SMARTCARE CALIFORNIA
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November 2017

# Reducing Opioid-Related Morbidity and Mortality:
## Payer Strategies

**GOAL.** By January 2019, every payer (including health plans, purchasers, and risk-bearing provider organizations) should launch an organization-wide opioid safety initiative. Its goal should be to lower overprescribing (decrease new starts on long-term opioids and more safely manage chronic pain) and to reduce opioid-related harm (improve access to addiction treatment and naloxone).

**METRICS.** Total MME pmpm (morphine milligram equivalents, from CA Opioid Dashboard),[1] high-dose prescribing (>120 MME pmpm, HEDIS measure),[2] concurrent use of opioids and benzodiazepines (PQA measure),[3] percent of patients who are identified with alcohol or drug disorder who received a prescription for FDA-approved medication for alcohol or drug use disorder or a referral for addictions treatment (The Joint Commission),[4] acute low back pain treated with opioids (Institute for Clinical Systems Improvement)[5]

| CORE PRIORITIES | APPROACH (all interventions should have exceptions for palliative care) |
|---|---|
| **1. PREVENT**<br>Decrease the number of new starts — fewer prescriptions, lower doses, shorter durations | **Medical management.** Remove prior authorization requirements for initial physical therapy series for acute lower back pain episodes, streamline access to nonpharmacological pain treatments (e.g., physical medicine/rehabilitation, acupuncture, chiropractic care, complementary therapy)[6]<br>**Benefit design.** Lower copay burden for physical therapy (e.g., one copay for series of physical therapy treatments)[6]<br>**Pharmacy benefit.** Implement quantity limits for new starts (e.g., three or seven days' supply),[7] ensure access to nonopioid pain medications[6] |
| **2. MANAGE**<br>Identify patients on risky regimens (high-dose opioids, or opioids and sedatives) and work with them to taper to safer doses | **Provider network.** Offer or support programs that help providers develop tapering plans for patients on high opioid doses or combinations (e.g., opioids and benzodiazepines)[8,9]<br>**Medical management.** Offer case management services for patients with chronic pain on high-risk regimens<br>**Pharmacy benefit.** Limit concurrent prescriptions for opioids and benzodiazepines,[9] remove high-dose formulations from formulary,[8] remove methadone from pain formulary[10] |
| **3. TREAT**<br>Streamline access to evidence-based treatment for substance use | **Provider network.** Evaluate network adequacy for opioid addiction treatment with buprenorphine and methadone, develop action plan to meet demand and incentivize providers to prescribe buprenorphine[11,13]<br>**Pharmacy benefit.** Remove authorization requirements and implement lower copays for buprenorphine[11,12] |
| **4. STOP overdose deaths**<br>Streamline access to naloxone for overdose reversal | **Provider network.** Offer or support provider education on co-prescribing naloxone[14,15]<br>**Pharmacy benefit.** Remove authorization requirements and implement lower copays for naloxone[14,15] |

## Endnotes


1. "California Opioid Overdose Surveillance Dashboard," California Department of Public Health, pdop.shinyapps.io/ODdash_v1.
2. "Summary Table of Measures, Product Lines, and Changes" in *HEDIS 2018*, vol. 2,, National Committee for Quality Assurance, ncqa.org (PDF).
3. "PQA Performance Measures," Pharmacy Quality Alliance, pqaalliance.org.
4. "Substance Use." National Quality Measures Clearinghouse, Agency for Healthcare Research and Quality, www.qualitymeasures.ahrq.gov.
5. "Adult Acute and Subacute Low Back Pain: Percentage of Patients with Low Back Pain Diagnosis Who Are Prescribed Opioids," Agency for Healthcare Research and Quality, www.qualitymeasures.ahrq.gov.
6. Deborah Dowell, Tamara M. Haegerich, and Roger Chou, "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016," *Morbidity and Mortality Weekly Report* 65, no. 1 (March 18, 2016): 1-49, doi:10.15585/mmwr.rr6501e1. The 2016 CDC guidelines for opioid prescribing recommend nonpharmacological therapy and nonopioid pharmacological therapy as the preferred first-line treatment for chronic pain. Clinicians should only consider opioid therapy if the expected benefits to both pain and function outweigh the risks to the patient.
7. Anuj Shah, Corey J. Hayes, and Bradley C. Martin, "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006-2015," *Morbidity and Mortality Weekly Report* 66, no. 10 (March 17, 2017): 265-69, doi:10.15585/mmwr.mm6610a1. The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after the first five days.
8. Kate M. Dunn et al., "Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study," *Annals of Internal Medicine* 152, no. 2 (January 19, 2010): 85-92, doi:10.7326/0003-4819-152-2-201001190-00006; "Performance Measures," ASAM. Doses >100 morphine milligram equivalents (MME) a day increase the death rate almost nine-fold compared to 1 to 20 milligrams daily.
9. Dowell et al., "CDC Guideline." The 2016 CDC guidelines for opioid prescribing recommend against concurrent use of opioids and benzodiazepines due to the increased risk of fatal overdose. Thirty percent of opioid overdose deaths include benzodiazepine use.
10. Leonard J. Paulozzi, Karin A. Mack, and Christopher M. Jones, "Vital Signs: Risk for Overdose from Methadone Used for Pain Relief — United States, 1999-2010," *Morbidity and Mortality Weekly Report* 61, no. 26 (July 6, 2012): 493-97, www.cdc.gov.
11. Nora D. Volkow et al., "Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370 (May 29, 2014): 2063-66, doi:10.1056/NEJMp1402780.
12. David Kan, *Insurance Barriers to Accessing Treatment of Opioid Use Disorders Identified by California Physicians*, California Society of Addiction Medicine, November 2016, www.csam-asam.org (PDF). Sixty-two percent of physicians whose patients have insurance coverage find it difficult to access medication-assisted treatment.
13. Catherine A. Fullerton et al., "Medication-Assisted Treatment with Methadone: Assessing the Evidence," *Psychiatric Services* 65, no. 2 (February 2014): 146-57, doi:10.1176/appi.ps.201300235. Treating opioid addiction with methadone is associated with improved outcomes for individuals and pregnant women with opioid use disorders.
14. Alexander Y. Walley et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *BMJ* 346 (January 31, 2013): f174, doi:10.1136/bmj.f174. Communities with increased naloxone availability have lower opioid overdose death rates.
15. "Naloxone Decreases the Use of Emergency Room in Patients Taking Opioids for Pain" [press release], San Francisco Department of Public Health, June 28, 2016, www.sfdph.org (PDF). Co-prescribing of naloxone with chronic opioid prescriptions lowered ED visits by 47%.

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# Reducing Opioid-Related Morbidity and Mortality:
## Provider Strategies

**GOAL.** By January 2019, every payer (including health plans, purchasers, and risk-bearing provider organizations) should launch an organization-wide opioid safety initiative. Its goal should be to lower overprescribing (decrease new starts on long-term opioids and more safely manage chronic pain) and to reduce opioid-related harm (improve access to addiction treatment and naloxone).

| | PREVENT | MANAGE | TREAT | STOP |
|---|---|---|---|---|
| **Core Priorities** | Decrease the number of new starts — fewer prescriptions, lower doses, shorter durations[1,2] | Identify patients on risky regimens (high dose, or opioids and sedatives) and work with them to taper to safer doses[3,4] | Streamline access to evidence-based treatment for substance use[5,6] | Stop overdose deaths: Streamline access to naloxone for overdose reversal[7] |
| **How will we know a change is an improvement?** | ▸ Percentage of patients with acute low back pain prescribed opioids[8]<br>▸ Timely access to nonpharmacologic modalities (physical therapy, alternative therapy)[9] | ▸ Number of patients taking both opioids and benzodiazepines per 1,000 patients (CA Opioid Dashboard)[10,11]<br>▸ Use of Opioids at High Dosage (>90 or >120 MME)[10,12] | ▸ Number of buprenorphine prescriptions per 1,000 patients (CA Opioid Dashboard)[10]<br>▸ Percentage of patients with alcohol or drug disorder who received a medication or a referral for addictions treatment[13] | ▸ Percentage of patients on daily opioids prescribed naloxone |

**Provider Approaches**

**Guidelines.** Adopt national or state prescribing guidelines (e.g., CDC, medical board)

**Provider education.** Offer or support provider education on:

- Pain management based on guidelines
- Buprenorphine prescribing
- Naloxone co-prescribing
- Tapering plans for high-risk regimens
- Addressing stigma

**Acute pain management.**

- Use nonopioid alternatives for acute pain (e.g., physical therapy, acupuncture, chiropractic, complementary therapy, nonopioid medications)[14]
- Refer to physical medicine/rehabilitation before nonemergent spine surgery[15]

**Data.** Use data to identify and reduce variations in opioid prescribing practices

**Integrated care.** Increase numbers of buprenorphine prescribers in primary care

## Endnotes


1. Deborah Dowell, Tamara M. Haegerich, and Roger Chou, "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016," *Morbidity and Mortality Weekly Report* 65, no. 1 (March 18, 2016): 1-49, doi:10.15585/mmwr.rr6501e1. The 2016 CDC guidelines for opioid prescribing recommend nonpharmacologic therapy and nonopioid pharmacologic therapy as the preferred first-line treatment for chronic pain. Clinicians should only consider opioid therapy if expected benefits for both pain and function outweigh the risks to the patient.
2. Anuj Shah, Corey J. Hayes, and Bradley C. Martin, "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006-2015," *Morbidity and Mortality Weekly Report* 66, no. 10 (March 17, 2017): 265-69, doi:10.15585/mmwr.mm6610a1. The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after five days.
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5. Nora D Volkow et al., "Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic," *New England Journal of Medicine* 370 (May 29, 2014): 2063-66, doi:10.1056/NEJMp1402780.
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7. Alexander Y. Walley et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *BMJ* 346 (January 31, 2013): f174, doi:doi.org/10.1136/bmj.f174. Communities with increased naloxone availability have lower death rates.
8. "Adult Acute and Subacute Low Back Pain: Percentage of Patients with Low Back Pain Diagnosis Who Are Prescribed Opioids," Agency for Healthcare Research and Quality, www.qualitymeasures.ahrq.gov.
9. Timeliness standards will vary depending on the health system. Medi-Cal Managed Care Plans are required to provide ancillary services within 15 days of call.
10. "California Opioid Overdose Surveillance Dashboard," California Department of Public Health, pdop.shinyapps.io/ODdash_v1.
11. "PQA Performance Measures," Pharmacy Quality Alliance, pqaalliance.org.
12. "Summary Table of Measures, Product Lines, and Changes" in HEDIS 2018, vol. 2,, National Committee for Quality Assurance, ncqa.org (PDF). There is still some debate about what constitutes a high dose opioid threshold (thresholds include 50, 90, and 120 MME), however in order to align with a national organization, NCQA measure specifications for high dose opioid use uses 120 MME as the threshold.
13. "Substance Use." National Quality Measures Clearinghouse, Agency for Healthcare Research and Quality, www.qualitymeasures.ahrq.gov.
14. Dowell et al., "CDC Guideline." The 2016 CDC guidelines for opioid prescribing recommend nonpharmacologic therapy and nonopioid pharmacologic therapy as the preferred first-line treatment for chronic pain.
15. *Bree Collaborative Spine/Low Back Pain Topic: Report and Recommendations*, The Bree Collaborative, November 21, 2013, www.breecollaborative.org (PDF). Priority Health Plan in Michigan instituted a requirement that patients with nonemergent spine-related pain or disability see a physiatrist before seeing a surgeon. Priority Health saw a 47% drop in surgical referrals and a 29% drop in spine surgeries.