Managing prescription opioid use in Medicare Part D

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Overview

- Context about opioid prescribing and use
- Updated data on opioid use in Part D
- Steps taken by CMS and plan sponsors to manage opioid use

Context about opioids prescribing and use by Medicare population

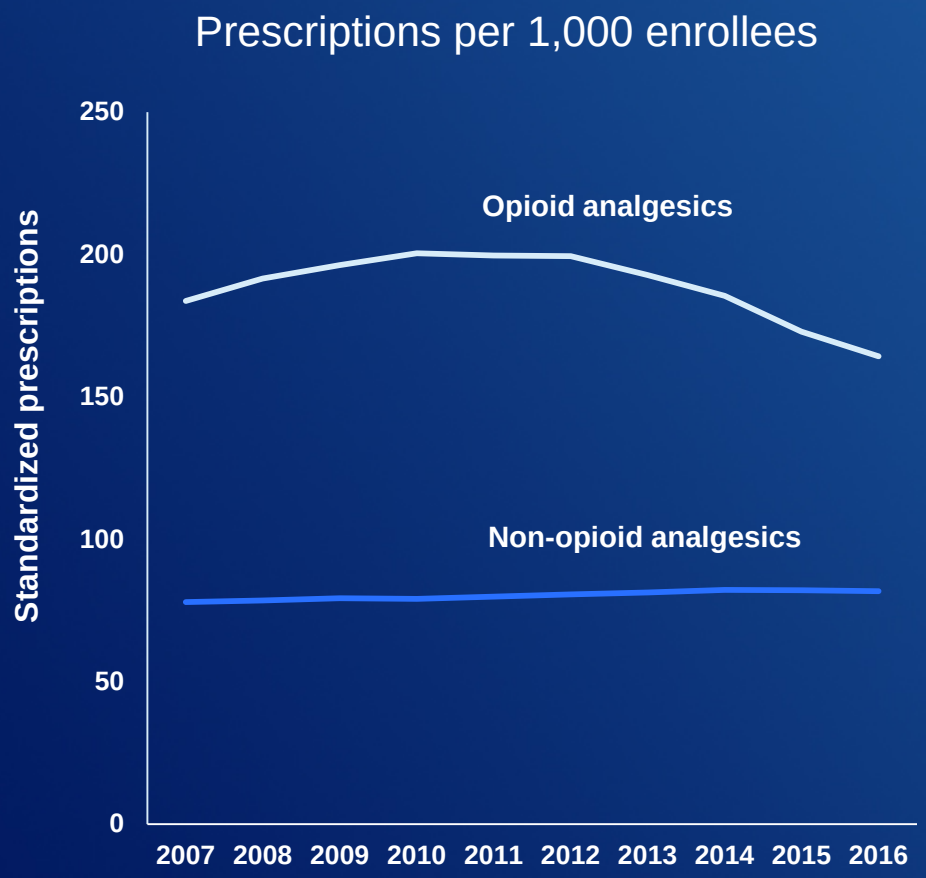
- More liberal prescribing since the 1990s
  - New extended-release formulations
  - Aggressive marketing
- Ambiguity about safe prescribing
- Opioid overdose epidemic
- Benefits and risks more apparent for Medicare beneficiaries
- Evidence of potential opioid overuse, misuse, and fraud in Part D

2016 CDC guideline on prescribing opioids for chronic pain

- Non-pharmacologic and non-opioid treatments preferred
- Minimize use in acute pain treatment to avoid long-term (chronic) use
  - Lowest effective dose of immediate-release opioid
  - Usually ≤3 days' supply; rarely >7 days
- Opioids for chronic pain should
  - Start with lowest effective dosage (<50 MME/day)
  - Reassess benefits and risks when increasing dosage, ≥90 MME/day not advisable in most cases
  - Use caution with patients age 65 and older

Note: MME (morphine milligram equivalent).

Opioid use in Part D has declined but is still widespread



- Opioid prescriptions per 1,000 enrollees have declined 18% since 2012
- But still broad use:
  - Nearly 1 in 3 enrollees had at least 1 opioid prescription in 2016
  - About 90% opioid prescriptions unrelated to cancer or hospice care
  - Part D gross spending of $4.1 billion

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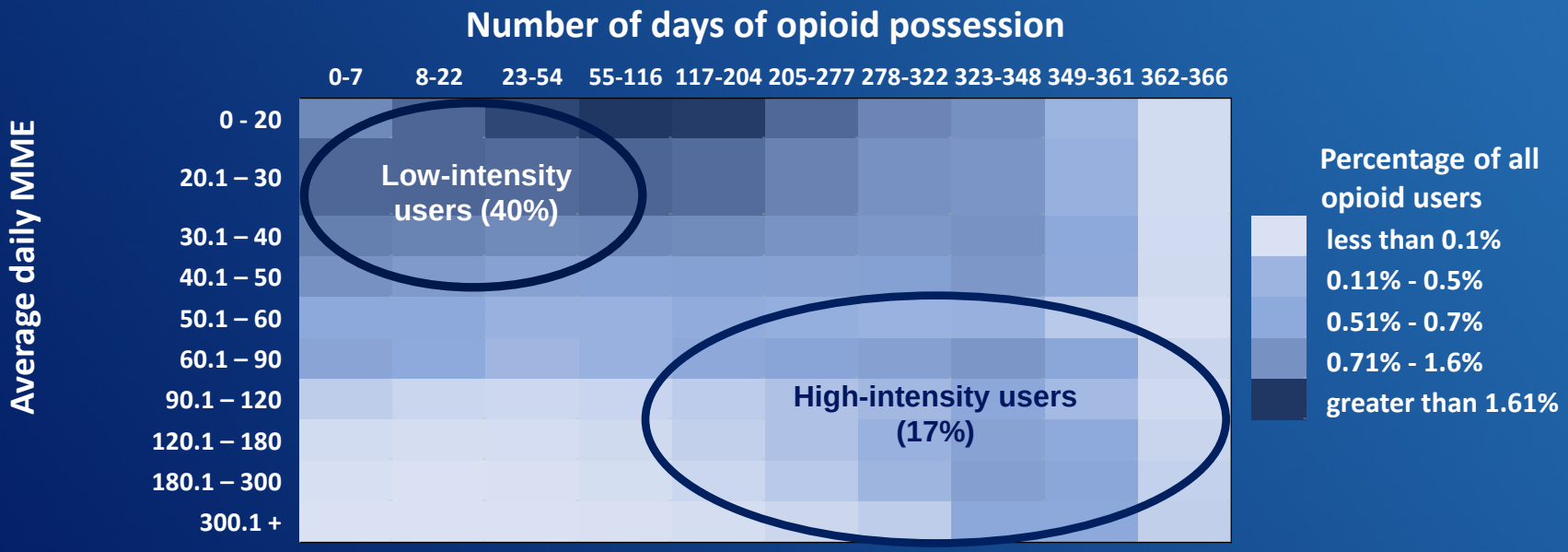
Note: Data are preliminary and subject to change. 90-day prescriptions standardized to three 30-day equivalents.
Source: MedPAC analysis of Part D prescription drug event data.

Intensity of opioid use varied among Part D enrollees, 2012



- Majority (78%) had average MME ≤ 50 per day
- Low intensity (40%): average MME ≤50 and <3 months
- High intensity (17%): average MME >50 and ≥3 months

Note: MME (morphine milligram equivalents). Data are preliminary and subject to change. Includes Part D enrollees who filled at least one prescription for opioid in 2012, and were continuously enrolled in Part A, Part B, and Part D in 2012 (about 6.7 million Medicare beneficiaries).
Source: Acumen LLC for MedPAC.

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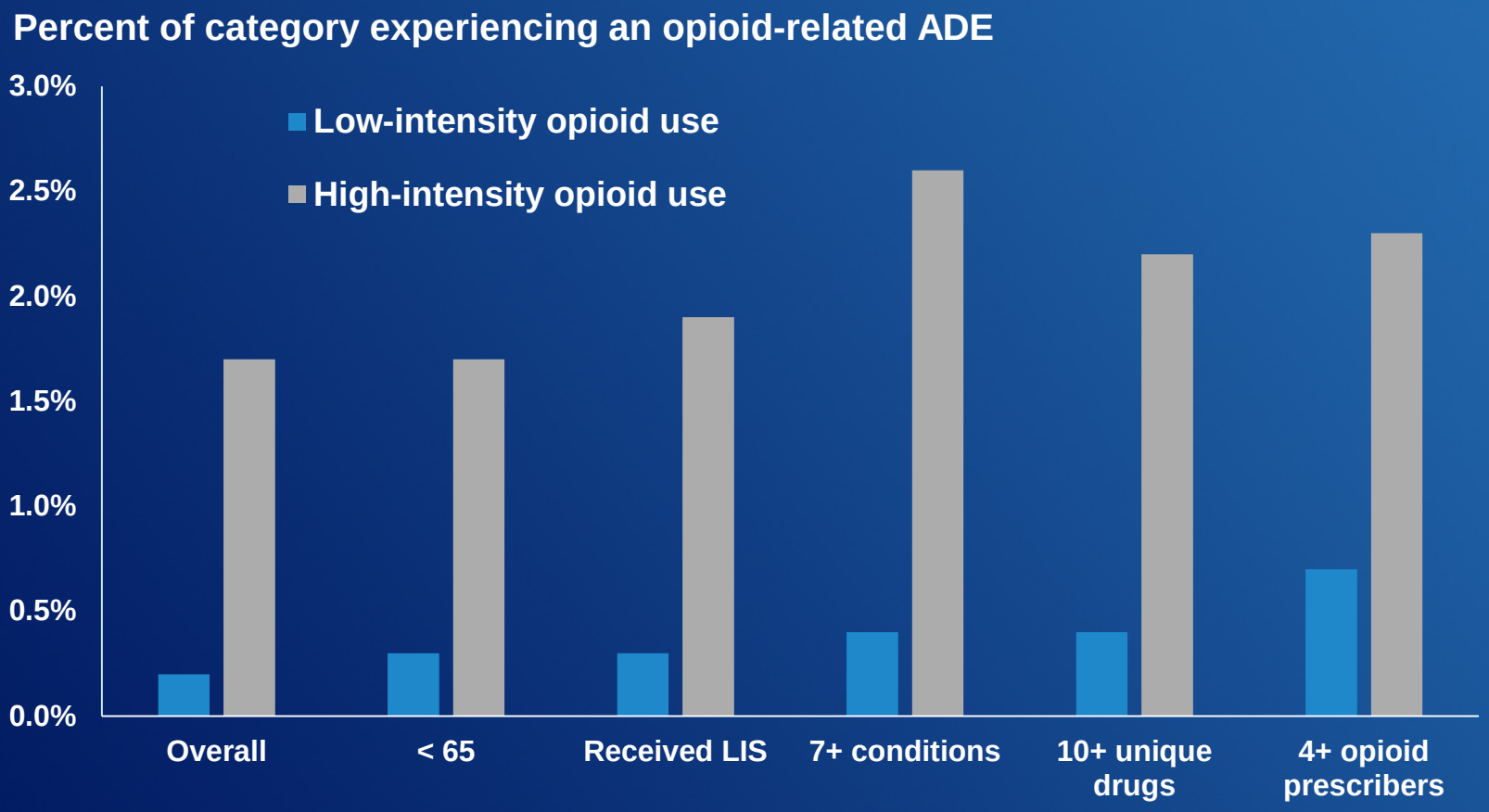
Characteristics associated with opioid-related adverse drug events, 2013



Note: ADE (adverse drug event), LIS (low-income subsidy), MME (morphine milligram equivalent). Data are preliminary and subject to change. Includes Part D enrollees who filled at least one prescription for opioid in 2012, and were continuously enrolled in Part A, Part B, and Part D in 2012. Low-intensity users had an average daily dosage ≤50 MME and <3 months' opioid treatment. High-intensity users had an average daily dosage >50 MME and ≥3-months' opioid treatment.
Source: Acumen LLC for MedPAC.

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Patterns among beneficiaries who filled opioid prescriptions raise concerns, 2015

- Average of nearly 6 opioid prescriptions
- Compared to enrollees without opioid fills, beneficiaries with opioids used more drugs
  - Higher average annual fills of all drugs (70 v. 40)
  - Drugs from more classes on average (10 v. 5)
- 45% filled prescriptions concurrently for benzodiazepines or gabapentin
- The top 5% ranked by opioid spending:
  - Filled an average of 22 opioid prescriptions
  - Average total opioid cost of more than $3,700
  - 75% also used benzodiazepines or gabapentin

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Note: Data excludes individuals who had hospice stay(s) or were being treated for cancer during the year. 90-day prescriptions standardized to three 30-day equivalents.

CMS's approach to managing opioid use in Part D is evolving

- Since 2013, plan sponsors must analyze claims retrospectively to identify high-risk beneficiaries and apply safety warnings at the pharmacy
- Overutilization Monitoring System (OMS)
  - High cumulative dosage
  - High numbers of prescribers and pharmacies
- For 2019, sponsors may, under certain conditions, limit at-risk enrollees' access to frequently abused drugs
- Quality measures and safety reports

CMS guidance for 2019 uses a more tailored approach

- Opioid-naïve patients: No more than 7-days' supply
- High-risk opioid users: Drug management programs integrated with OMS
- Other chronic opioid users:
  - Pharmacist notified to consult with prescriber when cumulative average daily dosage >=90 MME
  - May limit prescription fill at cumulative daily dosage of 200 MME or higher
- Pharmacist notified if duplicative opioid therapy or concurrent use of benzodiazepines

Note: MME (morphine milligram equivalent).

In 2019, drug management programs for beneficiaries at risk of opioid abuse or misuse

- If a plan sponsor uses a drug management program, it:
  - Must develop clinical criteria to assess risk
  - Must follow case management, notification, and appeals processes
  - May apply beneficiary-specific restrictions on fills or pharmacy and prescriber “lock-in”
  - Must have a process for terminating “at-risk” status
- “At-risk” enrollees with low-income subsidy cannot use special enrollment period

CMS efforts focused on abusive or fraudulent providers

- MEDIC analyzes claims and investigates suspicious prescriber or pharmacy behavior
- Leads shared with CMS and plan sponsors
- OIG could not determine the effectiveness of CMS's efforts
- In 2019, plans must reject a pharmacy claim if the prescriber is on the "preclusion list"

MEDPAC Note: MEDIC (National Benefit Integrity Medicare Drug Integrity Contractor), OIG (Office of Inspector General).

Summary

- Prescription fills for opioids continue to be widespread in Part D
- Concern about potential harm from polypharmacy and high opioid use
- CMS and plans moving toward more tailored approaches to managing opioid use
- Additional measures to begin in 2019