Changes in the Oregon Health Plan Coverage of Back and Neck Pain

2018 Oregon Pain + Addiction Treatment Conference

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Disclosures

Ariel Smits, MD, MPH works as a salaried employee as the Medical Director of the Health Evidence Review Commission of the Oregon Health Authority. Dr. Smits has disclosed that within the past 12 months, she has not had financial interest with any manufacturers of medical commercial products pertaining to the presented topics.
Learning Objectives

• Understand the background and processes of the Health Evidence Review Commission

• Understand the changes to the benefit packages for treatment of back and neck pain for the Oregon Health Plan and the problems these changes attempted to address

• Understand the anticipated and actual outcomes and barriers encountered in implementation of these benefit changes
The Oregon Health Plan

- Oregon Health Evidence Review Commission
  - Comprised of volunteers from many areas of medical care, health plans, consumer representatives
  - Regular public meetings
  - Two products:
    - The Prioritized List of Health Services
    - Evidence based reports, including coverage guidances
- Care provided through Fee for Service (FFS, approx. 13% of population) and Coordinated Care Organizations (CCOs)
- Federal Medicaid waver
The Prioritized List of Health Services

• Purpose is to ensure coverage for the most important services in maximizing population health while controlling costs
• Ranks all condition/treatment pairs in priority order
• Funding line determined by state Legislature
  – Only conditions “above the line” receive coverage
• Guidelines help further define coverage
• Mental, physical and dental health merged
• CAM treatments available for a variety of conditions
  – Include acupuncture, chiropractic, osteopathic manipulation, naturopathic care
Back Pain and Opioid Use on the OHP: The Problem

• Back pain is the most common OHP diagnosis for opioid prescriptions in OHP (2013 data)
  – Approximately 50,000 Medicaid patients with back pain diagnoses
  – Approximately 30,000 received a prescription for opioids
  – Average number of opioid prescription days for this group: 148
  – Approximately $5 million spent on opioids prior to benefit changes

• Treatment of back/neck pain was
  – uncoordinated,
  – did not include evidence based treatments
  – included treatments with known serious harms
HERC’s Review of Back Pain Interventions

- Back Pain Policy Actions
  - Advanced imaging coverage guidance (CG) (2012)
  - Artificial disc replacement CG (2014)
  - Lumber discography CG (2014)
  - Non-pharmacological, non-invasive interventions CG (2014)
  - Pharmacological and herbal therapies CG (2014)
  - Percutaneous interventions CG (2014)
  - Corticosteroid injections CG (2017)
  - Minimally invasive and non-corticosteroid percutaneous injections CG (in process)
Historic OHP back pain coverage (simplified)

With radiculopathy
- Medication
- Surgery
- Chiropractic
- Acupuncture
- PT/OT

Without radiculopathy
Theoretically no coverage w/o comorbidity rule.

Real world: Office visits, medication, including opioids
2014 Back Pain Taskforce

Taskforce membership
- Chiropractor
- Acupuncturist
- Physical therapists
- Pain specialist
- Neurosurgeon
- Orthopedic surgeon
- Physiatrist
- Primary care physician
- Medicaid managed care plan medical director
- Psychologist
- Addictions specialist
- National expert in back pain treatment evidence

- Series of public meetings held in 2014-2015
- Evidence review
  - 2012 HERC coverage guidance, new literature reviews on surgery and opioids, expert input
- Changes effective July 1, 2016
The New Back Care Paradigm

- Focus on biopsychosocial model
- Adding evidence-based effective treatments
  - Cognitive behavior therapy
  - Physical therapy
  - Chiropractic manipulation
  - Osteopathic manipulation
  - Acupuncture
  - Intensive interdisciplinary rehabilitation, supervised exercise therapy, yoga and massage are recommended and may be available in some CCOs

- Restricting or eliminating ineffective or harmful treatments
  - Long-term opiates no longer covered for opioid-naïve patients
  - For patients already on long-term opioids, requirement to develop a treatment plan including alternative therapies and taper off opioids by 1/1/2018
  - Surgery limited to conditions with known effectiveness
  - Epidural steroid injections
Guideline Note 56: New Treatment Pathways
(Medical Treatment Line)

Low Risk
- Office visits
- 4 visits
  - PT/OT/OMT/Chiro/Acupuncture/massage
- OTC meds, muscle relaxers

High Risk
- Office visits
- Cognitive Behavior Therapy
- Up to 30 visits
  - PT/OT/OMT/Chiro/Acupuncture
- OTC meds, muscle relaxers
  - Limited opioids
- If available:
  - Yoga, interdisciplinary rehab, supervised exercise, massage

Not Recommended:
- 1st line Opioid prescribing or Long Term Opioid use
Guideline Note 60: Opioid Medications
(Coverage Criteria)

During the first 6 weeks after injury, flare, surgery:
- Prescription limited to 7 days, and
- Short acting opioids only, and
- First line pharmacologic therapies are ineffective, and
- Treatment plan includes exercise, and
- Opioid risk assessment

Opioid use after 6 weeks, up to 90 days:
- Functional assessment – 30% improvement,
- Spinal manipulation, physical therapy, yoga, or acupuncture,
- Opioid Risk mitigation:
  - PDMP
  - Screen for opioid use disorder
  - Urine drug test
  - Prescriptions limited to 7 days and short acting only

Opioids after 90 days:
• Not Covered without new injury, flare, surgery

Transitional coverage for those on long-term opioid therapy through 1/2018:
• Taper plan
  • In place by January 2017
  • Include nonpharmacologic treatment strategies
Increased Coverage:
- Cognitive Behavior Therapy
- Spinal Manipulation
- Acupuncture
- PT/OT
- Non-opioid medications
- Yoga *
- Interdisciplinary Rehab *
- Supervised exercise *
- Massage Therapy *

* If available

Decreased Coverage:
- Surgeries
- Opioids
- Epidural Steroid Injections
Anticipated Outcomes

- Reduced opioid use for back conditions
  - Improved public health: fewer ER visits, overdoses, deaths
- Improved outcomes for patients
  - Reduced pain and better function
  - Access to evidence-based effective care
  - Reduced harms from opioids and ineffective surgery
- Better educated medical workforce
  - Evidence based assessments and tools
  - Improved knowledge of best practices
- Ultimately, reduced costs through paying only for effective care
**Opioid Use**
*(Patients without cancer exclusion)*

### Back patients 2016
- Opioid use 12/15-11/16
- 34.5% had an opioid prescription (for any reason)
- 9.2% had 1 day > 90 MED
- 2.5% had 30+ days > 90 MED
- 5.9% had 1 day >120 MED
- 1.6% had 30+ days >120 MED

### Back patients 2017
- Opioid use 1/17-12/17
- 33.9% had an opioid prescription (for any reason)
- 7.8% had 1 day > 90 MED
- 1.9% had 30+ days > 90 MED
- 4.9% had 1 day >120 MED
- 1.3% had 30+ days >120 MED
Uptake: Steady Growth
Proportion of those with back pain diagnosis using newly-added conservative therapies

HEALTH EVIDENCE REVIEW COMMISSION
Health Policy and Analytics
Frequency:
Average number of services for those using each type of service

<table>
<thead>
<tr>
<th>Service</th>
<th>Late 2015</th>
<th>Late 2016</th>
<th>Late 2017</th>
<th>All 2017</th>
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<tbody>
<tr>
<td>Psych</td>
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<tr>
<td>PT/OT</td>
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<tr>
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<tr>
<td>Chiro+Acup</td>
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Implementation Challenges

• Workforce
• Payment challenges (e.g., yoga)
• Education of providers, patients, public
• Dissemination of evidence based tools
• Controls on narcotic prescriptions (FFS vs. CCOs)
• Ability to taper chronic opioid patients
• Availability of treatment for patients with opioid use disorder
• Pushback from providers, patients, tribes, other stakeholders
Next Steps

• Feedback to HERC
  – OHP managed health plans’ medical directors
  – OHA Medicaid administrators
  – Patients/providers

• Current work on alternative treatments for other types of chronic pain
  – Chronic Pain Taskforce
For more information

www.oregon.gov/OHA/HPA/CSI-HERC

Health Evidence Review Commission
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