

Report to the Social Services Appropriations Subcommittee

Opioid Interventions

Prepared by the Division of Medicaid and Health Financing

July 1, 2018



EXECUTIVE SUMMARY

This report is submitted in response to the following language from the 2017 Interim's Budget Deep-Dive into Opioid Outreach Efforts:

The fiscal analyst recommends that the Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee intends that the Department of Health consult with the Public Employees Health Plan on its five changes made regarding opioid prescribing policies. The Department of Health shall report to the Office of the Legislative Fiscal Analyst by October 1, 2017 on whether the department should do something similar in Medicaid for all changes, a proposed timeline for implementation, and the reasons for pursuing or not pursuing each change taken by the Public Employees Health Plan.

Note: This intent language was passed in the Social Services Appropriation Subcommittee Interim meeting on June 20, 2017. Subsequently, the Subcommittee, in a motion on October 18, 2017, asked for an update to interventions not already fully addressed in the October 2017 report as follows:

The Department of Health shall report to the Social Services Appropriations Subcommittee by July 1, 2018 on the status of implementing each change taken by the Public Employees Health Plan for opioid interventions and not already fully addressed in the October 2017 report. (Action passed at 10/18/2017 meeting.) See <https://le.utah.gov/asp/interim/Commit.asp?Year=2017&Com=APPSOC> for the meetings minutes and recordings related to this motion. This will be discussed in the August Interim meeting.

Department of Health (DOH) staff attended a presentation by Public Employees Health Plan (PEHP) to discuss changes made to their opioid prescribing policies. PEHP has their own Pharmacy and Therapeutics (P&T) Committee to review and approve preferred drug status and utilization management strategies. With this responsibility, PEHP's P&T Committee is focused on safety and efficacy to determine its coverage for the opioid medications. These strategies were implemented by their contracted pharmacy benefit management vendor to manage the opioid medications.

DOH staff continue to work with PEHP staff to better understand the policy changes and will look at options allowed under law for Medicaid to consider.

PEHP Consultation Outcome

Department of Health (DOH) representatives met with Public Employees Health Plan (PEHP) representatives to discuss changes made to PEHP's opioid reimbursement policies. PEHP's general approach to employ private market practices such as:

- 1) Formulary management – This has two options: open or closed.
 - a) An open formulary covers all FDA approved drugs and utilizes cost sharing tiers to drive the utilization of prescription drugs. Tier 1 offers the lowest member cost sharing and Tier 3 offers the highest member cost sharing.
 - b) A closed formulary covers drugs chosen by the health plan and may not cover all FDA approved drugs. Closed formularies may utilize two or more cost sharing tiers.
- 2) PEHP has a Pharmacy & Therapeutics (P&T Committee) that meets quarterly to review prescription drugs based on available medical literature and treatment guidelines to determine clinical efficacy and safety along with utilization management criteria, if applicable. This Committee is comprised of seven local practicing physicians in the community representing the following specialties: Internal medicine; Neurology; Oncology; Psychology; and Rheumatology. The Committee provides clinical recommendations for coverage to PEHP.
- 3) An internal PEHP committee makes final determination on the coverage and tier placement for the prescription drugs.
- 4) Utilization management may include prior authorization or quantity limits.
 - a) Prior Authorization requires a prescribing provider to submit clinical information and meet predetermined standards before approval.
 - b) Quantity limits stop payment for quantities greater than doses recommended by the Food and Drug Administration.

PEHP made the following specific changes on their opioid medication coverage:

- 1) Placed opioid alternatives (non-opioid medications for pain) at Tier 1 or Tier 2 on the formulary, and eliminated associated prior authorization requirements;
- 2) Created quantity limits for short-acting opioid medications;
- 3) Created policy limiting the ability to shift overuse from long acting opioids to short acting opioids; Limited the number of long acting opioids covered at Tier 1 or Tier 2 and required prior authorization for all opioids covered at Tier 3;

- 4) Limited the quantity of long acting opioids to the FDA indication (e.g., a drug indicated to be taken twice per day is not allowed to be used four times per day)
- 5) Assist individuals who are using high opioid doses by:
 - a) Including only those who are using opioids to treat conditions not related cancer or end of life pain;
 - b) Identifying those receiving very high doses (e.g. doses greater than 150 morphine equivalents per day);
 - c) Requiring a consult with a pain specialist to re-authorize opioid treatment. The specialist's assessment may result in support of the current therapy or in a recommended plan to decrease opiate medication dose. Future authorizations are dependent on following the plan of care established by a specialist.
 - d) Those choosing not to follow the plan of care will not receive authorization.
 - e) Setting a total morphine equivalent dose (MME) limit to 150 MME / day (2014) and further reducing this to 120 MME / day (2018), thereby reducing opioid exposure per patient, per day.
 - f) Restricting the concurrent use of opioid and benzodiazepine medications. The pharmacy point of sale system will identify if a patient has received either an opioid or benzodiazepine medication in the last 30 days and will block a fill for either medication when filled within a 30 day window.

Should Medicaid make changes similar to the PEHP (Public Employees Health Plan) Opioid Management Program?

DOH staff continue to work with PEHP staff to better understand the changes made and to learn how DOH may use similar methods to identify Medicaid members who may benefit from treatment interventions. DOH pharmacy team have implemented the following strategies for the Medicaid fee for service (FFS) program:

- 1) Utah Medicaid's program has its own P&T Committee that meets monthly in a public forum to review prescription drug(s) based on evidence-based criteria and drug information to determine clinical efficacy and safety within each class for Preferred Drug List (PDL) recommendations. Based on these recommendations, decisions are made regarding the drug status (preferred or non-preferred) for the PDL. This Committee has the following representatives:
 - a) Four (4) physicians: Internal Medicine; Family Practice Medicine; Psychiatry; and Pediatrics;

- b) Four (4) pharmacists: Pharmacist in Academia; Independent Pharmacy; Chain Pharmacy; Hospital Pharmacy; and
 - c) DOH's P&T manager.
- 2) Utah Medicaid's utilization management for the pharmacy program is managed by the DUR (Drug Utilization Review) Board which have the following representatives:
- a) Four (4) physicians and one (1) physician engaged in academic medicine;
 - b) Three (3) pharmacists who are in retail pharmacy; one (1) pharmacist engaged in academic pharmacy; and one (1) pharmacist from the Accountable Care Organizations (ACOs);
 - c) One (1) dentist;
 - d) One (1) individual from pharmaceutical manufacturers; and
 - e) One (1) consumer representative.

This Board typically meets monthly in a public forum and is responsible for pharmacy utilization management with the development of prior authorization criteria, step therapy edits, and quantity limits based on the review of prescribing and dispensing patterns.

- 3) The University of Utah, College of Pharmacy is under contract with DOH to provide drug regimen reviews within its Drug Regimen Review Center (DRRC). This contract supports the DOH pharmacy team with two main goals:
- a) Researching and reviewing targeted drug classes and individual agents for the P&T Committee and DUR Board meetings.
 - b) Performing retrospective reviews on Medicaid client(s) who are frequent utilizers of the prescription drug program for appropriate therapeutic use with the safest pharmacotherapy.

The DRRC is staffed by six (6) pharmacists and three (3) data analysts.

- 4) The pharmacy prior authorization (PA) process is performed by two (2) registered nurses in the Bureau of Authorization and Community-Based Services (BACBS). This process helps ensure medications are provided based on medical necessity as determined by using criteria approved by the DUR Board. Prescribing providers submit their PA requests with supporting documentation for determination. The determinations are made within 24 hours of receipt of a complete request. Some PA requirements are as follows:

- a) High dose opioids are not authorized for use for non-cancer pain without a prior authorization.
 - b) Patients who are 18 years of age or younger may not receive a prescription for a long-acting opioid without a prior authorization.
- 5) Quantity limits on opiates were recommended by the DUR Board and implemented by the DOH pharmacy team:
- a) Short-acting opioid medications were limited to a 7-day supply effective on October 1st, 2016. On July 1, 2018, further restrictions on initial fills for short-acting opioid medications will be limited to a 3-day supply when prescribed by a dentist. These changes are intended to reduce the potential for abuse and addiction and to decrease potential waste by a person having more medication prescribed than was needed.
 - b) Each opioid medication was revised to have a specific quantity limit in order to reduce total pill count and discourage duplicate therapy. Some items that have been implemented are as follows:
 - i) Consistent with PEHP's policy, Utah Medicaid has instituted quantity limits for short-acting opioids. In addition, Utah Medicaid has placed a group quantity limit on monthly fills, restricting overall quantities for multiple short-acting prescriptions received per month.
 - ii) Similarly, long-acting opioid utilization is managed through monthly quantity limits on individual products. An additional monthly quantity restriction (a group quantity limit) limits the co-prescribing of multiple agents, identical methodology to the short-acting opioid limits.
- 6) Access to buprenorphine containing medications used for the treatment of opiate dependence has been increased to assist persons seeking help in overcoming an opiate addiction. Prescribing physicians do not need to submit a PA request for initial the start of treatment. After 180 days of treatment, a PA request will be needed for continuation of therapy on an annual basis.
- 7) Refills on opiates will be paid after 100 percent of the previous prescription has been exhausted. This policy is intended to discourage potential abuse and to encourage evaluation by the prescribing provider for appropriate medical use.
- 8) Utah Medicaid is evaluating opioid use patterns to identify better methods to enhance the safe and appropriate use of these medications.

- a) The FDA has placed a black box warning for concurrent use of benzodiazepine medications with opioids due to the increased risk of death due to respiratory depression. The DUR board has recommended the concurrent use of these two classes of medications be restricted. Utah Medicaid will further protect our membership by restricting concurrent access to these medications and is working to implement these changes by the end of this year.
- b) Daily morphine equivalent dosing (MME) limits have been established by the CDC as a standardized way to promote safety and limit abuse and addiction of opioid containing products. Utah Medicaid is working with its Point of Sale pharmacy vendor to build the necessary reporting to support MME conversion and promote improved standards of use.
- c) Like PEHP, Utah Medicaid will identify high-dose opioid users and build strategies to better assist in promoting appropriate care. Future strategies being considered include:
 - i) PA restriction for high-dose utilizers
 - ii) Referral to specialists and partnership with community prescribers
 - iii) Consideration for lock-in / restriction program
 - iv) Peer-to-peer consultations

Note: Some of the items PEHP is doing requires case management-type follow-up. DOH is not currently funded for case managers which makes implementation of portions of the PEHP changes impracticable to implement.

What Is the Proposed Timeline for Implementation of Changes?

Once a determination of changes is made, DOH staff will work through the normal process to update any changes determined.

Reasons for Pursuing or Not Pursuing Each Change Taken by PEHP

A cautious approach must be taken to ensure changes do not run afoul of any regulatory requirements as they are different for the Medicaid program.