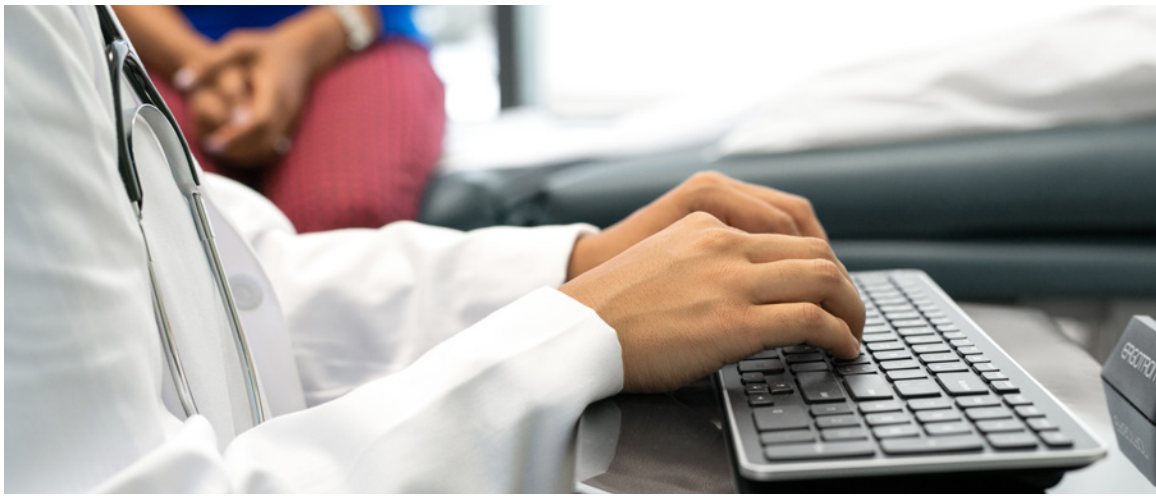
CONDUENT

Case Study

Targeting Opioid Abuse and Overutilization

24.6 million people 12 or older live with substance dependence or abuse. Fighting this wide-reaching epidemic takes getting opioid abuse and dose overutilization under control. That's why we help states build more responsive and effective care coordination initiatives.



A solution was needed for one of the worst man-made epidemics in history.

Prescription opioid-related overdose deaths have swept across the United States.

24.6 million people 12 or older live with substance dependence or abuse.1 And every day, 44 people die from overdose of prescription painkillers, making this one of the worst man-made epidemics in history.[2]

Long-term prescription opioid use may lead to adverse events, including addiction and overdose. These outcomes have a greater risk with patients who take multiple prescriptions to different pharmacies – or "pharmacy shop" – and overlap their opioid prescriptions.[3]

As a response to this epidemic, the Centers for Medicare and Medicaid Services (CMS) announced the implementation of a controlled substance overutilization monitoring system for the Medicare Part D program.[4] The program targets cancer-free patients who do not receive hospice care, whose daily morphine equivalent dose (MED) exceeds 120 milligrams (mg) for at least 90 days and who use more than three prescribers and more than three different pharmacies. The program also targets patients receiving daily doses of acetaminophen greater than four grams for longer than 30 days. Medicaid programs across the country have begun to adopt some of these same opioid abuse prevention parameters.

To help states better fight opioid abuse, the Pharmacy Solutions team at Conduent developed three effective strategies using our automated prior authorization solution, SmartPA, and our clinical rules engine – producing remarkable results.

The challenge: ensuring safe and effective opioid prescription use for your patients.
Approximately 10 percent of patients who are prescribed opioids and seek care from multiple doctors are prescribed high daily doses (greater than or equal to 100 mg morphine equivalent dose (MED) per day), and account for 40 percent of opioid overdoses.[5,6] Patients exceeding this MED cutoff are at high risk for overdose; they might also be diverting or providing drugs to other people who are using the medication without prescriptions.

Our clients needed strategies to prevent opioid overdose deaths that focused on high-dose opioid users, as well as patients who seek care from multiple doctors, receive high doses and are likely involved in drug diversion.[3]

While many patients have a legitimate medical need for treatment with opioid analgesics, these medicines are widely abused for various reasons, from dependency to diversion for profit. Our clients faced this situation with their patients and needed a way to ensure the safe and effective use of prescription opioids.

We developed three strategies to help our clients prevent adverse events associated with opioid abuse – which can ultimately result in saving lives and improving medical outcomes.

The solution: a multi-faceted approach for targeting opioid abuse.
Our Pharmacy Solutions team helped our clients attack opioid abuse both prospectively and retrospectively through a multi-faceted approach:

Strategy 1: Target opioid dose overutilization by limiting morphine equivalents.

Solution: In an effort to control opioid abuse, one state Medicaid program established a limit on the dosing of morphine and other pain medications prescribed to patients. They applied a prospective limit on Morphine Equivalent Dosing (MED) for all opioid claims at the point of sale (POS) greater than 120 milligrams of morphine equivalent (ME) per day. Any claims that exceed the 120 morphine equivalent limit per day are denied and a manual review of the claim performed to assess if there is a pattern of abuse in the patient's history.

Results: Just three months after implementing this strategy, the number of days the patients were on opioids at doses greater than the 120 mg morphine equivalent (ME) decreased by 25 percent.

Strategy 2: Prevent "doctor shopping" and "pharmacy hopping" by improving coordination of care.

Solution 1: Lock-in patients to one single pharmacy and physician. We coded the POS system for approximately 100 patients who received prescription controlled substances to be required to use one prescriber and pharmacy for a year. The system is coded so that the only controlled substance prescriptions that would pay had to be written by that single doctor and filled by that specific pharmacy.

Results: Our Analytics and Outcomes clinician compared the patients' histories six months prior to being locked in to one prescriber and pharmacy and reviewed the effects of the lock-in program six months after the program was initiated.

The program resulted in impressive improvements: the number of opiate and benzodiazepine/anti-anxiety prescriptions decreased 52.94 percent, compared to 31.82 percent in the usual care control group. The number of lock-in patients who exhibited doctor shopper or short-acting opiate overutilization behavior decreased 86.36 percent and 56.51 percent while the usual care group decreased by 44.29 percent and 12.50 percent, respectively.

Solution 2: Retrospective drug utilization review. We launched a population-based educational mailing campaign to physicians who prescribed drugs with abuse potential.

Results: Our team mailed 349 prescriber letters pertaining to their 1,491 patients who were identified as appearing to overutilize medications with potential abuse. Just six months after the letters were mailed, our client saw remarkable results.

The numbers tell the story:

- The client experienced a 73.9 percent reduction in the number of target patients flagged for overutilization (i.e. opioids and other drugs of abuse) compared to a 58.7 percent reduction in a group of patients with the same issues but whose prescribers did not receive letters.
- Financially, the amount paid for intervention-related drugs decreased $4.94 in the post-intervention period. This produced a whopping overall decrease of $44,163.62 in intervention-related drug expenditures during the six-month post-intervention period.

Strategy 3: Require Clinical Criteria, Prescription Drug List (PDL) and Quantity Limits.

Solution 1: Implement SmartPA clinical criteria for the long-acting opioid analgesics. We implemented a prospective edit for the long-active opioid analgesics using SmartPA, our automated, real-time point of sale Prior Authorization (PA) solution that virtually eliminates human intervention, to submit PA requests for the majority of drug coverage.

Results: In just one year after implementing the SmartPA edit, our strategy delivered these results:

- Our client saw $695,619 in pharmacy savings as a result of the SmartPA edit.
- Additionally, 37 percent of all long-acting opioid claims were denied because the claims did not meet established criteria.
- The client saved significantly due to increasing the use of preferred agents, preventing duplicate opioids and reducing overutilization (i.e. quantity and days' supply) of these medications.

Solution 2: Implement SmartPA clinical criteria for short-acting oxycodone. We implemented clinical criteria in a SmartPA edit for short-acting oxycodone claims, which evaluated the utilization of other similar opioids in addition to monthly limits.

Results: In just one year, automated prior authorization of all short-acting oxycodone claims – with the exception of claims for cancer patients – resulted in the denial of 267 claims and a huge savings of $70,772.

Summary

Pain control is a specialized treatment area that often requires individualized care. Without the right safeguards, it can lead to dangerous outcomes.

SmartPA and our clinical rules engine have helped our clients ensure safe and effective use of opioid analgesics. Using our clinical rules engine, several states now have the flexibility to adapt to changing opioid patterns and more options for fighting the epidemic of abuse. And that makes for better lives for at-risk program members.

You can learn more about us at www.conduent.com/pharmacysolutions.

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2. Injury Prevention and Control: Prescription Drug Overdose. Understanding the Epidemic. Available at: www.cdc.gov/drugoverdose/epidemic/index.html. Accessed on July 10, 2015.
3. Yang Z, Wilsey B, Bohm M, et al. Defining risk of prescription opioid overdose: pharmacy shopping and overlapping prescriptions among long-term opioid users in Medicaid. *J Pain* 2015 May;16(5):445-53.
4. Memorandum: Medicare Part D Overutilization Monitoring System. Available at: www.amcp.org/uploadedFiles/Production_Menu/Policy_Issues_and_Advocacy/Letters,_Statements_and_Analysis_-_docs/2013/OMS%20HPMS%20Announcement%20Memo_FINAL_070513.pdf Accessed on: Jan 15, 2014.
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6. Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA* 2011:305:1315-21.

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