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TO: Medicare-Medicaid Plans, PACE Organizations, and Dual Eligible
Special Needs Plans

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SUBJECT: Reminder of Opportunities for MMPs, PACE Organizations, and D-SNPs
to Effectively Address Opioid Dependency or Misuse among Dually
Eligible Beneficiaries

Purpose

The purpose of this memorandum is to remind Medicare-Medicaid Plans (MMPs), PACE organizations, and Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) of their unique opportunities to prevent, identify, and comprehensively treat opioid dependency or misuse among dually eligible enrollees. Across all forms of managed care, plans that integrate Medicare and Medicaid benefits have the broadest benefit packages and greatest potential for developing robust and fully-integrated approaches to address substance use disorder. Additionally, these organizations are in a leading position to develop and implement comprehensive pain management strategies including non-opioid and non-pharmacologic approaches, which may mitigate or prevent opioid dependency or misuse without the side effects and dangers associated with opioid medications.

The Opioid Crisis

In October 2017, President Trump declared the opioid epidemic a national public health emergency.¹ Based on the 2015 data in CMS' Overutilization Monitoring System (OMS), more

than 76% of all Part D beneficiaries who were estimated to be potentially at-risk of opioid misuse or abuse are eligible for the Part D Low-Income Subsidy (LIS) program,² the majority of whom are dually eligible for Medicare and Medicaid.

In 2015, about 43.5% of dually eligible beneficiaries (vs. 30.9% of Medicare-only) without cancer filled at least one prescription for an opioid analgesic. Among them, 10.4% were high-dose chronic opioid users (vs. 4.9% of Medicare-only opioid users). Between 2006 and 2015, the growth rate in high dose chronic opioid use among dually eligible opioid users was 17.8% (vs. 0.2% growth rate among Medicare-only opioid users).

These data underscore that dually eligible beneficiaries are at high risk for dependency and/or opioid misuse and warrant a focused effort by MMPs, PACE organizations, and D-SNPs to address these issues among their enrollees.³

Key Opportunities for Integrated Plans

MMPs, PACE organizations, and integrated D-SNPs have numerous opportunities to prevent and address opioid dependency or misuse among dually eligible enrollees, including:

PAIN TREATMENT & PRESCRIBING PRACTICES

- Taking advantage of new flexibilities for Part C plans to offer a broader array of supplemental benefits, starting in 2019. The reinterpreted definition of “primarily health related” allows medically-approved non-opioid pain management services to be offered as a supplemental benefit. Additionally, the reinterpretation of uniformity requirements allows targeted benefits (e.g., additional supplemental benefits) for identified disease states, such as opioid dependency.⁴
- Ensuring that providers are knowledgeable about safe versus unsafe opioid prescribing practices. Resources include federal guidelines and evidence-based practices for assessing and treating opioid dependency or misuse. For example, the CDC Guideline for Prescribing Opioids for Chronic Pain provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care (<https://www.cdc.gov/drugoverdose/prescribing/guideline.html>)
- Conducting assessments and periodic reassessments for potential opioid dependency or misuse as part of a comprehensive person-centered, goal-directed, and non-threatening plan of care.
- Educating enrollees about the risks of opioid dependency for themselves and family members.
- Educating enrollees who are prescribed opioids about the dangers of sharing prescribed medications and the need to properly dispose of unused prescriptions.
- Identifying each enrollee’s:
 - Goals and unmet needs, and
 - Risk profile, by assessing pain self-management practices, past successes and challenges, current medications, history of substance use disorder, opioid overdose, suicide attempts and mental health conditions, concomitant use of benzodiazepines, as well as any respiratory disease or other comorbidities that

- increase susceptibility to opioid toxicity, respiratory distress, or overdose.
- Covering and encouraging the use of non-opioid and non-pharmacologic approaches for pain relief. Resources include the following:
 - An alternative pain measurement tool that focuses on functional impact rather than pain intensity, the Defense and Veterans Pain Rating Scale (DVPRS), with video, which is available to health plans and providers: <http://www.dvcipm.org/clinical-resources/defense-veterans-pain-rating-scale-dvprs/>;
 - The Department of Veterans Affairs’ Opioid Safety Initiative (OSI) pain management toolkit: https://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp;
 - The VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain: <https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPGProviderSummary022817.pdf>.
- For D-SNPs – even those not capitated for Medicaid – ensuring that staff are knowledgeable of the Medicaid pain treatment opportunities in the state and actively support enrollees in accessing those services.

EARLY DETECTION AND TREATMENT FOR OPIOID USE DISORDER

- As noted in the “Pain Treatment” section above, the reinterpreted uniformity requirements allow plans to target supplemental benefits to enrollees with specific diseases, such as opioid dependency and/or misuse. For example, MA plans may cover methadone used in medication-assisted treatment as a supplemental benefit for enrollees with opioid dependency.⁵
- Ensuring that providers are knowledgeable about evidence-based treatments for opioid use disorder for dually eligible beneficiaries, including the FDA-approved medication-assisted treatment (MAT), such as buprenorphine (or buprenorphine and naloxone combination drug), naltrexone, and methadone.
- Ensuring that providers without the buprenorphine waiver have MAT referral resources for patients, for example, the SAMHSA has a buprenorphine treatment locator, which can be found at: <https://www.findtreatment.samhsa.gov/>.
- Incentivizing and encouraging providers to become approved to prescribe buprenorphine. Information on the SAMHSA waiver can be found at: <https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training>.
- Because buprenorphine and all MAT medications are essential components of a comprehensive treatment plan that also include counseling and participation in social support programs,⁶ training care coordinators and direct care staff on best practices in working with people with substance use disorders and providing resources for accessing behavioral health services. More information on behavioral approaches for opioid use disorder can be found at: <https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing>.
- Examining data from CMS’ OMS and implementing the guidance for Part D sponsors to identify Part D enrollees who may be potentially overutilizing opioids and perform case

management with enrollees' prescribers. Through the OMS, CMS provides Part D sponsors quarterly reports on specific high-risk enrollees and in turn, sponsors should provide CMS with the outcome of their review of each case⁷. CMS will enhance the OMS to include revised metrics to track high opioid overuse and to provide additional information to sponsors about high risk beneficiaries who take opioids and "potentiator" drugs (which when taken with an opioid increase the risk of an adverse event).

- Identifying opportunities for collaboration and data sharing between integrated plans and States on potential high-risk opioid overutilizers in Medicaid drug management programs and Medicare Part D OMS.
- Starting in 2019, leveraging new Medicare Part D authority to limit at-risk beneficiaries' coverage for frequently abused drugs to certain prescribers and pharmacies ("lock-in," similar to authority long available under Medicaid) and apply beneficiary-specific point-of-sale (POS) claim edits. These are authorized under the Comprehensive Addiction and Recovery Act of 2016 (CARA).
- For D-SNPs – even those not capitated for Medicaid – ensuring that staff are knowledgeable of the Medicaid opioid use early detection and treatment opportunities in the state and actively support enrollees in accessing those services.

Dually eligible beneficiaries as a group are at increased risk for opioid dependency or misuse as they have a higher prevalence of both substance use disorder and chronic pain when compared to beneficiaries with Medicare only. MMPs, PACE organizations, and integrated D-SNPs are in a prime position to prevent, identify, and treat opioid dependency or misuse. Given the scope of their coverage, MMPs, PACE organizations, and integrated D-SNPs have a tremendous opportunity to impact the current opioid crisis by supporting the evidence-based interventions and approaches, including those highlighted in this memo for at-risk, dually eligible beneficiaries.

¹ See <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-combatting-drug-demand-opioid-crisis/>

² See the November 28, 2017 Notice of Proposed Rulemaking “Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program,” <https://www.regulations.gov/document?D=CMS-2017-0156-0046>

³ Preliminary data, to be posted on the following CMS/MMCO website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html>

⁴ See HPMS memo of April 27, 2018 on Reinterpretation of “Primarily Health-Related” for Supplemental Benefits, and HPMS memo, also of April 27, 2018, on “Reinterpretation of the Uniformity Requirement,” on the CMS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>

⁵ See HPMS memo of April 27, 2018 on Reinterpretation of “Primarily Health-Related” for Supplemental Benefits, and HPMS memo, also of April 27, 2018, on “Reinterpretation of the Uniformity Requirement,” on the CMS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>

⁶ See <https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine>

⁷ See HPMS April 6, 2018, titled, “UPDATES - 2018 Medicare Part D Patient Safety and Overutilization Monitoring System Reports” on the CMS website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week1-Apr-2-6.html?DLPage=3&DLEntries=10&DLSort=1&DLSortDir=descending>