NAMD Opioid Abuse Report

Kathleen Nolan
National Association of Medicaid Directors
February 10, 2015
Impact of Rx Abuse in Medicaid

• Nationwide, prescription drug abuse increased dramatically in the past decade.
  – Much of the impact in opioids/pain medication.

• Medicaid bears more of the burden.
  – Medicaid participants twice as likely to be prescribed painkillers as their privately insured counterparts.
  – Medicaid enrollees account for 45% of overdose deaths, and have 6 times the risk.

National Association of Medicaid Directors
Some of the challenges

- Functional data for state and for providers
- Evidence-based pain treatment and co-occurring SUDs
- Diversion and cash payments
- Care coordination and treatment within different benefit structures and across provider types.

National Association of Medicaid Directors
Focus on options for state action

With support from Centers for Disease Control and Prevention, NAMD asked Mercer to recommend some options for state Medicaid. These ideas fall into six areas:

- Improving Medicaid data and analytic infrastructure
- Adopting prevention measures
- Tracking and intervening through enrollee and provider-level efforts
- Ensuring effective treatment of addiction
- Strengthening cross-agency collaboration
- Working at the national level and across states
Recommendations: Medicaid Infrastructure

• Leverage Medicaid’s role as purchaser to drive accountability through provider agreements/MCO contracts.

• Invest in technology enhancements for MMIS and claims processing systems that show “hot-spots.”

• Expand integrated SUD treatment options.

• Support plan and provider level innovations that reduce misuse and overdoes.
Recommendations: Proactive Prevention Measures

- Provider education around evidence-based practices.
- Consider daily dosing maximums or other limits.
- **Promote coordinated care, early detection, and early intervention.**
- DUR boards develop prospective edits and retrospective reviews for overutilization.
- Increase the use of non-pharmacological pain management interventions, including pain centers that limit Rx use.
Recommendations: Active monitoring and surveillance

- Identify excessive use of opioids
- Maximize your PDMP
- Mine data
- Establish or enhance lock-in programs
- Utilize clinical pharmacy resources for evaluation of prescribing and drug utilization patterns against evidence-based practice guidelines
Recommendation: Treatment for addiction

• Optimize timely access to SUD services, including MAT.

• Improve evidence-based treatment for chronic pain.

• **Promote high-quality, outcomes-driven SUD services.**

• Support access to Naloxone to reduce overdose deaths.
Recommendation: Cross-Agency Collaborative Efforts

• Lead/participate in cross-agency prevention and control initiatives.

• Advocate for enhanced PDMP functionality.

• Partner with other state agencies and health plans in monitoring and data mining efforts.

• Require mandatory e-prescribing of controlled substances.

National Association of Medicaid Directors
Making a Difference: State Successes

**New York**
75% ↓

**2012 Action:**
New York required prescribers to check the state’s prescription drug monitoring program before prescribing painkillers.

**2013 Result:**
Saw a 75% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose.

**Florida**
50% ↓

**2010 Action:**
Florida regulated pain clinics and stopped health care providers from dispensing prescription painkillers from their offices.

**2012 Result:**
Saw more than 50% decrease in overdose deaths from oxycodone.

**Tennessee**
36% ↓

**2012 Action:**
Tennessee required prescribers to check the state’s prescription drug monitoring program before prescribing painkillers.

**2013 Result:**
Saw a 36% drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher risk of overdose.

Source: [http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html#infographic2](http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html#infographic2)
Beyond Medicaid

• Working across agencies Public education campaigns and other prevention efforts.

• Provider leadership and commitment essential.

• Law enforcement partnerships can accelerate success.
For More Information


• Visit the NAMD website: www.medicaiddirectors.org

• Contact NAMD staff
Missouri Opioid Prescription Intervention

CMT
Use of Opioids for 60 or More Days with a Diagnosis Suggesting Opioid, Alcohol or other Substance Abuse in the Last Year

According to our data, your patient has received opioids for 60 or more days (including possession of an opioid prescription in the last 30 days of the 3-month reporting period). In addition, our data show that a diagnosis suggesting opioid, alcohol, or other substance abuse has been made in the last year. (We estimate that about 3% to 6% of adults receiving any opioid in the last 3 months meet the criteria for this alert.)

We understand that you may be already aware of this situation. In addition, the opioid abuse diagnosis may or may not be clinically accurate. On the other hand, this information would be useful to you if you were not aware of the opioid abuse diagnosis and it is accurate.

Please review the information to assess whether our data are consistent with your understanding of the patient’s case. You may wish to consider discussing this matter with your patient.

This indicator identifies adult patients (age 18 through 64 years) who have been prescribed opioids for at least 60 days in the last 3 months, with a diagnosis suggesting opioid, alcohol, or other substance abuse in the last year.

Diagnoses suggesting opioid abuse:
- 304.0* (Opioid dependence)
- 304.7* (Multi-drug [including opioid] dependence)
- 305.5* (Opioid abuse)

Diagnoses suggesting alcohol abuse:
- 291.0* (Delirium tremens)
- 291.1* (Alcohol amnestic syndrome)
- 291.2* (Alcoholic dementia)
- 291.81 (Alcohol withdrawal syndrome)

Diagnoses suggesting other substance (non-alcohol) abuse:
- 292.0* (Drug withdrawal syndrome)
- 292.1* (Drug-induced psychotic disorders)
- 292.8* (Drug-induced delirium, dementia/psychiatric disorders)
- 292.9* (Drug-induced Disorder NOS)
- 304.* (except 304.7*) (Various Substance Dependence)
- 305.* (except 305.1*, .5*, .8*) (Various Substance Abuse)
OPIOID Prescriber Benchmark Summary

July 24, 2014

Dear Dr. Webber:

... is committed to providing safe, quality health care for our members. The purpose of the Opioid Prescriber Benchmark is to partner with you to improve both patient safety and quality of care through the sharing of information. Recent paid prescription claims data have identified you as a High Dose Prescriber of Opioids. High dose prescribers were identified as those who have prescribed >120 Morphine Equivalent Dose (MED) of opioids to 1 or more members during the reporting period. "Please note members with a known malignant cancer diagnoses and oncologists are excluded from this data set.

The benchmark summary below compares your average prescribed dose of opioids to pain management specialists and non pain management physicians.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Your Mean Dose</th>
<th>Pain Management Specialists Mean Dose</th>
<th>Non-Pain Management Specialists Mean Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>FENTANYL</td>
<td>0.00 mgs/day</td>
<td>29.00 mgs/day</td>
<td>59.00 mgs/day</td>
</tr>
<tr>
<td>HYDROCODONE</td>
<td>20.00 mgs/day</td>
<td>22.00 mgs/day</td>
<td>30.00 mgs/day</td>
</tr>
<tr>
<td>MORPHINE</td>
<td>117.00 mgs/day</td>
<td>30.00 mgs/day</td>
<td>30.00 mgs/day</td>
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<tr>
<td>OXYCODONE</td>
<td>0.00 mgs/day</td>
<td>45.00 mgs/day</td>
<td>30.00 mgs/day</td>
</tr>
<tr>
<td>TRAMADOL</td>
<td>22.00 mgs/day</td>
<td>40.00 mgs/day</td>
<td>40.00 mgs/day</td>
</tr>
</tbody>
</table>

Patients receiving ≥ 100 MED have a 9 fold increase in overdose risk.1

Guidelines from Washington State Agency Medical Directors’ Group recommend NOT prescribing more than 120 MED without the patient demonstrating improvement in function and pain OR obtaining a consultation from a pain management specialist.

Please consider one or more of the following responses:

☐ This information was helpful and I will take into consideration.
☐ I would like to request a pain management consultation.
☐ I would like additional information or training materials on this subject.
☐ Other: _______________________________

If you have checked one or more responses please fax to 888-241-3361

Sincerely,

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Overview

Original Mailing QIs

• Patient’s use of 5 or more prescribers for Opioid prescriptions.
• Use of Opioids for 60 or more days with a diagnosis suggesting Opioid, alcohol or other substance abuse in the last year.
• Use of Opioids for 60 or more days with two or more diagnoses of malingering, somatization or factitious disorder.
• Use of Buprenorphine with another Opioid (prescribed by another physician).
• Use of Buprenorphine with a Benzodiazepine (prescribed by another physician).
Overview

New Mailing QIs Following Expansion

• Use of cough and cold medications containing Opioids - Adult / Child / Elderly

• Patient's use of 4 or more pharmacies for Opioid Rxs – Adult

• Patient's use of 5 or more prescribers for Opioid Rxs - Child / Elderly

• Use of Opioids for 60 or More Days in Absence of a Diagnosis Supporting Chronic Use - Adult / Child / Elderly
# Overview

## Mailing Statistics - Overview

<table>
<thead>
<tr>
<th>Mailing Date</th>
<th>Patients</th>
<th>Providers</th>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/25/2013</td>
<td>2,627</td>
<td>1,786</td>
<td>Original 5 QIs</td>
</tr>
<tr>
<td>4/22/2013</td>
<td>3,219</td>
<td>1,273</td>
<td></td>
</tr>
<tr>
<td>6/27/2013</td>
<td>33,780</td>
<td>1,675</td>
<td></td>
</tr>
<tr>
<td>8/30/2013</td>
<td>28,422</td>
<td>1,594</td>
<td>5 Original QIs + Expansion QIs</td>
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<tr>
<td>10/30/2013</td>
<td>27,238</td>
<td>1,566</td>
<td></td>
</tr>
<tr>
<td>12/20/2013</td>
<td>26,093</td>
<td>1,585</td>
<td></td>
</tr>
<tr>
<td>2/14/2014</td>
<td>25,900</td>
<td>1,646</td>
<td></td>
</tr>
<tr>
<td>4/21/2014</td>
<td>27,572</td>
<td>1,603</td>
<td></td>
</tr>
<tr>
<td>6/20/2014</td>
<td>27,897</td>
<td>1,756</td>
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</tr>
</tbody>
</table>
Overview

After mailing summary reports:

• Following each mailing, summary reports are emailed to Missouri administrative staff.

• Those reports include:
  – OPI QI Summary (list of QIs with patient and prescriber counts and percentages)
  – High Risk Substance Abuse Patient Report
  – Prescriber Identified High Risk Patients Report
  – Prescribers More Likely to Treat Patients with SA Report
  – OPI Intervention Report (selected QIs and counts of patients and prescribers)
  – OPI CMHC and CMHC-Prescriber Benchmark Reports
Overview

Successes of the current OPI program in Missouri – Original QIs:

QI 883: Use of Opioids for 60 or More days with a diagnosis suggesting Opioid, alcohol or other substance abuse in the last year

Initial QI Triggering Resulted in Intervention

<table>
<thead>
<tr>
<th>Data Year Month</th>
<th>% Patients Triggering QI per month</th>
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</thead>
<tbody>
<tr>
<td>201307</td>
<td></td>
</tr>
<tr>
<td>201309</td>
<td></td>
</tr>
<tr>
<td>201311</td>
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<tr>
<td>201401</td>
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<td>201407</td>
<td></td>
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<tr>
<td>201409</td>
<td></td>
</tr>
<tr>
<td>201411</td>
<td></td>
</tr>
</tbody>
</table>
Overview

Successes of the current OPI program in Missouri – Original QIs:

QI 889: Use of Opioids for 60 or more days with two or more diagnoses of malingering, somatization or factitious disorder

Triggering % Change | July 2013 Data | August 2013 Mailing

Initial QI Triggering Resulted in Intervention
Overview – Multiple Baseline Analysis FY2014

Successes of the current OPI program in Missouri – Original QIs:

Opioid Spend PMPM | Original 5 QIs | Adults

\[ y = 8.0306x + 31.423 \]
Overview – Multiple Baseline Analysis FY2014

Successes of the current OPI program in Missouri – Original QIs:

\[ y = 81.59x + 559.33 \]

Combined Hospital, ER and Opioid Spend PMPM | Original 5 QIs | Adults

- PharmacyTotalPaid_Cost_Hosp_Cost_ER (method 2) PRE
- PharmacyTotalPaid_Cost_Hosp_Cost_ER (method 2) POST
- PharmacyTotalPaid_Cost_Hosp_Cost_ER (method 2) PROJECTED
- Linear (PharmacyTotalPaid_Cost_Hosp_Cost_ER (method 2) PRE)
Overview – Multiple Baseline Analysis FY2014

Successes of the current OPI program in Missouri – New QIs:

Hospital Visits PMPM | Expansion QIs | Adults

\[y = 0.0007x + 0.0245\]

Graph showing the trend in hospital visits per member per month (PMPM) for Adults, with PRE, POST, and PROJECTED data points and a linear regression line.
Overview – Multiple Baseline Analysis FY2014

Successes of the current OPI program in Missouri – New QIs:

Hospital Visits PMPM | Expansion QIs | Children

\[ y = 0.0009x + 0.0041 \]
Overview – Three Month Pre/Post Analysis

Successes of the current OPI program in Missouri – Original QIs:

- Estimated savings of $217,034 in opioid pharmacy cost avoidance – an average of $20.69 per intervened patient per month for 3,496 individuals eligible for 3 months follow-up.

- Significant decrease of emergency department visits by 37.84%* and hospital admits decreased by 37.82%*

- Average patient usage of 37.1%* fewer opioid prescribers and 31.2%* fewer opioid pharmacies

- Average monthly dose of opioids (in morphine equivalents) dispensed fell 17.9%*

- Three Month Pre/Post analysis includes MO HealthNet clients from the eight OPI mailing interventions from 2/25/2013 through 4/21/14.

* comparing 3 months pre-intervention to 3 months post-intervention | p<.001
Multiple Baseline Regression Analyses Methodology

- Study included eligible adult/child/elderly first intervened in 2013/2014.

- Patient/Months in the analysis included where spend is greater than zero or subject is Medicaid-eligible for the entire month.

- Study excludes subjects who:
  - Were part of a BPM intervention in this report
  - Were included in any BPM or OPI intervention in 2012
  - Are dual eligibles

- End date for claims analysis was 8/22/2014.

- Cost avoidance related to Hospitalizations, ER and Opioid Rx estimate is $40 million.

Note: A multiple baseline analysis has multiple cohorts and multiple study periods, hence no single reporting period applies to all cohorts.
Overview

Successes of the expanded OPI program in Missouri – New QIs:

- Expansion started with mailings in June 2013
  - Substantial increase in mailing volume
  - Approximately 20x as many clients impacted as before per mailing
- Estimated $454K savings on Opioids for FY 2013-2014
  - Adult: $7.16 PMPM x 17,142 individuals x 3 Months = $368K
  - Child: $16.54 PMPM x 1,530 individuals x 3 Months = $76K
  - Elderly: $1.36 PMPM x 2,439 individuals x 3 Months = $10K
Overview

Successes of the expanded OPI program in Missouri – New QIs:

- Significant decrease of emergency department visits by 10.2%* for adults and a decrease of 45.3%* for children.

- Significant decrease in hospitalizations by 43.7%* for children.

- Average usage of opioid prescribers dropped by 12.6%* for adults, 11.8%* for elderly and 77.6%* for children.

- Average number of pharmacies used to obtain opioids decreased 13.1%* for adults, 77.1%* for children and 10.0%* for elderly.

- Average monthly dose of opioids (in morphine equivalents) dispensed fell 8.1%* for adults, 52.3%* for children and 11.3%* for elderly.

* comparing 3 months pre-intervention to 3 months post-intervention / p<.001
Addressing Opioid Abuse & Dependence

Connecticut Medicaid Program and Other Connecticut Based Initiatives to Address Opioid Abuse and Dependence

Lauren Siembab, Dept. of Mental Health and Addiction Services
William Halsey, Dept. of Social Services
OPIOID RELATED DEATHS

• According to the Office of the CT Chief Medical Examiner:

• 2012 – 174 heroin related deaths

• 2013 – 257 heroin related deaths

• Jan-June, 2014 – approximately 300 determined so far
CONNECTICUT APPROACHES

• Internal Single-State Agency Workgroup  (CT Department of Mental Health & Addiction Services)

• Statewide Overdose Prevention Workgroup  (Initiated by local HIV/AIDS Advocacy Group; includes numerous stakeholders)

• Regional Governor’s Association Initiative  (New England states and New York)

• SAMHSA Policy Academy  (multi-agency group consisting of state and PNP agencies)

• ASTHO (Association of State and Territorial Health Officials) Initiative  (collaborative with CT Department of Public Health)
Connecticut Interventions

• DMHAS: produced and widely disseminated a video titled “Back from the Brink: The Case for Narcan”.

• DMHAS Prevention Division and contracted agencies, CT Department of Consumer Protection/Office of State Drug Control: Education through media campaigns and training regarding proper medication storage, monitoring the use of prescription drugs, educating about the side effects/addictive qualities of drugs, parenting education related to drug abuse/misuse, etc.

• CT Department of Consumer Protection: Advocating and supporting proper medication disposal including advertising drug “take-back” days, expanding number of and promoting drop boxes at police departments. Currently, there are 45 drop-boxes statewide.
CT legislation supporting the use of Narcan:

October 2012, CT law allows prescribers to prescribe, dispense or administer naloxone to treat or prevent an opioid overdose without being liable for damages in a civil action or subject to criminal prosecution.

On May 6, 2014 CT law was passed and becomes law Oct 1, 2014. The law gives Good Samaritan protection, granting civil and criminal liability protection to a bystander who administers Narcan in good faith to someone who has overdosed.

Pending: Giving CT pharmacists prescriptive authority to allow citizens to purchase Narcan “over-the-counter”.
Connecticut Interventions (Continued)

• **The CT Department of Consumer Protection/Office of State Drug Control:** maintains the prescription drug monitoring program to decrease opportunities to receive opioid prescriptions from multiple prescribers.

• **The CT Department of Public Health:** changed the EMS “scope of practice” to allow administration of Narcan by not only paramedics but also by EMTs.

• **The CT Department of Public Health:** has developed and circulated “Opioid Prescribing Guidelines for Emergency Departments”.

• **CT State Police:** Received training in Narcan administration in mid-October using a training module developed by the CT Department of Public Health and now carry Narcan while on duty.
INDIVIDUALS RECEIVING METHADONE MAINTENANCE SERVICES IN CT

- 16,000 clients
- 28 clinics
- 10 agencies (8 PNP, 2 PFP)
Continuing Challenges

- Stigma associated with medication assisted treatment, especially methadone
- Expanding availability of Suboxone and Naltrexone in Outpatient Clinics
- Funding additional distribution of Narcan to PNP providers
- Prescribing behaviors of doctors and others regarding prescription opioid painkillers
CT. Medicaid Program

Covers traditional treatment services for opioid use & dependence:

- Hospital and Residential detoxification for acute withdrawal symptoms
- Ambulatory Detoxification
- Intermediate care (PHP & IOP)
- Routine Outpatient
- Chemical Maintenance Therapy/Methadone Maintenance
CT Medicaid Pharmacy Benefit

Medication is available to support individuals with opioid abuse and/or dependence:

– Naloxone
– Buprenorphine/Naloxone
– Naltrexone
Drug Utilization Review (DUR) collects and analyzes pharmacy claims data against established DUR Board approved criteria to identify and correct aberrant prescribing practices, client misuse, and fraud.

DUR also identifies potential pharmacy restriction candidates.

Medicaid members who are found to be misusing their pharmacy benefit are restricted to the use of a single pharmacy for one year under CT. state law.

DUR sets prospective edits: multiple drugs to treat the same condition, ingredient duplication (same drug), drug/drug interaction, and early re-fill.
Pharmacy Lock-in

• Members are restricted to a single pharmacy through a three step process
  – Initial letter to member, warning letter, restriction letter
• There is a three month period in between each step to allow the member to correct behavior
• Members on the pharmacy restriction are reviewed annually
Community Health Network (CHN), the medical Administrative Services Organizations (ASO) and ValueOptions (VO), the behavioral health ASO are collaborating on a pain management plan for Medicaid providers and beneficiaries.

- CHN identified 988 members in Q1 2014, over the age of 21, considered to be at high risk for inappropriate utilization of opiate medications:
  - 53% have a mental condition as a primary or secondary diagnosis
  - 15% have been identified as being high utilizers of the ED
Goals of the Pain Management Program

- Minimize the misuse, abuse and diversion of opiate pain medication;
- Ensure members receive comprehensive pain management services;
- Ensure members have access to Medicaid enrolled pain management providers;
- Facilitate timely access to treatment for substance use disorders;
- Decrease the inappropriate use of ED utilization in the target population.
Individuals with history of substance use discharging from nursing homes presented a challenge to the MFP program. Many individuals relapsed upon discharge or increased their use of substances. MFP modified their screening tool to ask about substance use prior to admission to the nursing home to better assess their treatment needs upon discharge. Current practice is to facilitate a referral and admission to substance abuse treatment two months prior to discharge from the nursing home.
Additional non-Medicaid Specific Initiatives to Address Opioid Abuse/Dependence and Pain Management
The Connecticut Hospital Association, Connecticut State Medical Society, Connecticut Chapter of the American College of Emergency Physicians and the Connecticut Dept. of Public Health have endorsed a set of voluntary guidelines for help ED physicians treat individuals who come to the ED with chronic pain conditions.

ED should coordinate care for frequent visitors
In general, prescriptions for acute injuries should not exceed 30 days;
ED staff should ask about history of substance use and if there is such a history, opioids should be prescribed with great caution;
In general, replacement prescriptions should not be provided for controlled substances lost, destroyed or stolen;
In general, long acting opioids should not be prescribed for acute pain management; and
Exercise caution in prescribing opioids if the identity of the patient cannot be verified.
CT Contacts

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