OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

Backgrounder: Medicaid and Opioids

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Issue

This report discusses federal guidance on methods states may implement within their Medicaid programs to address opioid overdoses and addiction. It also summarizes some of the Medicaid policies and practices in Connecticut related to opioid issues.

Summary

The federal Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin in 2016 recommending strategies states can use in their Medicaid programs to address opioid issues. The bulletin includes recommendations on pharmacy benefit management strategies, increasing Naloxone use, and expanding coverage of and access to treatment.

The federal Centers for Disease Control and Prevention (CDC) also published guidelines in 2016 for primary care clinicians prescribing opioids for chronic pain in most situations. At least seven states have adopted the guidelines in their fee-for-service Medicaid programs and two states have adopted them in Medicaid managed care programs.

As Connecticut's state Medicaid agency, the Department of Social Services (DSS) generally requires prior authorization for prescriptions for long acting or sustained release opioids and limits non-maintenance medications, which include most opioids, to a 30-day supply per prescription fill. The medical Administrative Service Organization (ASO) monitors Medicaid beneficiaries' use of prescription opioids and refers cases of high opioid use to specialists. A workgroup that includes DSS and the ASO is developing a program for comprehensive management of individuals with chronic pain conditions.

CMS Best Practices

CMS issued an informational bulletin in January 2016 to discuss and recommend strategies states can use in their Medicaid programs to address opioid misuse and addiction.

Pharmacy Benefit Management Strategies

According to CMS, states can minimize risks associated with opioid use by implementing various strategies for their Medicaid pharmacy providers, including the following:

1. increasing provider education by supporting training and distributing prescribing guidelines;
2. restricting methadone prescriptions by taking methadone off the state's preferred drug list (outside of end-of-life care);
3. aligning prior authorization requirements with evidence-based standards (e.g., requiring prior authorization for methadone pain prescriptions in doses higher than the recommended maximum daily starting dose);
4. using step therapy (e.g., requiring use of another preferred drug prior to using methadone therapy);
5. imposing quantity limits;
6. performing drug utilization review (DUR) to identify potentially inappropriate prescribing practices;
7. allowing state Medicaid agencies to access data from the state's prescription drug monitoring program; and
8. implementing patient review and restriction programs, which prevent beneficiaries with certain claim histories from obtaining non-emergency Medicaid services from certain providers for reasonable periods of time. (Patients must have notice and opportunity for a hearing.)

Increasing Naloxone Use

According to CMS, in most states, naloxone is not available as an over-the-counter drug. CMS's bulletin identifies the following strategies states have taken to improve access to naloxone:

1. including naloxone on their preferred drug lists,
2. expanding community-based naloxone distribution programs,
3. making naloxone available without a prescription,
4. offering or expanding training in overdose prevention and response, and
5. enacting laws to address liability concerns related to naloxone.

These recommendations apply beyond the Medicaid population. In Connecticut, the legislature has passed several bills to expand access to Naloxone or similar substances (i.e., opioid antagonists). Most recently, PA 17-131 allows a prescribing practitioner to issue a standing order (i.e., non-patient specific prescription) to a licensed pharmacist that would allow the pharmacist to dispense an opioid antagonist to a person at risk of an overdose or someone who could assist such a person.

PA 16-43 includes provisions (1) allowing any licensed health care professional to administer an opioid antagonist such as Naloxone to treat or prevent a drug overdose without civil or criminal liability and (2) ensuring certain first responders are equipped with an opioid antagonist and trained in administering it.

What is Naloxone?

As explained by the National Institutes of Health, naloxone is a drug meant to rapidly reverse opioid overdose, including restoring normal breathing for someone whose breathing has slowed or stopped due to an overdose.

The federal Food and Drug Administration has approved naloxone in the form of (1) injectable vials, (2) prefilled auto-injection devices, and (3) a nasal spray.

Expanding Coverage and Access to Treatment

CMS notes that states can assess their benefit coverage, delivery systems, payment mechanisms, and provider networks to ensure that Medicaid beneficiaries have access to effective treatment for substance use disorder. Among other things, the bulletin references 2014 guidance on medication assisted treatment (MAT) that provides background information, examples of state-based initiatives, and resources on proper delivery of MAT services.

CDC Opioid Prescribing Guidelines

In March 2016, the CDC published guidelines for primary care clinicians prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guidelines provide recommendations on the following:

1. when to initiate or continue opioids for chronic pain;
2. opioid selection, dosage, duration, follow-up, and discontinuation; and
3. assessing risk and addressing harms of opioid use.

According to Kaiser Family Foundation, as of October 2016, seven states have adopted CDC guidelines in their Medicaid Fee-for-Service programs and 13 states and the District of Columbia are considering doing so, as shown in Figure 1. Additionally, two states require their Medicaid managed care organizations (MCOs) to adopt CDC guidelines and nine states are considering requiring their MCOs to adopt the guidelines.

Connecticut Medicaid Policies and Practices

Prior Authorization and Other Limits

DSS is Connecticut's state Medicaid agency. According to DSS, the department has required prior authorization for all new prescriptions for long acting or sustained release opioids as of December 1, 2016. DSS allows patients who were prescribed such medications before that date to continue to receive them. DSS is monitoring the effect of these prior authorization requirements. Additionally, DSS limits non-maintenance medications, which include most opioids, to a 30-day supply per prescription fill. Generally, maintenance drugs are medications prescribed for chronic or long-term conditions (e.g., high blood pressure, heart disease, or diabetes).

Measuring Dosage

Some opioids are more potent than others. Morphine milligram equivalent (MME) per day is a measurement that uses a conversion factor to compare and measure various opioids. For example, according to the CDC, oxycodone is 1.5 times as strong as morphine, so 33 milligrams of oxycodone is 50 MME per day.

Monitoring and Outreach

DSS administers the state's Medicaid program through ASOs that perform various functions across Medicaid and other populations served by the state's HUSKY Health program. DSS requires a morphine equivalent dosage calculation with all opioid prescriptions. According to DSS, the medical ASO, Community Health Network CT (CHNCT) actively monitors use of opioid medications by HUSKY members and notifies primary care physicians quarterly if any of their patients have received over 100 morphine milligram equivalents (MME) per day of pain medication during the quarter. CHNCT conducts outreach to HUSKY members receiving over 50,000 MME in a 90 day period. They may refer such individuals to specialist providers (e.g., pain management specialists) or the CT Behavioral Health Partnership. For those individuals receiving very high doses of opioid medications (over 100,000 MME in a 90 day period or approximately 1,100 MME per day), CHNCT reviews the cases, analyzing pharmacy and medical claims, and may forward such cases to DSS for further action.

Workgroup

DSS has a workgroup with CHNCT, the CT Behavioral Health Partnership, and the CT Dental Health Partnership to develop a program for comprehensive management of individuals with chronic pain conditions. The workgroup has developed (1) a provider pain management questionnaire and (2) for primary care providers, an online toolkit and quick reference guide.

CDC Guidelines

According to DSS, the agency has reviewed the CDC recommendations and is implementing those that are evidence-based.

Resources

Centers for Disease Control and Prevention, *Calculating Total Daily Dose of Opioids for Safer Dosage.*

Centers for Disease Control and Prevention, CDC Guidelines for Prescribing Opioids for Chronic Pain. March 2016.

Centers for Medicare and Medicaid Services, *Best Practices for Addressing Prescription Opioid Overdoses, Misuse, and Addiction.* January 2016.

Centers for Medicare and Medicaid Services (with other agencies), *Medication Assisted Treatment for Substance Use Disorders.* July 2014.

Kaiser Family Foundation, *Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017*. October 2016.

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