TennCare’s Opioid Strategy

Benjamin S. Heavrin, MD, MBA, FACEP

Associate Medical Director
State of Tennessee
Division of TennCare

Rural Health Association of Tennessee
24th Annual Conference
November 15, 2018
Disclosures

I have no financial conflicts of interest.
TennCare is the state of Tennessee's **Medicaid program**.

TennCare provides health insurance to approximately **1.4 million** low-income Tennesseans.

TennCare is the **only state in the country** where 100% of membership is enrolled in managed care.
TennCare’s Mission and Core Values

**Mission**

Improving lives through high-quality cost-effective care.

**Vision**

A healthier Tennessee.

**Core Values**

- **Commitment:** Ensuring that Tennessee taxpayers receive tax dollar value.
- **Agility:** Be nimble when situations require change.
- **Respect:** Treat everyone as we would like to be treated.
- **Integrity:** Be truthful and accurate.
- **New approaches:** Identify innovative solutions.
- **Great customer service:** Exceed expectations.
What is TennCare?

- TennCare operates under a **managed care model**. This means we contract with health insurance plans - also known as managed care organizations (MCOs) – who coordinate care for TennCare members and maintain a network of providers (doctors, hospitals, specialists, pediatricians, nursing homes, etc.). These providers deliver services to TennCare members.

- TennCare pays the health plans a **Per Member Per Month (PMPM) rate** which is similar to a health insurance premium.

- The **health plans pay the providers** for services delivered to TennCare members.

- Starting January 1, 2015, three health plans began operating statewide: United, Amerigroup and Blue Care.

- **Magellan** is the Pharmacy Benefits Manager and **Dentaquest** is the Dental Benefits Manager.

- **TennCare Select** - a product of Blue Cross and Blue Shield. This is our back-up health plan should one of the other health plans fail and is the health plan to which certain members with unique coordination needs are assigned, including children in state custody and children receiving SSI.
USA vs. European Oxycodone Consumption (from 1980 to 2015)

Sources: International Narcotics Control Board; World Health Organization population data
“The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after 5 days or 1 month of opioids have been prescribed…”
Longer and larger 1\textsuperscript{st} time opioid prescriptions are associated with:

- A transition to chronic use
  

- Death from overdose
  
Opioids vs NSAIDs for Acute Pain

“For patients presenting to the ED with acute extremity pain, there were no statistically significant or clinically important differences in pain reduction at 2 hours among single-dose treatment with ibuprofen and acetaminophen or with 3 different opioid and acetaminophen combination analgesics.”

Table 2. Numerical Rating Scale (NRS) Pain Scores and Decline in Pain Scores by Treatment Group

<table>
<thead>
<tr>
<th></th>
<th>Ibuprofen and Acetaminophen</th>
<th>Oxycodone and Acetaminophen</th>
<th>Hydrocodone and Acetaminophen</th>
<th>Codeine and Acetaminophen</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>101</td>
<td>104</td>
<td>103</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>Primary end point: decline in score to 2 h</td>
<td>4.3 (3.6 to 4.9)</td>
<td>4.4 (3.7 to 5.0)</td>
<td>3.5 (2.9 to 4.2)</td>
<td>3.9 (3.2 to 4.5)</td>
<td>.053</td>
</tr>
<tr>
<td>Baseline score</td>
<td>8.9 (8.5 to 9.2)</td>
<td>8.7 (8.3 to 9.0)</td>
<td>8.6 (8.3 to 9.0)</td>
<td>8.6 (8.2 to 8.9)</td>
<td>.47</td>
</tr>
<tr>
<td>Score at 1 h</td>
<td>5.9 (5.3 to 6.6)</td>
<td>5.5 (4.9 to 6.2)</td>
<td>6.2 (5.6 to 6.9)</td>
<td>5.9 (5.2 to 6.5)</td>
<td>.25</td>
</tr>
<tr>
<td>Score at 2 h</td>
<td>4.6 (3.9 to 5.3)</td>
<td>4.3 (3.6 to 5.0)</td>
<td>5.1 (4.5 to 5.8)</td>
<td>4.7 (4.0 to 5.4)</td>
<td>.13</td>
</tr>
<tr>
<td>Decline in score to 1 h</td>
<td>2.9 (2.4 to 3.5)</td>
<td>3.1 (2.6 to 3.7)</td>
<td>2.4 (1.8 to 3.0)</td>
<td>2.7 (2.1 to 3.3)</td>
<td>.13</td>
</tr>
</tbody>
</table>

a Pain intensity was assessed using an 11-point NRS in which a score of 0 indicates no pain and a score of 10 indicates the worst possible pain.
b Patients received 400 mg of ibuprofen and 1000 mg of acetaminophen.
c Patients received 5 mg of oxycodone and 325 mg of acetaminophen.
d Patients received 5 mg of hydrocodone and 300 mg of acetaminophen.
e Patients received 30 mg of codeine and 300 mg of acetaminophen.
f Calculated using analysis of variance.
g One patient in each group had imputed NRS data.
TennCare Opioid Claims Rate by County
January 2018 – June 2018

Opioid Claims Rate (per 1,000 members)

TennCare Enrollment by County

Source: TennCare Internal Claims Data and Analysis
TennCare has been fighting the opioid epidemic

- Pharmacy lock-in program
- Opioid Preferred Drug List (PDL)
- Increased prior authorization and clinical criteria for controlled substances
- Implementation of State of TN/CDC chronic pain guidelines
- First fill requirements

**TennCare Members Using Opioids**

- Rate per 1,000 members

**TennCare NAS Live Births**

- Rate of NAS births per Thousand Live Births by CY

**TennCare Members with OUD**

- Rate of Opioid Use Disorder per Thousand Members by CY

Source: TennCare Internal Claims Data and Analysis
TennCare – 2018 Opioid Strategy

**Primary Prevention**
limit opioid exposure

**Secondary Prevention**
reduce misuse

**Tertiary Prevention**
active recovery for dependence and addiction

### Non-Chronic and First Time Users of Opioids
- Improve access to non-opioid pain medication therapies
- Establish strict opioid day limits and dosage limits for non-chronic users
- Increased prior authorization requirements for all opioid refills

### Women of Child Bearing Age & Provider Education
- Increase outreach to women of child bearing age
- Remove barriers to access for VLARC (IUD and implants)
- Focused provider education on appropriate prescribing

### Chronic, Dependent and Addicted Users
- Establish high-quality opioid use disorder MAT treatment programs
- Develop OUD treatment networks to ensure access for all members
- Lower TennCare-allowed maximum MME dosage for chronic opioid use
- Increase outreach to highest risk members to refer for treatment
TN Together is the state’s comprehensive plan to address the ongoing opioid epidemic through three primary levers:

- Prevention
- Treatment
- Law Enforcement

www.tntogether.com
Diagnosing Opioid Use Disorder

Two of the following conditions must occur within a year:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Exhibits tolerance.
11. Exhibits withdrawal.

Source: DSM V and taken directly from CDC guidelines - https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html
TennCare Members with an OUD Claim from January 2016 – June 2017

24,163 members at 21,952 locations

Source: TennCare Internal Claims Data and Analysis
TennCare Members with OUD Diagnosis

Rate of Opiate Use Disorder per Thousand Members by CY

Source: TennCare Internal Claims Data and Analysis
TennCare Opioid Use Disorder Incidence Rate – January 2018 – June 2018

Source: TennCare Internal Claims Data and Analysis
What is MAT?

1. Medication-Assisted Treatment

2. The use of both of the following to treat a substance use disorder:
   - Medication
   - Counseling and behavioral therapy

3. A “whole person” approach to treating substance use

4. A form of chronic disease management

Source: https://www.samhsa.gov/medication-assisted-treatment
**Medication-assisted treatment has been shown to:**

1. Increase survival
2. Decrease criminal activity (including illicit use)
3. Maintain employment
4. Improve birth outcomes
5. Reduce the risk of contracting HIV and hepatitis

Source: SAMHSA data, available at https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat
MAT – The Evidence

Treatment with buprenorphine for OUD is considered an evidence-based best practice by the SAMHSA Center and ASAM for substance abuse treatment.

**MAT Decreases:**
1. Opioid use
2. Opioid-related overdose deaths
3. Criminal activity
4. Infectious disease transmission
5. Symptoms of neonatal abstinence syndrome and length of hospital stay

**MAT Increases:**
1. Social functioning
2. Retention in treatment

After buprenorphine became available in Baltimore, heroin overdose deaths decreased by 37 percent.


Sources:
5. ACOG & ASAM. (2012).
High Quality MAT Networks

Establish MAT program description and quality standards

Build access and capacity across care spectrum

Increase care coordination and clinical integration

Goal: increase access, build capacity, and direct high risk members to effective providers

Long-Term

Near-Term

Value-based interventions
Why Become an MAT Provider?

1. Access to a larger TennCare formulary
2. Prior authorization forms are simpler, quicker, and easier to use
3. Care coordination support from our MCO team
4. Access to a coordinated behavioral health network
5. Resources that match the high level of care provided
How Do I Become a TennCare MAT Provider?

https://stateoftennessee.formstack.com/forms/bmatp
Future TennCare Strategies

1. **MAT network expansion**

2. **Outreach**
   - Chronic pain population
   - Adolescents and young adults
   - Providers

3. **Early integration into MAT-based care**
   - Emergency department based treatment and referral
Thank You
The probability of continued opioid use increases significantly when the cumulative dose of opioids reaches ≥700 MME.

Opioid use in adolescence is associated with future opioid misuse.

Prescription Opioids in Adolescence and Future Opioid Misuse

Richard Miech, PhD, Lloyd Johnston, PhD, Patrick M. O'Malley, PhD, Katherine M. Keyes, PhD, Kennon Heard, MD

BACKGROUND AND OBJECTIVE: Legitimate opioid use is associated with an increased risk of long-term opioid use and possibly misuse in adults. The objective of this study was to estimate the risk of future opioid misuse among adolescents who have not yet graduated from high school.

METHODS: Prospective, panel data come from the Monitoring the Future study. The analysis uses a nationally representative sample of 6220 individuals surveyed in school in 12th grade and then followed up through age 23. Analyses are stratified by predicted future opioid misuse as measured in 12th grade on the basis of known risk factors. The main outcome is nonmedical use of a prescription opioid at ages 19 to 23. Predictors include use of a legitimate prescription by 12th grade, as well as baseline history of drug use and baseline attitudes toward illegal drug use.

RESULTS: Legitimate opioid use before high school graduation is independently associated with a 33% increase in the risk of future opioid misuse after high school. This association is concentrated among individuals who have little to no history of drug use and, as well, strong disapproval of illegal drug use at baseline.

CONCLUSIONS: Use of prescribed opioids before the 12th grade is independently associated with future opioid misuse among patients with little drug experience and who disapprove of illegal drug use. Clinic-based education and prevention efforts have substantial potential to reduce future opioid misuse among these individuals, who begin opioid use with strong attitudes against illegal drug use.
“Among patients receiving opioid prescriptions for pain, higher opioid doses were associated with increased risk of opioid overdose death.”

Patients taking 50-100 MME per day were over 2.5 times more likely to die from an opioid overdose compared to patients taking 20-49 MME per day.

Risks vs. Benefits Associated with Long-Acting Opioid Use

“Prescription of long-acting opioids for chronic non-cancer pain, compared with anticonvulsants or cyclic antidepressants, was associated with a significantly increased risk of all-cause mortality, including deaths from causes other than overdose.”

Non-cancer chronic pain patients using long-acting opioids had a higher death rate compared to non-cancer chronic pain patients using non-opioid pain alternatives

**Opioid vs. Non-Opioid Pain Therapy for Acute Pain Episodes**

“The results of the reviews indicated that the ibuprofen-APAP combination may be a more effective analgesic, with fewer untoward effects, than are many of the currently available opioid-containing formulations.”

In multiple head to head studies, ibuprofen + acetaminophen used together reduced moderate to severe acute postoperative pain MORE in comparison to opioids.

---

Impact of Opioid Prescribing Efforts on Heroin Overdose

“We found no evidence to support the assertion that policies to curb opioid prescribing are leading to heroin overdoses.... Prior prescription opioid misuse is an important risk factor for heroin use.... Thus, our results that showed a reduction in MMEs prescribed support the statistically insignificant association between these policies and reduced heroin overdose death rates.”

State prescribing efforts using a PDMP and pain clinic laws reduced opioid MMEs prescribed by 8%, reduced prescription opioid overdose deaths by 12%, and did not lead to increase heroin overdose deaths.


### Estimated impact of opioid prescribing policies on state-level drug overdose death rates, 2006–13

<table>
<thead>
<tr>
<th>Policy/Outcome</th>
<th>Outcome 1: opioid MME prescribing rate(a)</th>
<th>Outcome 2: prescription opioid overdose deaths</th>
<th>Outcome 3: heroin overdose deaths</th>
<th>Outcome 4: combined drug overdose deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory PDMP review and pain clinic laws</td>
<td>-80.1**</td>
<td>-1.198**</td>
<td>-0.215</td>
<td>-1.103**</td>
</tr>
<tr>
<td>Pain clinic laws only</td>
<td>-54.7</td>
<td>-0.174</td>
<td>-0.356</td>
<td>-0.419</td>
</tr>
<tr>
<td>Opioid MME prescribing rate(a)</td>
<td>-d</td>
<td>0.006***</td>
<td>-0.001</td>
<td>0.008***</td>
</tr>
<tr>
<td>Pending death investigation rate(b)</td>
<td>-d</td>
<td>-0.145***</td>
<td>-0.026</td>
<td>-0.288***</td>
</tr>
<tr>
<td>Prescription opioid death rate(b)</td>
<td>8.0</td>
<td>-d</td>
<td>0.058</td>
<td>-d</td>
</tr>
<tr>
<td>Lagged prescription opioid death rate(b)</td>
<td>5.84</td>
<td>-d</td>
<td>-d</td>
<td>-d</td>
</tr>
<tr>
<td>Unspecified deaths rate(b,c)</td>
<td>-d</td>
<td>-0.002</td>
<td>-0.002</td>
<td>-d</td>
</tr>
</tbody>
</table>