

Evaluation of Opioid Drug Prescribing Practices Under Medicaid

As Required by

House Bill 1, 86th Legislature, Regular
Session, 2019 (Article II, Health and
Human Services Commission, Rider 34



TEXAS
Health and Human
Services

September 2020

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Executive Summary

The 2020-2021 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 34), requires the Health and Human Services Commission (HHSC) to evaluate and report on prescribing practices for opioid drugs in the State Medicaid program, including the extent practices align with the prescribing guidelines for opioid drugs adopted by the Centers for Disease Control and Prevention (CDC). The report also includes findings of the evaluation and recommendations for next steps. This report is due to Legislature, Legislative Budget Board, and the Governor by September 1, 2020.

The *Evaluation of Opioid Drug Prescribing Practices Under Medicaid* report evaluated eight of the twelve (12) CDC guidelines, using available Medicaid claims data, to determine if HHSC Medicaid members were being treated for chronic pain according to the CDC guidelines. Four CDC guidelines were not evaluated because they relate to member and provider communications that are not captured in claims data. The Medicaid data set included both fee-for-service (FFS) and managed care claims.

Though the CDC guidelines did not suggest an adherence threshold, the Texas Medicaid data reflected high percentages of prescribers aligning with the guidelines, suggesting general adherence. Texas Medicaid has taken steps to ensure the safety of Medicaid members. Since 2011, Medicaid began implementing clinical prior authorizations (PA), quantity limits, and Morphine Milligram Equivalents (MME) limits for pharmacy opioid claims. Managed care organizations (MCOs) can utilize approved clinical PAs, quantity, and MME limits.

HHSC is implementing a uniform policy on September 1, 2020, for opioid prescribing. The policy will align MCO and FFS processes for prescribing opioids, including claim review limitations, required retrospective drug utilization review (DUR) activities, requirements for monitoring antipsychotic medications for children, and fraud and abuse identification. HHSC will continue to remain diligent in aligning with CDC prescribing guidelines.

1. Introduction

Texas HHSC evaluated the prescribing practices for opioid drugs in the state Medicaid program, including the extent they align with the CDC guidelines for prescribing opioids for chronic pain, in accordance with HHSC Rider 34. HHSC used the following CDC guidelines and opioid claims data to evaluate prescribing practices. Though the CDC guidelines did not suggest an adherence threshold, the Texas Medicaid data reflected high percentages of prescribers aligning with the guidelines, suggesting general adherence.

Texas Medicaid has taken steps to ensure the safety of Medicaid Members. Since 2011, Medicaid began implementing clinical prior authorizations (PA), quantity limits, and Morphine Milligram Equivalents (MME) limits for pharmacy opioid claims. Managed care organizations (MCOs) can utilize approved clinical PAs, quantity, and MME limits. In July 2020, a new CDC opioid workgroup was established to evaluate the 2016 CDC guidelines. Texas HHSC will continue to monitor the CDC workgroup's progress and make any necessary changes to align with best practices for opioid therapy prescribing methods.

Category One - Determining when to initiate or continue opioids for chronic pain

1. Opioids are not first-line therapy - Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Establish goals for pain and function - Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.
3. Discuss risks and benefits - Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Category Two - Opioid selection, dosage, duration, follow-up, and discontinuation

1. Use immediate-release opioids when starting - When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
2. Use the lowest effective dose - Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to greater than or equal to 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to greater than or equal to 90 MME/day or carefully justify a decision to titrate dosage to greater than or equal to 90 MME/day.
3. Prescribe short durations for acute pain - When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
4. Evaluate benefits and harms frequently - Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Category Three - Assessing risk and addressing harms

1. Use strategies to mitigate risk - Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (greater than or equal to 50 MME/day), or concurrent benzodiazepine use, are present.

2. Review prescription drug monitoring program (PDMP) data - Clinicians should review the patient's history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.
3. Use urine drug testing - When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
4. Avoid concurrent opioid and benzodiazepine prescribing - Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
5. Offer treatment for opioid use disorder - Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

2. Background

In March 2016, the CDC published guidelines for primary care clinicians treating adult patients for chronic pain in outpatient settings, *CDC Guideline for Prescribing Opioids for Chronic Pain*.¹ Patient care and safety is central to the guideline and it was developed to:

- Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain,
- Provide safer, more effective care for patients with chronic pain, and
- Help reduce opioid use disorder and overdose.

The 12 CDC guidelines fall into three categories: determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms. The guidelines are intended for primary care clinicians (e.g., family physicians and internists) who are treating patients with chronic pain (i.e., pain lasting greater than three months or past the time of normal tissue healing) in outpatient settings. The guidelines are intended to apply to patients aged 18 years of age or older with chronic pain outside of active cancer treatment, sickle cell disease, palliative or end-of-life care. The recommendations are not intended to provide guidance on use of opioids as part of medication-assisted treatment for opioid use disorder.

In October 2017, the President of the United States declared the opioid crisis a public health emergency. According to Alex M. Azar II, Secretary of the Department of Health and Human Services, more than 72,000 Americans died in 2017 due to drug overdose, most of the overdoses involved opioids.²

¹ Center for Disease Control and Prevention. Fact sheet: CDC Guideline for Prescribing Opioids for Chronic Pain. March 18, 2016. Retrieved April 9, 2020 from www.cdc.gov/drugoverdose/prescribing/guideline.html

² Azar, A. Trump Administration Making Progress in Fight Against Opioid Epidemic. September 19, 2018. HHS.gov, 2018. Retrieved April 8, 2020 from <https://www.hhs.gov/about/leadership/secretary/op-eds/trump-administration-making-progress-in-fight-against-opioid.html>

Texas continues to have one of the lowest rates of drug overdose deaths involving opioids. In 2017, there were 1,458 overdose deaths involving opioids in Texas — a rate of 5.1 deaths per 100,000 persons, compared to the national rate of 14.6 deaths per 100,000 persons.³

From 2011 to 2017, the Texas Medicaid program implemented policies and processes to promote appropriate prescribing and utilization of opioids.

- January 2011 - Texas Medicaid implemented an opiate overutilization PA. This PA ensures members do not have three opioid claims within 60 days of a new prescription. The oxycodone extended-release agents low dose PA was also implemented. Extended-release opioids relieve pain for a longer amount of time. The extended-release medication works in a slower manner, safer, and they use lower doses and offer much more consistent results.
- July 2016 - A new PA examining opiate, benzodiazepine, and muscle relaxant combinations was implemented to ensure the safety of members and help reduce addiction to opioids and opioid overdoses.
- December 2017 - To help mitigate the risks of high opioid dosages, Texas Medicaid developed a clinical PA for Morphine Milligram Equivalents (MME) limits, based on CDC guidelines. The PA identifies opioid claims above a 90 MME threshold alerting the pharmacist and requiring the prescription to be reviewed and resolved with the prescriber. In accordance with CDC guidelines, this clinical PA does not restrict patients with sickle cell disease, cancer pain, palliative or hospice care.

³ National Institute on Drug Abuse. Texas Opioid Summary. March 2019. Retrieved on April 9, 2020 from <https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/texas-opioid-involved-deaths-related-harms>

3. Methodology and Results

Methodology

For this report, HHSC conducted a retrospective DUR. A retrospective DUR is an examination of medical and pharmacy claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs. This examination involves a pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. A retrospective DUR uses the latest data, typically the last 30 days of information. If the review identifies outlier prescribing patterns an intervention is performed. Interventions can occur in the form of contacting a prescriber or a peer-to-peer review with the prescriber.

This retrospective DUR consisted of a review of FFS and managed care claims data for Medicaid members who were prescribed opioids from February 15, 2020 to March 15, 2020. The examination consisted of a pattern analysis of physician prescribing practices, using CDC guidelines. There are 12 CDC recommendations. Of those, eight are measurable by examining claims data and the other four require access to detailed medical records. For this reason, the analysis only included the CDC guidelines which are measurable using claims data.

The total number of opioid prescription drug claims for the reporting period was 52,622. The 52,622 opioid claims represent 1.9% of all prescription drug claims for the reporting period.

Results

The results of the analysis for each individual guideline are presented within the three CDC categories, including information about which CDC guidelines were not measurable through the use of claims data.

Category One - Determining when to initiate or continue opioids for chronic pain

1. Opioids are not first-line therapy - Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined

with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Results - The guideline is a clinician and member-centered decision involving consideration of options such as the use of over-the-counter pain relievers and multi-modal therapies that may combine exercise or physical therapies with psychological based approaches. HHSC was unable to quantitatively measure this guideline because this information is not available in the claims data.

2. Establish goals for pain and function - Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Results - The guideline is a clinician and member-centered decision. HHSC was unable to quantitatively measure this guideline because this information is not available in the claims data.

3. Discuss risks and benefits - Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Results - The guideline is a clinician and member-centered decision. HHSC was unable to quantitatively measure this guideline because this information is not available in the claims data.

Category Two - Opioid selection, dosage, duration, follow-up, and discontinuation

1. Use immediate-release opioids when starting - When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.

Results - The data showed 99.9% of the claims used immediate-release opioids.

2. Use the lowest effective dose - Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to greater than or equal to 50 MME/day, and should avoid increasing dosage to greater than or

equal to 90 MME/day or carefully justify a decision to titrate dosage to greater than or equal to 90 MME/day.

Results - The data showed 95.1% of claims contained doses of less than or equal to 90 MME/day.

3. Prescribe short durations for acute pain - When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

Results - To measure adherence to this guideline, HHSC used a PA edit which checks if a prescription is for 10 days or greater. From the subset of prescriptions impacted by this edit, HHSC identified those which were within the CDC guidelines. The data showed 92.8% of the acute pain claims were for less than or equal to 7 days of opioid therapy.

4. Evaluate benefits and harms frequently - Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Results - The guideline is a clinician and member-centered decision. HHSC was unable to quantitatively measure this guideline because this information is not available in the claims data.

Category Three - Assessing risk and addressing harms

1. Use strategies to mitigate risk - Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (greater than or equal to 50 MME/day), or concurrent benzodiazepine use, are present.

Results - The data showed 89.1% of the claims included naloxone for those members who could have an increased risk of opioid overdose.

2. Review prescription drug monitoring program (PDMP) data - Clinicians should review the patient's history of controlled substance prescriptions using state

PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

Results - HHSC was unable to quantitatively measure the specific guideline because information on clinician review of PDMP data is not available in the claims data. However, the data showed 97.5% of claims did not have multiple prescribers for opioids.

3. Use urine drug testing - When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Results - The data showed 81.5% of claims had a urinalysis conducted for Medicaid members receiving opioid therapy. HHSC was unable to determine if a urine drug test was conducted prior to starting opioid therapy with the prescription drug claims that were reviewed since the prescriber does not need disclose the reason for the urinalysis test.

4. Avoid concurrent opioid and benzodiazepine prescribing - Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Results - The data showed 94.8% of claims did not have concurrent opioid and benzodiazepine prescribed.

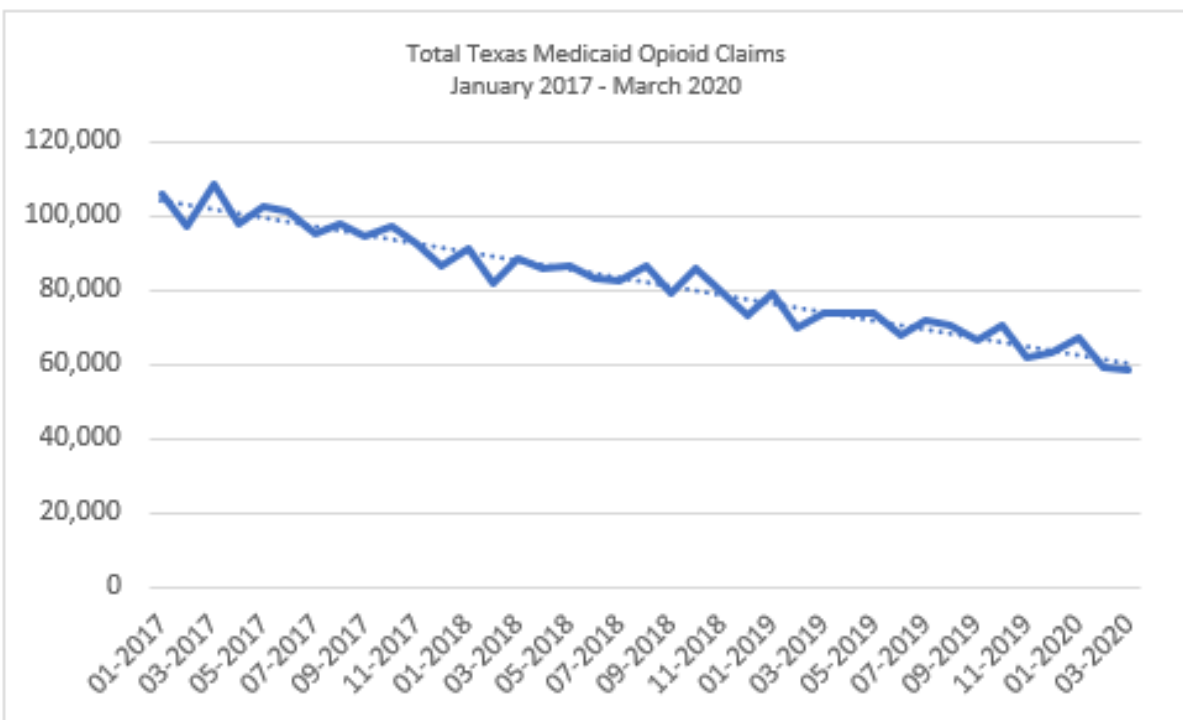
5. Offer treatment for opioid use disorder - Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Results - The data showed 98.7% of the claims indicated medication-assisted treatment for Medicaid members with opioid use disorder.

4. Next Steps

Texas Medicaid will continue using the CDC guidelines and evidence-based therapies to fight the opioid crisis and promote our members' health and safety. The table below shows the continued decline of opioid claims in Texas Medicaid since January 2017.

Table 1: Total Medicaid Opioid Claims



To further support this trend, HHSC is implementing a uniform policy for FFS and managed care, for opioid prescribing on September 1, 2020. The policy includes claim review limitations, required retrospective DUR activities, requirements for monitoring antipsychotic medications for children, and fraud and abuse identification. The update will align MCO and FFS processes when prescribing opioids. The policy includes:

- Claim review limitations – Prospective reviews will check for MME and day supply limits prior to dispensing of a prescription. This review will recommend immediate-release formulation at the lowest effective dose and other actions based on a member's prior opioid use. Day supply limits will be

reviewed for prescribing opioids for acute pain and apply a maximum of ten days for opioid naïve clients to reduce the risk of addiction and diversion of unused opioids.

- Required retrospective DUR activities - On an annual basis, a retrospective review will be performed to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. If outlier prescribing patterns are identified, a review must be conducted and, if necessary, an intervention, such as contacting the prescriber or a peer-to-peer review with prescribers.
- Requirements for monitoring antipsychotic medications for children - If an MCO identifies patterns outside of the MCO's parameters for psychotropic medications, or if HHSC notifies the MCO of outlier prescribing patterns, then the MCO must conduct a review and, if necessary, an intervention, such as contacting the prescriber or a peer-to-peer review between the prescriber and the MCO.
- Fraud and abuse identification - MCOs must have processes to identify potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies.

5. Conclusion

Texas HHSC evaluated the prescribing practices for opioid drugs in the state Medicaid program, including the extent they align with the CDC guidelines for prescribing opioids for chronic pain. Though the CDC guidelines did not suggest an adherence threshold, the data reflected high percentages of prescribers aligning with the guidelines, suggesting general adherence.

Since 2011, Texas Medicaid began implementing clinical PAs, quantity limits, and MME limits for pharmacy opioid claims. MCOs can utilize approved clinical PAs, quantity, and MME limits. With our uniform policy effective September 1, 2020, HHSC will continue to remain diligent in aligning with the CDC prescribing guidelines. Texas HHSC will continue to monitor the CDC opioid workgroup's progress and make any necessary changes to align with best practices for opioid therapy prescribing methods.

List of Acronyms

Acronym	Full Name
CDC	Centers for Disease Control and Prevention
DUR	Drug Utilization Review
ER/LA	Extended-Release/Long-Acting
HHSC	Texas Health and Human Services Commission
MME	Morphine Milligram Equivalents
PA	Prior Authorization
PDPM	Prescription Drug Monitoring Program