This could include practices for sharing proactive PDMP reports to these entities, rather than awaiting specific queries or data requests.
 - Common data elements and user-friendly methods for accessing PDMP data.

- Strategies to ensure all prescribing providers submit timely data to the PDMP. This should address steps states can take to integrate PDMPs into electronic health records (EHR)
- While the PDMP is a terrific resource, it can be a negative time sink for providers. Centene health plans have started supporting our providers by offering, at no cost, front end tools which drastically improve the usability and efficacy of the PDMP sites.
- Another approach that MCO and states are taking to address prescribing patterns is through value based payment models. Specific strategies include enhanced payments for:
 - Appropriate post-surgical or post-emergency department discharge prescribing of opioids and/or opioid addiction treatments; adoption of opioid review committees; use of registries to track chronic pain patients; and physicians attending opioid education trainings.

Through our efforts, Centene has seen a reduction in inappropriate utilization. Since 2015, by all measures, we have seen improvement in our utilization trends, consistent with our stated goals. Results 2015 to 2017 include:

- reduced total # of members using opioids by 50% over 3 years
- # Members utilizing Opioids for >30 days decreased 14-30% year on year
- Total # opioid utilizers decreased 10-15% year on year
- Total # Opioid Prescriptions decreased 15-20% year on year

Member Treatment and Outcomes

The second area I want to address is states and MCOs' focus on expanding access to treatment for Medicaid beneficiaries in order to improve outcomes.

As context, there are general shortages of providers providing substance use treatment services and even greater shortages of Medicaid participating providers. MACPAC found the following:

- In 2016, 62 percent of specialty SUD facilities report that they accept Medicaid.
- SUD provider participation varies greatly by state; provider participation in Medicaid ranges from 29 percent in California, to 91 percent in Vermont.
- About 60 percent of U.S. counties have at least one outpatient SUD facility that accepts Medicaid, although this rate is lower in many Southern and Midwestern states.
- Counties with a higher percentage of black, rural, or uninsured residents are less likely to have one of these facilities.

Medication Assisted Treatment (MAT).

- There continues to be a shortage of MAT providers. That being the case, several states and MCOs are also working to expand the availability of MATs-- Medication-Assisted Treatment (MAT) recognizing the significant shortages. MAT, as defined by SAMHSA, is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. These approaches apply the value of integrating MAT into the primary care setting to expand access and leveraging

centers of excellence that can provide expertise and support to providers and patients.

- States, through waivers, and MCOs are training providers and expanding the continuum of MAT. For example in California and Vermont, the states are implementing MAT Expansion Projects. The projects strategically focus on populations with limited MAT access, including rural areas and American Indian and Native Alaskan communities, and increasing statewide access to buprenorphine. The states are implementing a hub and spoke model. The Regional Hubs offer daily support for patients with complex addictions. At the spokes, doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general healthcare and wellness services. This framework efficiently deploys opioid use disorder expertise and helps expand access to opioid use disorder treatment to the entire state. These innovative models in CA and VT are spreading to other states via MCOs and state policies
- Several states have also implemented Medication Units to increase access in rural areas to MAT. This includes, AZ, CA, IA, and KS. These states are finding great success as a Medication unit increases access, offers MAT in the community, and cuts down on patients' traveling.

ASAM criteria

- Another important component of the continuum of treatment solutions is ASAM including the many components of medication-assisted treatment (MAT). MACPAC has found that there is considerable variation in available ASAM services across states, since many are optional under the Medicaid statute.

- On average, state Medicaid programs cover six of the nine services described by ASAM.
- Nearly half of states provide anywhere from four to seven services.
- Seven states only cover up to three services.
- Only 10 states offer the full continuum of care.
- Congress should enact policies that further state and MCO adoption of the continuum of ASAM treatment services

IMDs

- One of the ASAM treatment policies that Congress must address relates to residential treatment and the IMD exclusion. Many states and MCOs point to the IMD exclusion as a barrier to treatment. And the 15-day limit for managed care IMD in lieu of services has been operationally challenging. While 21 states have sought Section 1115 waivers to provide residential SUD treatment in IMDs, the waiver process is cumbersome and not the long run solution. Congress should act to eliminate the exclusion of Medicaid payment for beneficiaries residing in a residential treatment setting.
- And, based on discussions with key experts, the elimination of the IMD exclusion should be tied to evidence regarding whether individuals with substance use disorders experience greater treatment gains in residential treatment settings than in outpatient treatment, or if specific lengths of stay are associated with certain therapeutic gains. As such, it is important to emphasize that the elimination of the IMD rule must be part of a comprehensive solution that

encourages states and MCOs to provide a continuum of ASAM treatment modalities.

Primary care and behavioral health integration.

- MCO and states are taking approaches to develop team based physical and behavioral health approaches to address treatment. For example, Centene is using analytic tools, coupled with team based, behavioral health treatment capabilities, to identify and treat members with hidden, previously untreated, impactable behavioral health disorders (anxiety, depression, trauma) which are often the root cause of polysubstance use/abuse

Reform of 42 CFR Part 2

- Promoting effective and timely sharing of data across physical health and SUD care teams requires statutory changes or reform of 42 CFR Part 2. Part 2 statute and SAMHSA regulations create more stringent privacy protections for patient SUD data than for other sensitive health data protected by modern HIPAA rules.
- The lack of alignment between Part 2 and HIPAA creates challenges across the healthcare system, from state Medicaid agencies to managed care plans and down to individual provider practices. Congress should prioritize reform of 42 CFR Part 2 to align SUD privacy protections with HIPAA, while maintaining appropriate protections for patient SUD information – namely prohibiting such information from being used to initiate or substantiate criminal, civil, or administrative proceedings.

- In doing so, individuals with SUD can realize the benefits of integrated care approaches without fear of adverse impacts on their families and livelihoods for seeking treatment.

I leave you with one final point. States continue to face considerable staff turnover in their Medicaid agencies. In order to ensure that states have the right leadership to address the epidemic and invest the appropriate resources in MCOs to execute policies on behalf of the states, Congress should implement policies that support state recruitment and retention of strong Medicaid executive leadership. A stable and strong state leadership team will be best equipped to respond to the opioid crisis and future public health crises.