FEHB Program

All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Health Matters Newsletter: Opioid Stewardship

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Purpose/Disclaimer: This newsletter on opioid stewardship is for informational purposes only.

Background

According to data from the Centers for Disease Control and Prevention (CDC), there were an estimated 107,000 deaths caused by drug overdose in the United States in 2021.[1] The CDC reports that the age-adjusted overdose death rate increased 28.5% from 2020, which is a stark increase.[2] An estimated 75,673 deaths were attributed to opioids, including both prescription opioids and illicit opioids like heroin and illegal fentanyl.[2] In recent years, CDC data reports fentanyl causes more overdose deaths than heroin or prescription opioids.[3] Dispensing rates of prescription opioids have been declining over the past several years; however, opioid overdose deaths are increasing.[2,4]

The opioid epidemic is a serious public health crisis which requires a multi-faceted approach that includes prevention, early intervention, and effective treatment for patients diagnosed with opioid use disorder (OUD). This newsletter discusses new guidance from the CDC on pain management and OUD, changes in federal regulation of controlled substances, and potential strategies to facilitate safe use of opioids while mitigating the opioid epidemic**.**

2022 CDC Pain Management Guideline Updates

The CDC released new guidelines in 2022 entitled "2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain," ("New Guidelines") discussing the use of opioids for pain management.[5] There are many changes from the previous 2016 guidelines which may impact opioid prescribing practices; therefore, Carriers should carefully review the New Guidelines. One significant change to prescribing best practices is the removal of the total daily

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Jun 14, 2023.
[2] Centers for Disease Control and Prevention. Drug Overdose Deaths in the U.S. Top 100,000 Annually. Updated November 17, 2021. Accessed June 14, 2023. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm
[3] Centers for Disease Control and Prevention. Opioid Overdose: Data and Statistics. Updated June 1, 2022. Accessed February 15, 2023. https://www.cdc.gov/opioids/data/analysis-resources.html.
[4] Centers for Disease Control and Prevention. Prescription Opioid Overdose Data. Updated November 10, 2021. Accessed February 15, 2023. https://www.cdc.gov/drugoverdose/rxrate-maps/index.html
[5] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a

equivalent morphine dose recommendation. Previously, the CDC recommended that clinicians avoid increasing dosage for patients to 90 morphine milligram equivalents (MMEs) or more and to carefully justify a decision to titrate dosage to greater than or equal to 90 MME/day due to an expected plateau in pain control and worsening of long-term risks, such as respiratory depression, constipation, and potential overdose. However, the New Guidelines change this recommendation and encourage prescribers and patients to have shared decision-making when dosing opioid analgesics without imposing a firm MME limit. This is a significant development and allows prescribers to better individualize opioid dosing for patients with chronic pain.[5]

Consequently, it is appropriate to assess opioid utilization management edits after reviewing the New Guidelines. Examples of other important recommendations in these guidelines include tapering opioid doses rather than abrupt discontinuation, encouraging alternative pain management strategies, such as physical therapy and exercise when possible, and avoiding co-prescribing certain medications such as benzodiazepines with opioids.[5]

Medicare/CMS e-Prescribing Rule for Opioids

Electronic prescribing, or e-prescribing, is now mandatory for schedule II-V controlled substances covered under Medicare Part D.[6] This rule went into effect on January 1, 2023, and it requires that all prescribers utilize e-prescribing technology to write prescriptions for controlled substances for Medicare patients. E-prescribing has many benefits that can improve patient care and safe use of opioids. For example, e-prescribing can reduce errors due to miscommunication when prescriptions are called in telephonically or written illegibly.[7]

When prescriptions are securely sent via electronic interfaces, there is a clear record of who prescribed the opioid medication and when, which can prevent abuse. Furthermore, e-prescribing technology within an electronic health record (EHR) platform can improve patient care by allowing prescribers and pharmacies to review opioid prescribing history, check for drug interactions and other pertinent patient factors, and view safety alerts, such as medication allergies and contraindications.[2] The implementation of e-prescribing for controlled substances is one tool with many patient-safety benefits. Other tools that may be built into the EHR system can support the safe use of opioids; this will be discussed later in this newsletter.

Medication-Assisted Treatment and DATA X-Waiver

Medication-assisted treatment (MAT) is a key strategy clinicians use to combat the opioid epidemic. Prescribers utilize specific regimens of opioids such as buprenorphine with or without naloxone or methadone to treat patients with opioid addiction and to prevent withdrawals caused by more potent prescription opioids or illegal narcotics. Prior to the 2023 Consolidated Appropriations Act signed into law on December 29, 2022, prescribing clinicians were required to receive approval from the Drug Enforcement Agency (DEA) to treat OUD with

[6] Centers for Medicare & Medicaid Services. CMS Electronic Prescribing for Controlled Substances (EPCS) Program. Updated October, 4 2023. Accessed November 15, 2023. https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program

[7] Academy of Managed Care Pharmacy. Electronic prescribing. Updated July 18, 2019. Accessed February 20, 2023. https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/electronic-prescribing.

buprenorphine; prescribers were also limited in the number of patients who could be treated.[8] Under the Drug Addiction Treatment Act (DATA), the Substance Abuse and Mental Health Services Administration (SAMHSA) previously issued waivers (termed DATA-X waiver) to authorize eligible prescribers to treat patients for OUD with buprenorphine.[9] Section 1262 of the 2023 Consolidated Appropriations Act removed the DATA X-waiver requirement and the limits on how many patients a prescriber could treat.[8] This expands access to MAT for patients with OUD, and any prescriber who is authorized to prescribe schedule III controlled substances may prescribe buprenorphine for OUD and must be aware of SAMHSA's new guidance.[9] Prescribers are subject to the laws in their state of practice, which may restrict prescribing abilities.

According to the new guidance, prescribers are required to obtain 8 hours of accredited training on substance use disorder to receive or renew their DEA license.[9] More information about the new requirements can be found on SAMHSA's frequently-asked questions page.[9] Reducing barriers to MAT has the potential to expand access to this critical service and benefit individuals living with OUD.

Health Disparities in Pain Management

It is well established that disparities exist in pain management, particularly when assessing and treating pain by race, ethnicity, and gender. The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain highlights these disparities and their impacts.[10] For example, Black patients are less likely to be prescribed opioids for pain and likely to get lesser quantities than White patients.[11] Similarly, women experience higher rates of musculoskeletal pain, migraine pain, and nerve pain than male patients.[12] Ultimately, health disparities in pain management result in undertreatment of pain, which can lead to decreased quality of life, lost productivity, and other unfavorable health outcomes.[5]

Listed below are contributing factors for health disparities in pain management:

1. Implicit bias: Prescribers may be unknowingly biased against certain individuals or groups based on factors such as socioeconomic status, race, or gender. This bias can affect prescribing habits to the detriment of the patient's care. Research suggests that prescribers are more likely to underestimate pain experienced by Black patients compared to White patients.[13]
2. Stereotyping: Societal perceptions or myths may permeate medical practice, which can be harmful to patients. For example, members of the medical community previously

[8] Consolidated Appropriations Act, HR, 2617, 117, (2023).
[9] Waiver Elimination (MAT Act). SAMHSA. Updated October 10, 2023. Accessed November 3, 2023 Waiver Elimination (MAT Act) | SAMHSA https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement .
[10] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.
[11] Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*. 2016;113(16):4296-4301. doi:10.1073/pnas.1516047113
[12] Leresche L. Defining gender disparities in pain management. Clin Orthop Relat Res. 2011;469(7):1871-1877. doi:10.1007/s11999-010-1759-9
[13] Todd KH, Deaton C, D'Adamo AP, Goe L. Ethnicity and analgesic practice. *Ann Emerg Med*. 2000;35(1):11-16. doi:10.1016/s0196-0644(00)70099-0

believed that Black individuals have a higher pain tolerance or feel less pain than other races.[11] This scientifically unfounded myth may contribute to inadequate pain treatment in Black patients.

3. Lack of trust: Unethical medical experimentation has been conducted on Black and Hispanic patients in the United States as recently as the 1960s. This has damaged the relationship these groups have with healthcare in the U.S., which may cause them difficulty in advocating for themselves when seeking care for pain.[14]
4. Geographic area and access to care: In a survey-based chronic pain research study published in *Preventing Chronic Disease*, individuals residing in rural and suburban communities of North Carolina reported higher rates of chronic and neuropathic pain compared to those living in urban communities. [15] Inequities in healthcare access due to lack of resources in rural communities may contribute to this disparity.[5]
5. Socioeconomic conditions and access to care: Healthcare disparities are exacerbated when patients cannot afford treatment or are worried about the cost of receiving care. This may cause patients to delay care, which may lead to worse outcomes.[16,17]

Healthcare disparities may be mitigated by offering prescriber resources to address the issues above. For example, cultural competency training can help close gaps when prescribers work with diverse patients. This approach to care has multiple benefits; prescribers and health plans can improve health for vulnerable populations while members receive more personalized care. Furthermore, providing cultural competency resources can address implicit bias during patient visits and consequently mitigate stereotyping and prejudice. SAMHSA provides a directory of resources for cultural competency training.

Opioid Stewardship Tools

Opioid stewardship involves utilizing technology and best practices that allow for the safe and effective use of opioids while mitigating the risks of misuse and overdose. Many organizations, such as the Food & Drug Administration (FDA), CDC, and state entities provide guidance and enforce policies to enhance opioid stewardship. The information below describes effective opioid stewardship policies that may mitigate the risks of opioid prescribing.

1. **Screening for OUD:** Encourage prescribers to use screening tools that assess patient risk of opioid misuse prior to prescribing opioids. This may allow prescribers to identify patients who may need additional monitoring, education, or pain management strategies with non-opioid modalities.[5]
2. **Prescription drug monitoring programs (PDMP):** Prescribers should use prescription drug monitoring tools to review a patient's history with controlled substances and opioids to

[14] National Academies of Sciences, Engineering, and Medicine 2020. The Impacts of Racism and Bias on Black People Pursuing Careers in Science, Engineering, and Medicine: Proceedings of a Workshop. Washington, DC: The National Academies Press. https://doi.org/10.17226/25849.

[15] Rafferty AP, Luo H, Egan KL, Bell RA, Gaskins Little NR, Imai S. Rural, Suburban, and Urban Differences in Chronic Pain and Coping Among Adults in North Carolina: 2018 Behavioral Risk Factor Surveillance System. Prev Chronic Dis 2021;18:200352. DOI: http://dx.doi.org/10.5888/pcd18.200352

[16] Nanney MS, Myers SL Jr, Xu M, Kent K, Durfee T, Allen ML. The Economic Benefits of Reducing Racial Disparities in Health: The Case of Minnesota. Int J Environ Res Public Health. 2019;16(5):742. Published 2019 Mar 1. doi:10.3390/ijerph16050742

[17] Weissman JS, Stern R, Fielding SL, Epstein AM. Delayed access to health care: risk factors, reasons, and consequences. Ann Intern Med. 1991;114(4):325-331. doi:10.7326/0003-4819-114-4-325

assess potential signs of misuse before initial opioid prescribing and when continuing therapy. Many states require pharmacists to check state PDMP databases prior to dispensing. Some states require prescribers to check state PDMP databases prior to prescribing.[18] EHR systems can integrate state PDMPs to facilitate easier use of PDMPs prior to making prescribing decisions.[19]

3. **Pain Management Agreements:** A pain management agreement is a written document between the prescriber and patient when the patient is treated for chronic pain. The agreement describes opioid treatment expectations and often defines treatment goals. These agreements can keep patients and prescribers accountable for the opioid treatment risks and can mitigate worse health outcomes.[20,21]
4. **Medication disposal programs**: Many pharmacies and law enforcement agencies provide resources for patients to return unused and/or expired medications, including controlled substances.[22] This allows patients to safely dispose of medication, which limits potential diversion and misuse. As of April 2023, the FDA requires opioid manufacturers to provide postage-prepaid mail-back envelopes to outpatient centers where opioids are dispensed, such as retail pharmacies.[23] This provides patients with a safe and easy-to-use tool to dispose of any unused opioids. The DEA also organizes the National Prescription Drug Take Back Day, which is coordinated with state and local stakeholders. This program educates the public on prescription drug abuse and misuse while providing an opportunity for individuals to safely dispose of unwanted medications.[24]

Naloxone Dispensing

Naloxone is a life-saving medication that temporarily blocks and reverses the effects of opioid overdose. On March 29, 2023, the FDA approved the first formulation of intranasal naloxone as an over-the-counter (OTC) product.[25] This is an important step to expanding access to resources that effectively combat the opioid epidemic and decrease deaths from drug overdose. Although Carriers may differ in their approach to covering OTC products, OPM recognizes rescue naloxone as preventive care as specified in Carrier Letter 2023-03.

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[18] Prescription Drug Monitoring Programs (PDMPs). Centers for Disease Control and Prevention. May 19, 2021. Accessed June 2, 2023. https://www.cdc.gov/drugoverdose/pdmp/.

[19] Prescription Drug Monitoring Programs. The Office of the National Coordinator for Health Information Technology (ONC). Accessed June 2, 2023. Prescription Drug Monitoring Programs | HealthIT.gov

[20] West M. How many chances do you get at pain management? Medical News Today. March 30, 2023. Accessed June 2, 2023. https://www.medicalnewstoday.com/articles/how-many-chances-do-you-get-at-pain-management.

[21] Argoff C. Pain contracts vs agreements between clinicians and patients. Pharmacy Times. April 29, 2021. Accessed June 2, 2023. https://www.pharmacytimes.com/view/pain-contracts-vs-agreements-between-clinicians-and-patients.

[22] Drug Disposal: Drug Take Back Locations. U.S. Food and Drug Administration. Updated October 17, 2022. Accessed June 21, 2023. https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-drug-take-back-locations

[23] FDA moves forward with mail-back envelopes for opioid analgesics dispensed in outpatient settings. U.S. Food and Drug Administration. April 3, 2023. Accessed June 2, 2023. https://www.fda.gov/news-events/press-announcements/fda-moves-forward-mail-back-envelopes-opioid-analgesics-dispensed-outpatient-settings.

[24] Take Back Day. Drug Enforcement Agency. Accessed June 21, 2023. https://www.dea.gov/takebackday

[25] FDA Approves First Over-the-Counter Naloxone Nasal Spray. U.S. Food and Drug Administration. March 29, 2023. Accessed June 16, 2023. https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray

Plan Performance Assessment – Opioids

OPM is committed to addressing the impacts of the opioid epidemic on the FEHB population. One of the tools OPM utilizes to measure the performance and impact of healthcare services is through the Plan Performance Assessment (PPA). Currently, Carriers report on two opioid measures in the Farm Team: *Use of Opioids from Multiple Providers, UOP* (Collection as of 2018) and *Risk of Continued Opioid Use, COU* (Collection as of 2020). These measures are located in Carrier Letter 2022-19 Attachment 1. The Use of Opioids from Multiple Providers: Multiple Prescriber Rate will be scored in Clinical Quality, Customer Service and Resource Use (QCR) beginning in 2024 as noted in Carrier Letter 2022-13.

Key Takeaways

- The opioid epidemic is an ongoing public health issue in the United States that continues to negatively impact patient outcomes and cause tens of thousands of deaths annually.
- Strategies to combat the opioid epidemic are evolving, and developments in opioid stewardship and public policy are being monitored by OPM.
- Facilitating safe and effective opioid use while minimizing the risks to patients, such as preventing overdose and opioid abuse, remains a top focus for OPM.
- OPM would like to thank Carriers for their continued focus and ongoing efforts in opioid stewardship.

Please direct questions or comments to Nick Taylor, PharmD, at OPMPharmacy@opm.gov with a cc: to your Health Insurance Specialist.