Opioids and alternatives in hospital settings: Payments, incentives, and Medicare data

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January 17, 2019

MEDPAC

SUPPORT for Patients and Communities Act

Calls on MedPAC to report to the Congress by March 15, 2019 on 3 items:

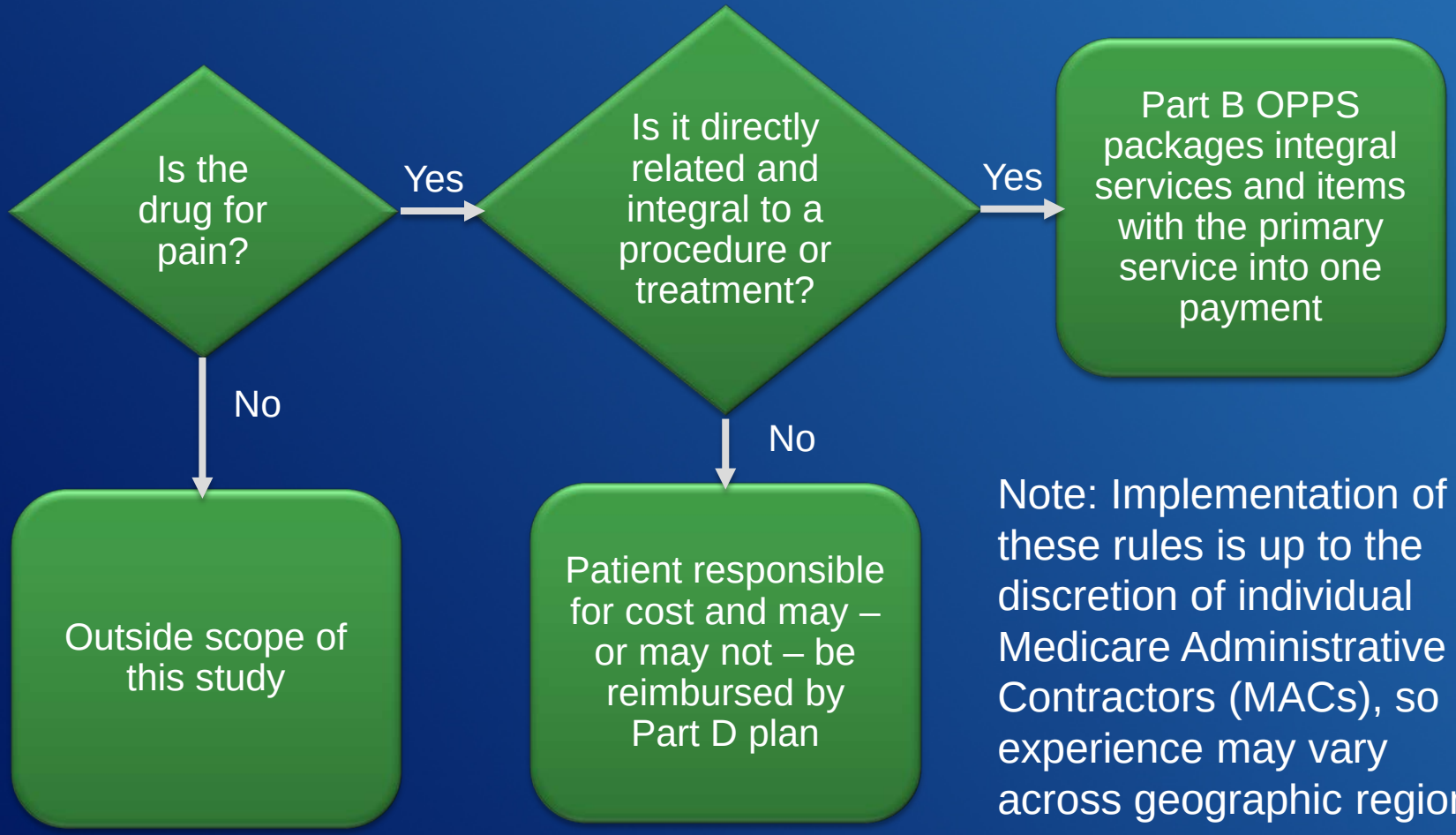
1. How Medicare pays for opioids and non-opioid alternatives in inpatient and outpatient hospital settings
2. Incentives under these prospective payment systems for prescribing opioids and non-opioid alternatives
3. How Medicare tracks opioid use

Note: SUPPORT (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment)

1. How Medicare pays for opioids and alternatives in hospital settings

- Medicare uses bundled payments in both the inpatient and outpatient settings
- The inpatient prospective payment system's (IPPS) bundles include *all* goods and services
- The outpatient prospective payment system's (OPPS) bundles include *integral* goods and services

Outpatient hospital payment for opioids and non-opioid alternatives



Note: Implementation of these rules is up to the discretion of individual Medicare Administrative Contractors (MACs), so experience may vary across geographic regions.

2. IPPS and OPPS incentives for opioids and non-opioid alternatives in hospital settings

- The SUPPORT Act asks for identification of payment system incentives
  - This study focuses on these financial incentives
  - There are also patient-specific and clinical factors that guide prescribers' pain drug choices
- IPPS and OPPS create a financial incentive for hospitals to select the lowest-cost goods and services possible
  - This incentive is balanced by Medicare's quality measurement and reporting programs, along with providers' clinical expertise and professionalism
  - These balanced incentives are intended to result in high-quality outcomes for patients at the best prices

Analysis of prices for pain drugs commonly used in hospital settings

- Consulted with clinicians to determine which pain drugs are commonly used
- Examined relative prices of opioids and non-opioids
- However, drug price data are not readily available
  - Actual acquisition costs not reported by hospitals
  - Average sales prices (ASP) not available for many of the drugs in our study

Publicly available list prices

- Examined wholesale acquisition cost (WAC) and average wholesale price (AWP); present WAC alone for brevity
- WAC is an upper bound on prices hospitals actually pay
- WAC provides an important view of relative prices

Pain drug prescribing flexibility in hospital settings

- Prescribing options include route of administration (e.g., oral, IV) and dosage form (e.g., tablet, capsule, solution)
- Multiple drugs can be used in combination to address pain
- Non-opioids may not always be the best choice
- Alternatives to opioids include multiple drug groups

Opioids and their alternatives are available at overlapping price ranges

Pain drug group	Number of options with WAC less than $1 per dose	WAC per dose	
		Minimum	Maximum
Opioids	10 (31%)	$0.05	$1,361.16
Opioid agonists/antagonists	0	2.27	62.33
NSAIDs and other non-opioid pain relievers	27 (47%)	0.02	64.80
Neurologic agents (for nerve pain)	2 (67%)	0.43	6.00
Sedative agent	8 (80%)	0.05	23.37
Musculoskeletal therapy agents	1 (13%)	0.37	405.00
Ophthalmic agents	2 (50%)	0.65	581.67
General anesthetics	0	2.59	18.42*
Local anesthetics	5 (26%)	0.05	738.47

Note: WAC (wholesale acquisition cost). Options include unique drug–route of administration–dosage form combinations (e.g., Acetaminophen oral capsule, Fentanyl citrate injection solution).
*List prices marked with an asterisk use average wholesale price (AWP) in lieu of non-available WAC.

Source: MedPAC summary of Acumen, LLC analysis of Medi-Span data Copyright 2017, Clinical Drug Information, LLC.

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Data are preliminary and subject to change.

3. Medicare monitoring of opioid use through data

- CMS monitors opioid use through data available in the Part D program
  - Overutilization Monitoring System (OMS)
  - Quality measures
  - Medicare Part D opioid prescribing mapping tool
- These rely on prescription drug event (PDE) data
- The agency does not operate opioid tracking programs in Part A and Part B

Compelling reasons for Medicare to track the use of opioids and alternatives in hospital settings

- Severity of the opioid epidemic
- Gap in knowledge about the degree to which Medicare beneficiaries are exposed to opioids while in the hospital
- Program oversight of hospitals' use of opioids versus non-opioids
- Alternative oversight programs lack tracking in the hospital setting:
  - FDA, CDC, SAMHSA
  - State prescription drug monitoring programs (PDMPs)

Options for implementing a Medicare hospital opioids and alternatives tracking program

- Require prescription drug event (PDE)-type reporting by hospitals
- Require hospitals to report prescribed drugs on Part A and Part B claims
- Incorporate opioid use disorder (OUD) in CMS's Hospital-Acquired Condition Reduction Program (HACRP) or any replacement program

Discussion

- Questions?
- Chapter in March 2019 report