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| **Provider Education**  **Value Statement 1** |  | Direct mail to providers |
|  |  | Email to providers |
|  |  | Videos with CME credit for providers |
|  |  | Anti-fraud education (for pharmacists) |
|  |  | Provider coaching |
|  |  | Data-driven provider outreach (patient risk info, comparison data) |
|  |  | Education on drug storage and disposal |
|  |  | Pay for performance (for following guidelines or quality practices, not for not prescribing opiates)  Education about turn the tide initiative and encouraging participation  Instructions about step therapy  Evidence based guidelines for acute pain (advocating for the development of guidelines)  Education about how to taper opioid use  Live CME for providers with coaching  Academic detailing to counteract new drug advertisement  Make education mandatory  Engaging medical schools and medical boards  Disseminate information about drugs, costs, and guidelines at point of prescribing (turning guidelines into clinical decision making tool).  Future Study: Testing communication strategies to see what works best. |
|  |  | Education for home health nurses/agencies/hospice. |
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| **Patient Education** |  | Data driven patient outreach and education (reaching out to high risk patients) |
|  |  | Nurse case management |
|  |  | Media outreach/popular press (see Consumer Reports examples) |
|  |  | Public outreach coordinated with Health Department  1 on 1 consultation with a pharmacist  Factoring education into patients’ lock-in experience  Giving patients information about what questions to ask when speaking with a doctor (see Consumer Reports examples)  Develop strategies tailored to particular demographics  Building a tool/app/web-based tool for entering data and sharing information. Identifying high-risk situations.  Following up on denied claims so that pharmacist can educate patients about the reasons behind the denial (point of sale rejection edit).  Coordination of care for prescribing  Educating caregivers (informal caregivers, but first consider privacy implications)  Anonymous help line for patients and families to ask for help  Questions about effectiveness of certain mass-communication strategies  Develop materials in a wide range of languages.  Using social media and digital advertising tools  Put a face to the problem/social normalizing  Roundtable discussions with particular groups of members to understand how to communicate more effectively. Gather information about patient opinions/experiences.  Better explain expectations for non-opioid pain treatments (see previous examples, mindfulness training).  Future Studies: Look at effectiveness of communication strategies. |
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| **Non-opioid/Non-pharma treatment** |  | Improved access to mental health substance abuse services  EAP (standalone or integrated). Consider incentives. |
|  |  | Prioritization of evidenced-based treatment options |
|  |  | Lower cost for non-opioid alternative prescriptions  Identify gaps in research/evidence on non-opioid/non-pharma treatments so that extending coverage can be better considered.  Better assess the appropriate level of evidence needed for a strategy.  Understand best practices for alternatives or benefit design.  Information sharing about alternatives and benefit design.  Mindfulness/meditation  Cognitive behavioral therapy for pain  HSA plans present barriers to coverage. Rules change needed to create a value based benefit design and create incentives.  Monetary and time cost of some alternatives present a challenge.  Understand the difference between people’s desires and the actions they are willing to take. |
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| **Treatment including MAT** |  | Coverage of methadone and buprenorphine |
|  |  | Coverage of inpatient and outpatient drug Tx |
|  |  | Case management/intensive Tx for severe addiction |
|  |  | Support community-based Tx over inpatient rehab |
|  |  | Defining/preferring high quality Tx (e.g. centers of excellence and their practices, understanding minimum standards) |
|  |  | Orally administered Naltrexone as a component of Tx |
|  |  | Injectable Naltrexone/Vivitrol (examine co-requirements for reimbursement)  Better understand new and emerging treatments and develop guidelines. |
|  |  | Urine testing integrated with treatment or sober living |
|  |  | Verification/accreditation of sober living facilities  SBIRT- Screening, Brief Intervention, and Referral to Treatment  Research best practices in sober home living cities and clarify the standards.  Residential or custodial care, not medical, so coverage likely not appropriate.  Sober homes facilities create risks. Some evidence that it encourages drug use (heroin and others).  Reassess reimbursement of urine tests (those associated with being allowed to stay in a sober home). |
|  |  | Supporting innovative but untested MAT/Tx designs  More access to MAT.  Reduce barriers to suboxone or burden on suboxone providers. Increase the number of suboxone prescribers.  Allowing pharmacists to prescribe MAT.  Unlikely that restrictions on MAT will be reduced in the near term given particular challenges.  Future Study: Review sober home landscape and develop best practices. |
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| **Access to Naloxone** |  | Support and participate in community efforts/drug task forces related to Naloxone |
|  |  | Cover Naloxone when prescribed |
|  |  | Develop internal program (details undefined) |
|  |  | Support generic not auto-injector |
|  |  | Support expanded use for high risk patients |
|  |  | Do not mandate for universal naloxone with every Rx  Allow members to call 800 number to request Naloxone. Advertise the service in member materials.  Investigate making Naloxone OTC (weigh positives with risks of having it readily available). Some states have done this. CVS as well.  Identify groups that should have access (school nurses, public venues (outdoor concerts, restaurants), EMTs, universities/campus life/Greek life,  Assisting with expense of Naloxone for certain groups (e.g. law enforcement).  Future Study Topic: investigate routine prescription of Naloxone  Investigation: Understand if literature supports expanding use of Naloxone and whether it impacts abuse levels. |
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| **Other** |  | Eliminate or restrict opioid prescribing for acute conditions |
|  |  | Remove pain management rating from quality assessments  Increasing drug take back programs |
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| **Formularies** |  | Step therapy and dosage control with prior authorization for tx > 120 MED |
|  |  | Flag and limit cross-prescribing (opioids + benzos/hypnotics) |
|  |  | Preference drugs with lower abuse potential |
|  |  | Higher copay for opioid prescriptions |

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| **Formulary** |  | **Value Statement 2**  Limit quantity by procedure and/or diagnosis. There are barriers to this idea because prescribing data is limited (diagnosis information is optional in part D).  Limit brand name drug in the formularies. Everything is generic. Lessens the street value of the drugs.  Limiting the time period for refills.  Morphine equiv. dose level lower than 120. |
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|  |  | Future study: Address challenge raised in limiting quantity by procedure/dx  Require step therapy that shows documented pain therapies and non-opioid treatments.  Reimbursing limited number of pills  Ensure that dispensing pharmacies cannot override rejected claims without a doctor’s exception.  Limiting prescriber privileges (e.g. dentists cannot issue long term prescriptions).  Understand the implications of being more restrictive (e.g. patients leaving the plan, patient becomes angry and argues with plan)  Understand the impact of compounding pharmacies. These pharmacies take approve drugs and compound them. Limited FDA regulation. Provide a significant amount of opioids. Plans will reimburse them. Spike a few years ago; compound pharmacies popped up. Plans reacted with exclusions, limits. Compounding pharmacies reacted by categorizing under an active ingredient. Example: Lidocane. Creams. Not seeing overdoses as much as excessive charges and unclear levels of active ingredients. These operations are large and also produce opioid tablets. Example: New England Compounding. Barrier to prescribing non-opioid pain relief. Charging large amounts for what is essentially an OTC equivalent product. Non-opioid pain management product that’s being sold for high costs.  Prior authorization |
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| **Improve Data Sharing and use of PDMP** |  | Increase access to PDMP information for providers and pharmacists  Centralized PDMP analysis to identify problem providers  Encourage participation |
|  |  | Drug utilization review and provider/pharmacist notification |
|  |  | Call for the ability of state monitoring programs to communicate with each other so that physicians/pharmacists are required to review data. Data should be real time. PDMPS should be funded. Get states and PDMPS involved. |
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|  |  | Require DUR for benzos and hypnotics |
|  |  | Require plan reporting to CMS of number of instances of potential fraud, waste, and abuse identified (authorized by CARA) |
|  |  | Track movements of known users/abusers/others |
|  |  | ID instances of prescription discordance with medical indications  Plans would like access to PDMP information. Some states allow limited access but it presents challenges.  Evidence: is mixed, and weak on reducing the amount of opioids prescribed. But it helps identify high-users. Jump to the next level of curbing overdose is difficult. Challenges are lack of real time data and lack of use. Quality of the data is likely mixed.  Question: Is limited experience with PDMP effectiveness due to the current limitations of PDMPs?  Example: Physicians are not using the PDMP as much as the plan would like.  Call for research: What is the effectiveness of PDMPs if they were used in an ideal way.  Policy Question: What methods can be implemented to encourage or mandate use?  Enforcement of PDMP mandates.  Evidence of use of PDMPs can lead to increased prescribing. Identify clinical environments where this can be effective.  Timing is a significant challenge. Information is not current.  Messaging about mandates can be complex.  From enforcement perspective, used to find abusers and bad actors, but there are hurdles to accessing data.  Encourage standardization and interoperability. |
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| **Improve e-prescribing** |  | Mandate or encourage e-prescribing |
|  |  | Limit exceptions to e-prescribing requirements |
|  |  | Place edit on high utilizers to require medical justification |
|  |  | Non-lock-in Point of Service Edits. |
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| **Lock-in programs** |  | Reduce complexity of implementing lock-in's across states |
|  |  | Limit the ability of problem beneficiaries to switch plans  Drug courts to identify addicts and lock people in on Medicaid side. May be difficult for private plans. Consider Medicare (authority recently given). |
|  |  | Experience: CA has a currently inactive program interested in lessons learned. OH does case management prior to lock in. Once in lock in, there’s only one pharmacy allowed. |
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| **Other** |  | Referral to Law Enforcement/selected prosecutions |
|  |  | Field visits and background checks to validate locations for new provider applications |
|  |  | Safe disposal locations/drug boxes for unused opioids  Flushing opioids vs. drug drop boxes or take back programs. Take back programs are expensive and time consuming. Pharmacies can engage in take back programs, but cost falls on pharmacies and there is risk involved. DEA has evidence that contamination comes from alternate sources. |
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| **Coalition Building** |  | Support HFPP |
|  |  | Participate in National Associations |
|  |  | Participate in State and Local opioid abuse committees |
|  |  | Facilitate Cross-industry information sharing |
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| **Other** |  | Support research using HFPP data |
|  |  | Patient outcome studies |
|  |  | Fraud studies |
|  |  | Provider/treatment type studies |
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**Value Statement 3**