

# Report to the Office of the Legislative Fiscal Analyst

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## Opioid Interventions

Prepared by the Division of Medicaid and Health Financing

September 30, 2017



## 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.

Department of Health (DOH) staff met with representatives from the 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 opioid medications. These strategies were implemented by their contracted pharmacy benefit management vendor to manage opioid medications.

DOH staff continue to work with PEHP staff to better understand their 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 is to employ private market practices such as:

1. Formulary management – There are 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 the final determination on the coverage and tier placement for 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 to 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.

**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 PEHP made and to learn how DOH may use similar methods to identify Medicaid members who may benefit from treatment interventions. The DOH Medicaid pharmacy team has 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 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 by:
  - 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 three (3) 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.
- 5) Quantity limits on opiates were recommended by the DOH DUR Board and implemented by the DOH pharmacy team:
  - a) Short-acting opioid medications were limited to a 7-day supply effective on October 1<sup>st</sup>, 2016. This change is intended to reduce potential of addiction and to decrease potential waste by a person having more medications 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.

- 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.

Note: Some of the strategies PEHP uses require care management services. For example, PEHP uses nurse care managers to reach out to beneficiaries. DOH is not currently funded for nurse case managers which makes implementation of this strategy used by PEHP difficult to implement.

### **What Is the Proposed Timeline for Implementation of Changes?**

Many of the strategies used by PEHP are already in place for Medicaid. Some strategies employed by Medicaid such as limiting the way in which certain drugs are dispensed are not used by PEHP due to the difference in beneficiary demographics. Implementing the use of nurse case managers in Medicaid will require an additional appropriation. DOH staff continue to have discussions with PEHP's Pharmacy Director to share strategies and ideas

### **Reasons for Pursuing or Not Pursuing Each Change Taken by PEHP**

Some strategies used by PEHP will require additional appropriations before they can be implemented by DOH. In addition, any change must be evaluated to assure it is appropriate and effective with the different populations served by Medicaid and that it is not in conflict with federal regulations