Advising the Congress on Medicare issues

Polypharmacy and Medicare beneficiaries with a focus on opioid use in Part D

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Roadmap

- Opioid use in Part D
- Concerns raised by high opioid use
- General polypharmacy concerns
- Potential solutions:
  - Clinical approaches to polypharmacy
  - Policy approaches to opioid overuse / polypharmacy

Opioid use in Part D – an update w/ 2012 data

- About 36% of Part D enrollees (12.3 million) filled at least one prescription for an opioid
- Varies widely across states, with higher use in many Southern states
- Most use likely unrelated to pain associated with cancer or terminal conditions (but use of opioids for other types of pain can be clinically appropriate)
- Some conditions were more prevalent among opioid users (e.g., osteoporosis, bipolar disorders, depression)
- The 10.7 million without hospice stays or cancer diagnoses were:
  - More likely to be disabled under age 65
  - More likely to receive the low-income subsidy (LIS)

Beneficiaries with very high opioid use

- About 500k beneficiaries accounted for $1.9 billion (nearly 70% of total opioid spending in 2012)
- Filled 23 opioid prescriptions at a cost of over $3,500, on average
- 65% were disabled (< 65) receiving the LIS
- More likely to have ≥4 prescribers (32% vs. 9% for other opioid users)
- More likely to obtain opioids from ≥3 pharmacies (32% vs. 6% for other opioid users)

Patterns of opioid use raise concerns

- Opioid use is often associated with polypharmacy in the elderly
- Opioids have addictive properties with high risk for abuse, and are often connected to unintentional overdose
- Inappropriate use increases Part D's program costs without providing health benefits

Nearly one third of beneficiaries fill more than 6 Rxs per month

Part D enrollees by average # of Rx filled per month in 2012	
Less than 1	11%
1	10%
2	12%
3	13%
4	12%
5	11%
6+	31%

Data are preliminary and subject to change

- Polypharmacy definitions:
  - Often defined as patient taking more than 5-7 drugs concurrently
  - Patient is prescribed more drugs than are clinically warranted
  - All medicines are clinically appropriate but too many for patient to manage

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Notes: Prescriptions standardized to a 30 day supply. Average monthly prescriptions estimated by taking the annual total prescriptions and dividing by 12 for a full-year enrollees.
Source: MedPAC analysis of Part D prescription drug event data.

How do adherence studies and polypharmacy studies differ?

- Adherence literature
  - Typically use administrative data with large data sets
  - Adherence defined as possession of study medications
  - Outcome measures: medical service use and spending
- Polypharmacy literature
  - Require medical records and/or patient interviews, with smaller study samples
  - Adherence defined as taking drugs as prescribed and in correct dosage, and discontinuing after adverse drug events (ADEs)
  - Outcome measures: ADEs, use of EDs or hospitals, with less focus on costs

Polypharmacy is associated with nonadherence to appropriate drugs

- Patients have difficulty managing complicated drug regimens
- Especially difficult when patients are discharged from a hospital with some medications added and some ended
- Patients may not tell provider about OTC drugs and dietary supplements that can interact with other medications

Polypharmacy is associated with ADEs

- The relationship between the number of drugs taken and ADEs was consistent in multiple studies using different data, sites of care, and research designs
- Statistically significant predictor of hospitalization, nursing home placement, decreased mobility, cognitive decline, and death

Polypharmacy can result from different mechanisms

- Therapeutic competition – treatment for one condition worsens another condition
- Therapeutic duplication – use of multiple medications from the same therapeutic class at the same time
- Toxic combinations – when the interaction between two medications leads to serious complications

How can clinicians respond to polypharmacy?

- Reduce the number of medications prescribed
- Simplify drug regimen
- Limit the number of prescribers
- Avoid treating ADEs with more drugs if possible
- Patient/provider education

Potential policy options focused on opioids

- Point-of-service (POS) edits based on morphine equivalent dose (MED)
  - No FDA maximum dose
  - Require prescriber involvement
- Pharmacy and/or prescriber lock-in
  - Plans will still need to use MED and involve prescribers
  - May not be effective for LIS enrollees who switch plans

➔ Combine with an allowance for a temporary supply (e.g., 3-day supply) while determining clinical appropriateness?

Potential policy options for broader polypharmacy and inappropriate uses

- Incentives for Part D plans
  - Quality/performance measures tied to payment
  - More flexibility around utilization management
  - Medication synchronization
    - Aid in detection and prevention of polypharmacy?
    - Convenience (e.g., fewer trips to pharmacy)?
- Provider and/or pharmacy profiling

Summary

- Patterns of opioid use by Part D enrollees raise both clinical and program integrity concerns
- Goals of improving medication adherence must be balanced against polypharmacy
- Policy options to prevent opioid overuse may be applicable to broader polypharmacy issues and/or other inappropriate medication uses
- Potential policy changes would need to provide plans with incentives and tools to improve quality of pharmaceutical services