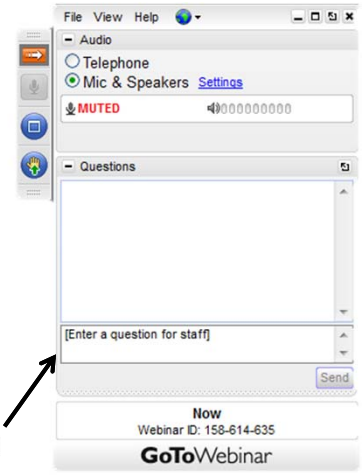
Integrating Evidence-Based Guidelines for the Use of MAT into Managed Care Policies and Procedures

November 30, 2016

AMCP Academy of Managed Care Pharmacy®

How to Ask A Question



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Integrating Evidence-Based Guidelines for the Use of MAT into Managed Care Policies and Procedures

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California Markets
Nov 2016

Disclosures

Dr. Ghani is a full-time employee of Magellan Health Services

Dr. Ghani is on no pharmaceutical company advisory boards or speakers bureaus

Dr. Ghani has no grant or research support other than from Magellan Health Services as an employee

He has no financial interest in pharmaceutical companies or research grants

Dr. Ghani serves on the Magellan pharmacy and therapeutics committees for California Health plans as a part of his role with Magellan Health Services

Learning Objectives

At the conclusion of this exercise, the participants will be able to:

- List five medications used to assist in the treatment of substance use disorders (SUD)
- Demonstrate the effective use of Naltrexone in alcohol and opiate use disorders
- Discuss the use of acamprosate in alcohol use disorders
- Discuss the use of buprenorphone in the treatment of opiate use disorders
- Understand barriers to the wide spread use of MAT
- Explain the role of medication-assisted treatment in the continuum of care for patients with SUD

Literature reference: showing the prevalence of substance use in readmissions by percentage and cost

Secondary data analysis of claims for 20,752 patients found use of a Food and Drug Administration (FDA) approved medication (Naltrexone XL) for alcohol dependence is associated with reduced readmissions and cost. (Baser, 2011)

Secondary analysis of claims data for 11,515 individuals with Alcohol Use Disorder (AUD) found those on Naltrexone XL (n=211) had lower nonpharmacy costs and utilization of acute services compared to acamprosate, disulfiram, oral natrexone and psychosocial treatment. (Bryson, 2011)

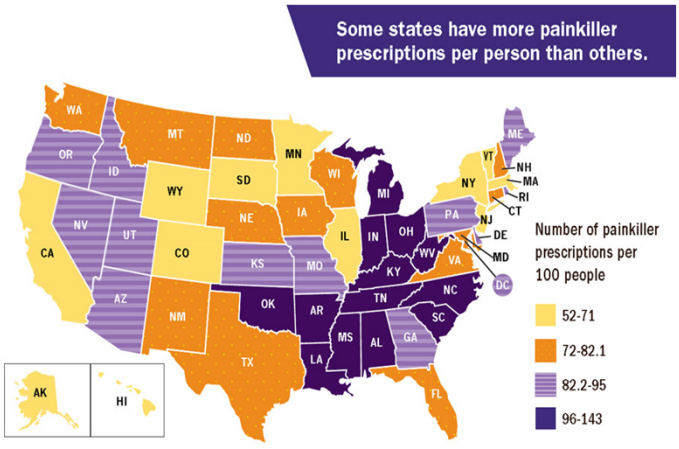
Would you believe that 20% of the US population — more people that live in all of California — are suffering from one of America's biggest health crisis?

17.6 million Americans	• Suffer from alcohol abuse[1]
24.6 million Americans	• Have used an illegal drug within the past 30 days[2]
48 million Americans	• Have used prescription drugs for non-medical reasons[3]

[1] (2016) https://ncadd.org/for-the-media/alcohol-a-drug-information
[2] ibid
[3] (2005) http://archives.drugabuse.gov/PrescripAlert/

Increased Use of Opioid Medications

- These medications are being sold legally and illegally in record quantities. [4]
- Health care providers in different parts of the country don't agree on when to prescribe opioid painkillers and how much to prescribe.
- Many states report problems with for-profit, high-volume pain clinics (so-called "pill mills") that prescribe large quantities of painkillers to people who don't need them medically.

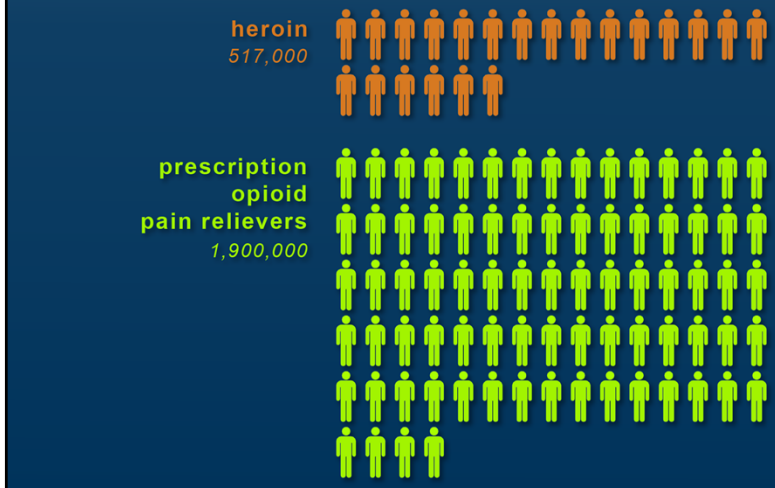


SOURCE: IMS, National Prescription Audit (NPA™), 2012.

[4] (2015) http://www.cdc.gov/drugoverdose/epidemic/index.html
[5] (2012) http://www.cdc.gov/drugoverdose/data/prescribing.html

Heroin vs. Prescription Opioids

Drug dependence or abuse in the past year 2013*



* Note that the terms dependence and abuse as used in the NSDUH are based on the diagnostic categories used in DSM-IV; in the DSM-V, those categories have been replaced by a single Substance Use Disorder spectrum.

Source: National Survey on Drug Use and Health (NSDUH)

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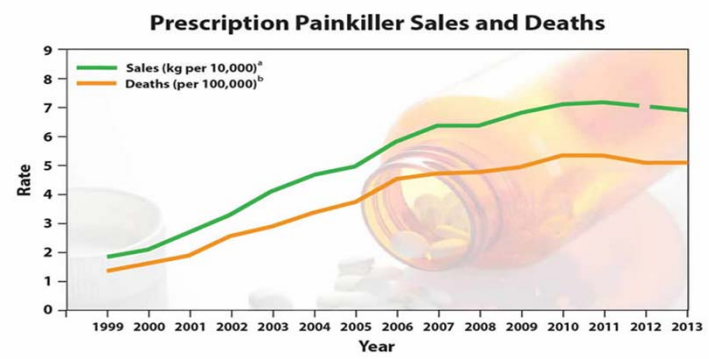
Unintentional Overdose with Prescription Opiates

Deaths from prescription painkillers have **quadrupled** since 1999, killing more than **16,000** people in the U.S. in 2013.[6] **Nearly two million** Americans, aged 12 or older, either abused or were dependent on opioids in 2013.[7]



[6] (2015) CDC. National Vital Statistics System mortality data. http://www.cdc.gov/nchs/deaths.htm

[7] (2013) SAMHSA, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: SAMHSA

Traditional SUD Treatment Approaches

Treatment—abstinence is the goal

- Detoxification (safe management of withdrawal syndrome)
- Rehabilitation
  - *Counseling—group, individual & family*
  - *12-step group support*

Provider community attitudes about medications…negative

- "Substances are the *problem* not the solution"

SUDs tend to be chronic, difficult to treat and relapsing

- Opioid treatment drop-out rates are high

Substance Use Disorders (SUD): The Problem

National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA)* in 2010 found:

16.9 million Americans over the age of 12 **reported heavy drinking** (defined as five or more drinks on the same occasion on at least five different days in the past 30 days)

140,000 **new heroin users**

58.6 million Americans **participated in binge drinking**

1.2 million Americans **used hallucinogens** for the first time within the past 12 months

http://www.samhsa.gov/

Substance Use Disorders (SUD): The Problem

Members with co-occurring disorders (substance abuse and psychiatric conditions) are very high-risk and costly.

Claims analysis for 2009

Initial use of pain relievers for non-medical purposes is now second to marijuana use with 2 million more users every year since 2002.

http://www.samhsa.gov/

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FDA-Approved Medications for Substance Abuse Treatment and Tobacco Cessation

Medications for Alcohol Dependence	Naltrexone (ReVia®, Vivitrol®, Depade®) Disulfiram (Antabuse®) Acamprosate Calcium (Campral®)
Medications for Opioid Dependence	Methadone Buprenorphine (Suboxone®, Subutex®, and Zubsolv®) Naltrexone (ReVia®, Vivitrol®, Depade®)
Medications for Smoking Cessation	Varenicline(Chantix®) Bupropion (Zyban® and Wellbutrin®) Nicotine Replacement Therapy (NRT)

(SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS, 2014)

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SUD – Opiates

Drug Class	Drug	Starting Dose	Usual Titration /Withdrawal	Usual Therapeutic Range	Max Dose
Partial Opioid Agonist	**Subutex** (Buprenorphine)	Induction: 8mg on day 1; 16mg on day 2; Target dose = 16mg daily (range 4-24mg daily); Give first dose at least 4 hrs after last use of opioids			24mg daily
	Suboxone (Buprenorphine/ naloxone)		Maintenance: Titrate to individual response; adjust in increments/decrements of 2-4mg daily	4-24mg daily	24mg daily

SUD – Alcohol / Opiates

Drug Class	Drug	Starting Dose	Usual Titration/Withdrawal	Usual Therapeutic Range	Max Dose
Opioid Antagonist	**Revia** (naltrexone)	Must be opioid-free 7-10 days Consider naltrexone challenge if not sure- 25mg po x1, repeat in 1 hour if no withdrawal symptoms	Maintenance: 50 mg per day, higher doses have been reported, side effects must be monitored	Maintenance: 50-150mg daily	150mg per day
Opioid Antagonist	**Vivitrol** (naltrexone extended release injection)		380 mg delivered intramuscularly every 4 weeks or once a month.		380mg IM every 4 weeks

SUD – Alcohol

Drug Class	Drug	Starting Dose	Usual Titration /Withdrawal	Usual Therapeutic Range	Max Dose
	Campral (acamprosate)	After withdrawal, begin 666mg 3x/day, lower if renal impairment	Same as starting dose	333 Tid to 666mg Tid	666mg Tid
	Antabuse (disulfiram)	Patient alcohol-free for 12 hrs or more Begin 500mg per day if tolerated	500mg per day	500mg per day	500mg per day alcohol-Antabuse reaction

Increasing Recognition of the Role of Medications in Treatment of SUD

AMA Physician Consortium for Performance Improvement

NCQA performance measures

- Psychosocial interventions
- Pharmacologic interventions

ASAM Guideline

Surgeon General's Report on Addiction

Medications mandated in VA since 2008

Magellan's OBOT initiative

Medications highly underutilized

With demonstrated efficacy - how to encourage use?

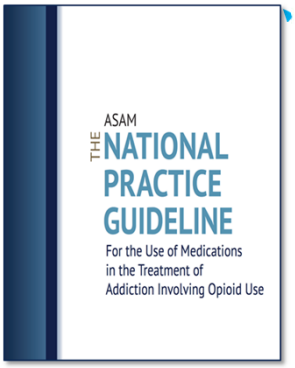
Barriers to Utilization of These Medications

- Lack of education of clinicians
- Philosophical objections
- Perceived ineffectiveness
- Medications will reduce motivation for psychosocial treatment
- Side effects
- Cost
- Network issues
- Lack of time in patient management
- Reluctance to take medications
- Formulary status in health plan
- Lower level of education in SUD facility staff
- Managed care internal barriers

Harris AHS, Kivlahan DR, Bowe T, Humphreys KN. Pharmacotherapy of Alcohol Use Disorders in the Veterans Health Administration. *Psychiatric Services*. April 2010. 61:4: 392-398

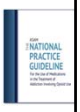
ASAM Guideline Premise

- **FDA-approved medications to treat OUD are clinical & cost-effective interventions**
  - Saves lives, saves money
  - One component, along with psychosocial treatment
- **30% of treatment programs offer medication**
- **Less than half of eligible treatment program patients receive medications**
- **Missed opportunity to utilize most effective treatments**



Opioid Withdrawal Management

- Medications for withdrawal preferred to abrupt cessation
- Advise patients medications alone for opioid withdrawal not a complete treatment method
- Medical history & physical exam focus on withdrawal signs & symptoms
- Methadone withdrawal symptom management in OTP or inpatient setting



www.asam.org/quality-practice/guidelines-and-consensus-documents/npg

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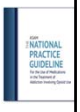
Psychosocial in Conjunction with Medications

Recommended with any pharmacological treatment – at a minimum should include:

- Psychosocial needs assessment
- Supportive counseling
- Links to existing family support
- Referrals to community services



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Psychosocial in Conjunction with Medications (cont'd)

- Collaboration with behavioral provider
- Psychosocial treatment generally recommended for patients receiving opioid agonist treatment
- Offered with oral and extended-release injectable naltrexone

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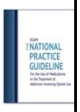

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The MAT promotion Challenge

Can a large health care system with over 8000 physicians in network encourage the use of MAT?

Magellan MAT Initiative (continued)

Established research and other educational material postings on our provider website

Numerous provider and member communications through webinars, newsletters, emails and website postings

Included MAT as part of our customer presentations

Included MAT expectations in our provider handbook and Medical Necessity Criteria

Diagnoses Included in the Study

291.0	**Alcohol withdrawal**
291.8, 291.81	**Alcohol withdrawal**
303.00	**Alcohol intoxication**
303.90	**Alcohol dependence**
304.00	**Opioid dependence**
305.00	**Alcohol abuse**
305.50	**Opioid abuse**

Opportunities for improvement for Magellan

Enhancements to systems and reports are in development

- Will distinguish between changes in prescribing vs. changes in processes used to track prescribing
- Will provide information by specific SUDs and medications

Future outcomes analytics to use advanced statistical methods

- Multivariable modeling to obtain adjusted results
- Propensity score matching for comparison group(s)
- Will allow analysis of readmissions & other utilization metrics

Improved assessment opportunities when claims data are available

- May better reflect use vs. prescribing as compared to authorizations
- Can measure continued use via refill data

Co-Occurring Disorder Awareness

Many consumers with SMI have SUD as well

Many SUD consumers have SMI

Medications for these can interact

Suboxone + antipsychotics

Suboxone + antidepressants

Suboxone + benzodiazepines

Naltrexone + antipsychotics

Imperative that clinicians communicate regarding medications!

Exchange of critical information facilitated by EHR

Barriers (providers)

I'm concerned about lab testing, coordinating multiple providers, and other logistical issues.

I'm concerned about DEA intrusion into my practice.

I'm concerned that I'll need to be available 24/7 for my patients in OBOT.

I'm concerned that I will attract more drug users than I can comfortably manage in my practice if I start prescribing buprenorphine more regularly.

I want immediate telephone or Internet access to consult with an addiction/OBOT expert.

I am never really clear which treatment codes to use to ensure adequate and timely reimbursement for OBOT.

I don't know which resources are appropriate for referring my patients who need counseling, social support, or family therapy.

I don't have the ability to send difficult patients to a substance abuse treatment program.

I'm concerned that the presence of patients with opioid dependence in my office could possibly cause disruption of my other patients.

I'm concerned that patients might sell buprenorphine on the street or take more than the prescribed amount.

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Office-Based Opioid Treatment (OBOT)

- ✓ **Suboxone must begin post-detox**
- ✓ **Induction can take several days**
- ✓ **Detox with Suboxone can take 2-12 weeks on outpatient basis**
- ✓ **Overseen by network physician with buprenorphine waiver from DEA**
- ✓ **Patient must be engaged in psychosocial treatments as well**
- ✓ **Patient progress monitored**
- ✓ **Barrier is lack of sufficient buprenorphine prescribers**

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The Case of Max

- 43 year-old pipe fitter, developed severe disc disease
- Multiple surgeries, pain continues, started on prescription opiates
- Escalated dosage to control pain, started methadone as an attempt to detox from opiates
- Had sedation, confusion with methadone
- Unsuccessful in detox attempts, Suboxone suggested
- Began induction with Suboxone, began 2mg per day
- Had mild withdrawal symptoms, saw M.D. daily
- Increased to 16mg per day
- Entered university-based pain management program
- Tapered Suboxone over $_{6}$-month period
- Remained relapse free

The Case of Jennifer

- 28 year-old female, mother of 2 year-old twins
- Began drinking wine in post-partum period
- Increased to two bottles per day
- Underwent detox after developing daily tremors
- Still had cravings for alcoholic beverages
- Began naltrexone 50mg bid
- Had problems with non-compliance
- Began Vivitrol®, one injection per month
- Cravings for alcohol abated, drinking much reduced after six months to an occasional glass of wine with dinner

The 5 Tenets of Medication-Assisted Treatment Program

Increase Recognition of the Role of Medications in Treatment of SUD

Addressing the following barriers:

- Lack of education of clinicians
- Perceived ineffectiveness
- Reducing the stigma of substance abuse and the medications
- Side effects
- Cost
- Lack of availability of MAT providers in the community
- Formulary status in health plan
- Lower level of education in SUD facility staff

Ensure Provider Network Sufficiency

- Expand the network of MAT prescribers by actively promoting and campaigning to healthcare providers
- Actively partner with healthcare providers to increase provider comfort and knowledge of the proven effectiveness of MAT
- Intervene early in the treatment process and work closely with both providers and patients

Free materials: OBOT Resource Toolkit, *Appendix B* (Ciaverelli, 2008)

Improve Care Coordination Activities to support continued MAT treatment across all levels of care

- ❑ **Referrals to Disease Management Program** (*High Risk*)
  - Care Manager outreaches the member to discuss continued MAT Rx, confirm appointments, connects to SA counseling and/or community resources. Identifies additional barriers.
- ❑ **Transitions of Care for all members discharged with MAT** (*all Risk levels*)
  - Member assigned when discharged with MAT medication. The Magellan Navigator will assist the member with linkage to a prescriber, substance use disorder counseling, and peer-to-peer supports.

Magellan MAT initiative

Expand network of MAT prescribers by actively promoting and campaigning to healthcare providers

- Provider and member communications through webinars, newsletters, emails and web
- Include MAT expectations in provider handbook and Medical Necessity Criteria
- Share research and other educational material postings with providers

Intervene early in the treatment process and work closely with both providers and patients

Initiate procedures to improve care coordination activities in support of transition of care

- Capture use of MAT medications in all systems
- Create internal benchmarks for use of MAT and medication guideline for staff
- Train clinical and medical staff for peer to peer discussions to increase use of MAT
- Develop outcome measures (increase in use of MAT medications and re-admission data)

National quality improvement study for NCQA

MAT interventions

Care manager responses to the program assessments are evaluated to determine the member's' engagement categories. When an assessment is administered, a positive response for question #1 prompts a response to questions #1 and #4. A positive response to question #2 prompts a response to question #3. The assessment questions and associated engagement categories listed below.

Assessment Question	Engagement Category
1. Care manager discusses medication assisted treatment (MAT)?	Promotion
2. Has the member been prescribed MAT medication?*	Prescription
3. Does the Member have a scheduled appointment with a MAT prescriber?	Appointment
4. Has the Member been referred for continuing counseling/peer support treatment?	Support

Performance Measurement

Reports for the MAT program monitor the effectiveness of the program both internally and externally. The reports consist of aggregate measures based on completed assessments for substance use admissions with a concurrent review or discharge

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Use of MAT still needs improvement

During the first quarter of 2016, our care managers reached out to almost 13,000 members and their care providers nationally to encourage the use of MAT.

Of these, 8,343 had an opiate use disorder, or opiate use disorder combined with other drugs or alcohol, or were also diagnosed with a mental health condition.

Only 1,154 or 13.8 percent received prescriptions for MAT medications at discharge.

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Care Coordination Activities: Risk Stratification

High (Intensive Care Coordination)	Moderate (Community Connection)
Duration: 4 – 6 months	**Duration: 3 to 12 weeks**
Commercial criteria: 1. >3 IP admissions 2. 18-26yo with 1 IP/RTC SA admission 3. Pregnant women who abuse substances 4. Referral by Care Mgr	Commercial criteria: 1. >27yo primary & secondary Dx of abuse or dependence 2. >18yo primary Anxiety or Depression & secondary Dx of abuse 3. Referral by Care Mgr
Public Sector criteria: 1. 18-26yo Dx SA with 2 IP/RES admissions w/in 60-days 2. Pregnant women who abuse substances 3. Referral by Care Mgr	Public Sector criteria: 1. >18yo primary & secondary Dx of abuse or dependence 2. >18yo primary Anxiety or Depression & secondary Dx of abuse 3. Referral by Care Mgr

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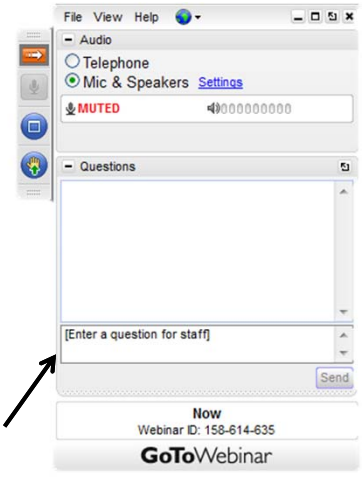

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