February 16, 2018

The Honorable Orrin Hatch  
Chairman, Senate Committee on Finance  
104 Hart Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member, Senate Committee on Finance  
221 Dirksen Building  
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

America’s Health Insurance Plans (AHIP) appreciates the opportunity to provide the Committee with recommendations and strategies to prevent opioid overutilization and treat addiction within Medicare and Medicaid in response to the Committee’s February 2nd letter, where policy recommendations were requested.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Drug overdoses are now the leading cause of death for Americans under 50 years of age, with 142 Americans dying every day from an opioid overdose. The crisis is multifaceted and continues to evolve with synthetic opioids (such as fentanyl) and heroin increasingly entering the market. Further complicating prevention and treatment efforts is the increased prevalence of HIV and Hepatitis C among illicit drug users, as well as new cases of these diseases emerging due to intravenous use.

AHIP members experience first-hand the complications and consequences of the opioid public health crisis, including those on our nation’s most vulnerable populations. Though no one should be debilitated by unrelenting pain, no one should live with the disease of opioid addiction either. AHIP continues to work collaboratively with other national and regional stakeholder partners to help unravel and solve the nation’s multi-faceted opioid crisis. Insurance providers continually work with Congress, state and community leaders, and health care providers to develop and implement the safest, most proven, and most effective policies and solutions that help people manage pain, prevent opioid misuse and abuse, and overcome the disease of addiction.
Further, AHIP has and continues to convene, as part of the AHIP Opioid Work Group, chief medical officers, behavioral health clinicians, pharmacists, and policy staff from more than 40 AHIP member organizations. Together with our plans, we launched the Safe, Transparent Opioid Prescribing (STOP) Initiative to support widespread adoption of clinical guidelines for pain care and opioid prescribing. As part of the STOP Initiative, we have developed the STOP Playbook, which provides practical examples of the various innovative strategies that health plans deploy to combat the opioid public health crisis. Namely, the Playbook provides examples of how health plans use a comprehensive approach that encompasses: (1) prevention; (2) early intervention; and (3) treatment and recovery. Taken together, these strategies reflect a high level of health plan innovation and our industry’s commitment to solving the opioid health care crisis. Our STOP Playbook is attached for your reference.

Additionally, last fall, AHIP launched the STOP Measure – a robust, evidence-based methodology health plans can use to measure how provider practices compare to the Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids for Chronic Pain. Health plans have consistently supported the CDC’s Guidelines to promote evidence-based pain care and reduce unnecessary opioid prescribing. The STOP Measure takes these efforts much further by establishing an industry-wide approach to measuring performance against the CDC guidelines, tracking and reducing the number of opioid prescriptions. We recently released the first nationwide benchmark data for the STOP Measure to show the health care industry’s progress in combatting the opioid crisis and to identify specific actions that can be taken to reduce addiction and abuse. We have attached the STOP Measure baseline analysis for your review.

Medicare & Medicaid Programs

Approximately 43 million seniors and individuals with disabilities are covered under the Medicare Part D program, with more than 17 million receiving their benefits through a Medicare Advantage (MA) plan and more than 25 million receiving their benefits through a stand-alone Prescription Drug Plan (PDP). The Part D program is based on a highly successful model that has increased consumer choice and market competition, improved access to prescription drugs, and reduced out-of-pocket costs for tens of millions of beneficiaries. Consumers are highly satisfied with these benefits.1

In addition, the Part D program has been shown to significantly improve the health outcomes of Medicare beneficiaries. A 2014 study found that beneficiaries with Medicare Part D coverage, on average, experienced 8 percent fewer hospital admissions, incurred 7 percent lower Medicare expenditures, and used 12 percent fewer total health care resources than beneficiaries without Part

---

D coverage. This study found that taxpayer costs were reduced approximately $1.5 billion each year.²

While prescription drug coverage by Medicaid is optional, all states cover outpatient prescription drugs for most or all their Medicaid enrollees. Medicaid prescription drug spending accounted for $31.7 billion in 2015, about 5.8 percent of total Medicaid expenditures. While Medicare provides prescription drug coverage primarily for older adults, Medicaid is the primary source of prescription coverage for younger enrollees with limited incomes, complex medical needs, serious persistent mental illness, and/or substance use disorders.

Current Solutions in Medicare & Medicaid

We applaud and share the Committee’s commitment to reducing the number of addictive substances in communities, preventing misuse and abuse of opioids, and compassionately treating those suffering from opioid and substance use disorders within the Medicare and Medicaid programs. We also applaud Congress for passing into law the Comprehensive Addiction and Recovery Act of 2016 (CARA), which included a provision that allows the use of lock-in programs in Medicare. A lock-in program is a utilization management tool used to limit whom can prescribe opioids for a beneficiary (i.e., selected prescribers of opioids), and where a beneficiary can access coverage for opioids (i.e., selected pharmacies), or both. Pursuant to CARA, the Centers for Medicare and Medicaid Services (CMS) released the MA/Part D Proposed Rule in November of 2017, offering a proposed implementation plan for these programs. More recently, in the CY 2019 Advance Notice and Call Letter, CMS proposed additional policy changes aimed at reducing opioid overutilization in Medicare.

The recently proposed Medicare implementation plan for CARA and opioid safeguard provisions in the Medicare Advantage CY 2019 Call Letter are likely to become effective tools to reduce prescription opioid use, misuse, and abuse among Medicare beneficiaries. Since these programs are still in the early implementation-stage, AHIP recommends a watchful wait-and-see approach, where Congress monitors ongoing progress, investigates incremental improvements, and acts only when it finds such improvements as necessary.

While variations exist from state to state, Medicaid programs in many states have implemented programs aimed at screening and early intervention, overdose prevention, and improved access to medication assisted treatments (MAT) for Medicaid enrollees. However, Medicaid managed care plans offer coverage and services that are largely determined by a state’s Medicaid plan. While health plans work closely with states to help inform this process, the decisions around program structure, including pharmacy/prescriber lock-in requirements and other prevention and treatment methods provided, ultimately lie with the states.

As part of its CARA implementation plan, CMS included the following proposals:

- Allow plan sponsors to implement drug management programs informed by regular Overutilization Monitoring System (OMS) reports to identify beneficiaries who are at-risk of misusing or abusing opioids and to limit their coverage to frequently-abused drugs (i.e., opioids);
- Allow implementation of lock-in programs where beneficiaries would be limited to a single prescriber and/or a single pharmacy for obtaining frequently-abused drugs;
- Require that drug management programs use evidence-based clinical guidelines, implemented in consultation with Medicare plan sponsors, and robust case management to identify at-risk beneficiaries and the appropriate limit to coverage of frequently-abused drugs; and
- Gather stakeholder feedback on which additional drug categories (i.e., benzodiazepines, sedatives, and other high-risk medications) to add to the list of frequently-abused drugs, currently composed of opioids only.

AHIP has provided CMS with comments and some recommendations on the proposed CARA implementation plan, including the following:

- The limitations placed on the plan sponsor’s ability to lock a beneficiary to a prescriber may be too restrictive in many instances (e.g., a mandatory waiting period before limiting a beneficiary to a single provider);
- Plan sponsors should be able to go above and beyond proposed guidelines in identifying at-risk beneficiaries and limiting their coverage to frequently abused drugs (i.e., concurrent benzodiazepine and opioid use); and
- CMS should consider looking at ways to ease potential burdens and challenges in operationalizing the program.

**Opioids Provisions in the CY 2019 Advance Notice and Call Letter**

As part of the CY 2019 Advance Notice and Call Letter, CMS proposed several additional provisions aimed at stemming and preventing opioid misuse and abuse among Medicare beneficiaries, including the following:

- Limit the dispensing of first time opioid prescriptions (i.e., opioid naïve beneficiaries) for acute pain to a 7-day supply, with or without a maximum dosage threshold;
- Flag the concurrent use of “potentiator” drugs such as gabapentin and pregabalin for future OMS reports;
- Implement changes to existing Pharmacy Quality Alliance (PQA) endorsed opioid measures used by CMS;
• Introduce a new PQA-endorsed measure that identifies the concurrent use of benzodiazepines and opioids (“double threat”) as part of the CMS Patient Safety reports;
• Apply a hard edit whenever a patient reaches a 90 Morphine Milligram Equivalent (MME) dose over the past 90 days with a 7-day allowance; and
• Apply a soft edit whenever a potentially inappropriate duplication in opioid therapy is detected.

Solutions in Medicaid

Although lock-in programs can now be used to protect Medicare beneficiaries, these programs have already been implemented in most states’ Medicaid programs and have been shown to reduce prescription opioid misuse and abuse among Medicaid enrollees. Though variations exist among the states, the use of lock-in programs has shown dramatic results. For example, according to a study evaluating the impact of implementing the Medicaid Lock-In Program (MLIP) in North Carolina, the MLIP resulted in both a lower average number of opioid prescriptions filled per month and a lower number of pharmacies visited to obtain those prescriptions.3 Also, for states that reported savings from the use of lock-in programs, the average reported savings was $3.13 million in FY 2016 and $7.88 million in FY 2015.4,5

Proposed Policy Recommendations

Our STOP Playbook (attached) outlines some potential policy solutions to consider as they relate to prevention, early intervention, and treatment of opioid use disorders. Insurance providers continue to expand and refine a comprehensive, multi-faceted approach for combatting the opioid crisis encompassing: (1) prevention; (2) early intervention; and (3) treatment and recovery. Though more detailed descriptions can be found in the STOP Playbook, some examples include:

• Promoting the CDC’s opioid prescribing recommendations, including non-opioid pain care, cautious opioid prescribing, and careful patient monitoring;
• Encouraging provider education on evidence-based pain care and how to screen people for risk of addiction;
• Educating consumers and communities on the risks of opioids;
• Leveraging medical management tools, such as step therapy and prior authorization, to ensure patients receive safe, effective access to care at an affordable cost;
• Facilitating coordination between physicians and pharmacies when patients are “doctor shopping” or “pharmacy shopping” and receiving prescription opioids from multiple providers;

• Analyzing pharmacy claims to identify prescription patterns that may indicate overuse or misuse to inform early interventions;
• Providing patients struggling with opioid use disorder access to evidence-based treatment, including medication assisted treatment (MAT), counseling, and recovery support; and
• Improving access to treatment services such as counseling, peer support services, and community-based support groups.

In consultation with our members, AHIP has identified some potential ways that Congress could improve upon and advance the ongoing efforts by CMS and plan sponsors:

• For non-integrated arrangements in Medicare and Medicaid, eliminate unnecessary restrictions and allow for data sharing;
• Codify that CMS should use notice-and-comment rule-making processes or the Advance Notice and Call Letter to seek input on, and to finalize changes to, various components of the CARA, OMS, and Drug Utilization Review (DUR) programs (e.g., additions to list of frequently abused drugs, changes to clinical guidelines);
• Provide CMS and plan sponsors the ability to access state prescription drug monitoring programs, with state authorization, to obtain more comprehensive information on Medicare beneficiaries identified as being at-risk;
• Modernize the statute governing 42 C.F.R. Part 2 to allow the confidential sharing of information on substance use diagnosis and treatment information to improve patient safety, quality, and care coordination, as is done with any other chronic illness under HIPAA;
• Require that Medicare beneficiaries receive, at the point of sale, a government notice indicating the potential and likely dangers of opioid use and the legal consequences for inappropriate diversion of opioid products;
• Investigate the role that telehealth could play in providing behavioral and mental health services to Medicare beneficiaries; and
• Provide Medicaid managed care organizations with more formulary autonomy and flexibility to create stronger leverage to negotiate lower drug costs.

AHIP believes that much of the necessary foundation has been created in the Medicare and Medicaid programs through the collaborative efforts of Congress, CMS, states, many health care stakeholders, and plan sponsors. We recommend that Congress continue to monitor the progress of this critical work, investigate incremental improvements, and act only when it finds such improvements are necessary.
Again, we thank you for the opportunity to provide these comments. If you have any questions, or would like to request more information, please contact Kate Berry at kberry@ahip.org.

Sincerely,

Marilyn B. Tavenner
President and CEO

Attachments:

STOP Playbook: How Health Plans are Tackling the Opioid Crisis
STOP Measure: Safe and Transparent Opioid Prescribing to Promote Patient Safety and Reduced Risk of Opioid Misuse
Since 1999, the number of overdose deaths involving opioids has quadrupled (CDC). Drug overdoses, the majority of which are from opioids, are now the leading cause of death among Americans, outnumbering both traffic accidents and gun-related deaths (CDC). More than two million Americans are estimated to be dependent on opioids (SAMHSA). An additional 95 million people used prescription painkillers in the past year — more than used tobacco (SAMHSA).

Health plans nationwide are working closely with state and federal leaders, as well as with physicians and other providers, to address the opioid crisis that is devastating individuals and their families in communities across the country. In October 2017, America’s Health Insurance Plans (AHIP) launched its Safe, Transparent Opioid Prescribing (STOP) Initiative. The STOP Initiative is designed to support widespread adoption of evidence-based clinical recommendations developed by the Centers for Disease Control and Prevention (CDC) for pain care and opioid prescribing.

Recognizing that addressing the opioid crisis is a complex and multi-faceted challenge, health plans use a comprehensive approach encompassing

- prevention,
- early intervention, and
- treatment and recovery.

This STOP Playbook is designed to provide practical examples of different strategies health plans have deployed for all three components of this comprehensive approach. Taken together, these strategies reflect innovative ways plans are combatting this public health crisis and the industry’s commitment to be part of the solution.
Health Plan Prevention Strategies

Health Plan Prevention Overview

Health plans, health care providers, and patients all play a critical role in the prevention of opioid misuse and addiction. Recognizing that people deal with pain differently, patients and health care providers should talk openly and honestly about pain and how to manage it – from lifestyle changes and exercises, to over-the-counter options and the dangers of opioids. Plans work closely with providers to ensure patients have access to safe, evidence-based, and effective approaches to manage pain.

Key Health Plan Strategies to Prevent Opioid Misuse and Addiction

STRATEGY 1.1
Encouraging proven ways to manage pain, such as non-narcotic medications, physical therapy, and acupuncture.

Health plans are providing evidence-based protocols for physicians and pharmacists to prevent patients from receiving too much pain medication. These protocols may include reasonable medical management techniques, such as step therapy, prior authorization, and quantity limits consistent with best practices. This also includes encouraging physicians and patients to develop treatment plans for pain that consider non-narcotic treatment options, and providing patients who receive large amounts of narcotic medications access to pain experts, non-narcotic methods of pain control, and improved care coordination.

Plans are also encouraging the use of non-opioid treatments to treat chronic pain. Recent research shows that non-opioid medications, even over-the-counter options like ibuprofen, can provide just as much relief as opioids with much less risk. Additionally, there is a growing body of research that suggests that interventions like physical therapy, massage, and acupuncture may be effective in treating chronic pain. Several plans have integrated coverage of these interventions into their coverage policies.
STRATEGY 1.2
Promoting the CDC opioid prescribing recommendations including non-opioid pain care, cautious opioid prescribing, and careful patient monitoring.

In 2016, the CDC released their Guideline for Prescribing Opioids for Chronic Pain which included recommendations for prescribing opioid pain medication for patients 18 and older in primary care settings. These include recommendations to prescribe the lowest dose and fewest pills that would be effective for each patient, regular review of the risks associated, and close patient monitoring to promote safer use of opioids to improve clinical practice, patient outcomes, and public health. Health plans strongly support these recommendations and promote them across their provider networks. Health plans also engage patients to provide support programs, such as substance use disorder coaching and pharmacy home programs to coordinate care and medication access.

STRATEGY 1.3
Launching the STOP Measure, a robust, evidence-based methodology health plans can use to measure how well provider practices are adhering to the CDC Guideline for Chronic Pain.

As described above, health plans have consistently supported the CDC Guideline to promote evidence-based pain care and reduce unnecessary prescribing. The STOP Measure takes these efforts to the next level by establishing an industry-wide approach to measuring performance against the CDC recommendations, and ultimately using this information to inform quality improvement efforts. In collaboration with clinical experts, members of the AHIP Opioid Work Group – consisting of 40+ member health plans – created the STOP Measure for six of the twelve CDC recommendations as a foundation. Using this methodology, the health insurance industry can identify:

- Percent of prescriptions for immediate-release opioids versus extended-release or long-acting opioids
- To what extent opioids are prescribed concurrently with benzodiazepines
- The dosages and duration being prescribed for those patients with acute or chronic pain
- When and how often urine drug tests are being administered when appropriate before or during long-term opioid therapy
The STOP Measure has been shared widely with health plans; as experience is gained, the initial methodology may be updated, and further validated.

**STRATEGY 1.4**

**Encouraging provider education on evidence-based pain care and screening people for risk of addiction.**

As leading researchers have noted, the number of prescriptions for opioids (e.g. hydrocodone and oxycodone products such as Vicodin and Percocet, respectively) have escalated from approximately 76 million in 1991 to nearly 207 million in 2013. Analysis by the CDC found that prescription patterns peaked in 2010; since then, the annual prescribing rate dropped 13%. However, despite these efforts, doctors are still prescribing three times as many opioids as they were in 1999.

AHIP and its members support efforts by medical and professional societies to offer and enhance education and training on pain treatment and management, as well as safe opioid prescribing for providers. Health plans look to provider education and training on pain treatment and management when developing their networks of facilities and providers, identifying centers of excellence, and collaborating with providers and emergency departments to facilitate appropriate triage and care coordination.

**STRATEGY 1.5**

**Educating consumers and communities on the risks of opioids.**

Between 1999 and 2015, more than 560,000 people in our nation died due to drug overdoses. In 2015, nearly two-thirds of drug overdoses were linked to Percocet, OxyContin, heroin, and fentanyl.

Patient education is a key component of any prevention strategy, and research indicates that it is effective in preventing opioid misuse. A 2016 study from the Annals of Family Medicine found that patient education may have positive behavioral consequences that could lower the risks of prescription painkiller abuse. The authors conducted a phone survey of adults aged eighteen and older who had been prescribed strong prescription painkillers within the last two years. They estimated that nationally (when adjusting for socioeconomic variables), 20% of respondents who did not remember discussing addiction risk with their physician reported saving pills for later, compared with 8% who did remember discussing addiction risk.
Additionally, a study from the Rothman Institute, looking at carpal tunnel release surgery, found that patients who received pre-surgery education used an average of 1.4 pills during their recovery and those who did not receive the pre-surgery education used an average 4.2 pills during their recovery.

To support patient education, AHIP created a Question and Answer resource titled, “The Facts on Pain Care and Prescription Opioids” to support dialogue between patients and providers about options for managing and relieving pain.

**Ways to Improve Prevention of Opioid Misuse and Addiction**

AHIP’s health plan members work together to share best practices and identify potential policy recommendations to combat this crisis. Some policy ideas that have been discussed pertaining to prevention include:

- Improve education and training efforts by medical and professional societies for pain treatment and management, as well as more cautious opioid prescribing, including offering CME/CE credit, or requiring such training for license renewal.

- Encourage the use of CDC opioid prescribing recommendations including limits on initial opioid prescriptions.

- Encourage use of electronic prescribing of controlled substances including opioids to prevent prescription tampering, improve security, reduce fraud, and limit opioids getting in the wrong hands.

- Oppose mandated coverage of abuse deterrent formulations of opioids based on the lack of evidence that they reduce the risk of addiction for most patients who are prescribed opioids.

- Advocate for expanded research efforts on the effectiveness of non-opioid pain alternatives (e.g., acupuncture, yoga, tai chi).
Health Plan Early Intervention Strategies

Health Plan Early Intervention Overview

By combining effective education, prevention, behavioral health care, and evidence-based treatment, health plans are making real, measurable progress in intervening early to mitigate the risk of opiate overuse and address addiction. Working closely with doctors, nurses, and other care providers, plans are continually improving their early intervention strategies to identify at-risk populations and provide them with better pathways to healing.

Key Health Plan Early Intervention Strategies for Patients at Risk of an Opioid Addiction

**STRATEGY 2.1**
Leveraging medical management tools, such as step therapy and prior authorization, to ensure patients receive access to safe, effective care at an affordable cost.

Health plans use medical management practices to design and develop value-based approaches that provide access to necessary treatments, confirm treatment regimens ahead of time, dispense appropriate amounts of prescription drugs, and utilize cost-effective therapies. This helps ensure that patients receive safe, effective care at an affordable cost.

Medical management can take several forms such as prior authorization for prescription pain medication, step-therapy which promotes an evidence-based, systematic approach to therapy, and prescription tiering, in which certain drugs or drug classes are preferred over others. Taken together, these techniques provide evidence-based protocols for physicians and pharmacists to prevent patients from receiving too much pain medication.

Studies have shown that medical management techniques can be successful in curbing opioid misuse. A study from the American Journal of Managed Care compared rates of opioid abuse and overdose among enrollees in Medicaid plans that varied in their use of prior authorization (PA) from “High PA” (where PA was required for 17 to 74 opioids), “Low PA” (where PA was required for 1 opioid), and “No PA” policies. The study concluded that enrollees within
Medicaid plans that utilize PA policies have lower rates of abuse and overdose following initiation of opioid medication treatment.

**STRATEGY 2.2**

**Facilitating coordination between physicians and pharmacies when patients are “doctor shopping” or “pharmacy shopping” or receiving multiple prescriptions.**

Health plans coordinate with physicians and pharmacies to identify patients who receive prescriptions from multiple providers. Some health plans also have implemented programs to direct patients who are accessing multiple opioid prescriptions from multiple providers to a single prescriber and pharmacy for improved monitoring.

Issues related to doctor and pharmacy shopping are also impacting Medicare beneficiaries. A 2017 report from the HHS Office of Inspector General found that 90,000 beneficiaries are at serious risk of opioid misuse and overdose, and that approximately 22,000 beneficiaries appear to be doctor shopping. To combat this issue within the Medicare population, health plans support the process for sharing information among Medicare Part D plans when beneficiaries who have been identified as potential over-users of opioids move from one Part D plan to another.

**STRATEGY 2.3**

**Analyzing pharmacy claims to identify prescription patterns that may indicate overuse or misuse to inform early interventions.**

Health plans analyze their pharmacy claims data to identify prescription patterns that show someone at high-risk of potential overuse or misuse. Plans share information with providers and collaborate to intervene with at-risk individuals to provide education, counseling, and encourage treatment. Additionally, if warranted, controls can be implemented at the point-of-sale to trigger a pharmacist’s review of a member’s prescription.

This type of analysis may also uncover potentially dangerous drug interactions such as patients who are prescribed benzodiazepines with opioids, to trigger review and discussion with the patient.
Ways to Improve Early Intervention for Patients at Risk of an Opioid Addiction

AHIP’s health plan members work together to share best practices and identify potential policy solutions to combat this crisis. Some policy solutions that have been discussed pertaining to early intervention include:

- Advocate for improving prescription drug monitoring programs (PDMPs) and for health plans and pharmacy benefit managers to have access to the Pharmaceutical Benefit Management Procedures for a more complete view of patients’ controlled substances prescriptions.

- Modernize of 42 C.F.R. Part 2 to allow the confidential sharing of information on substance use diagnosis and treatment to improve patient safety, quality and care coordination as is permitted with any other chronic illness.

- Support additional resources for immediate “warm” handoffs to opioid addiction treatment for patients in emergency departments after overdose and connect family caregivers to appropriate support groups.

- Advocate for expanded efforts to develop valid quality and outcome metrics for pain and substance use disorder treatment.
Health Plan Treatment & Recovery Strategies

Health Plan Treatment & Recovery Overview

The consequences of the opioid crisis are profound, impacting individuals and families no matter where they live, how much they earn, or how young or old they are. The impact is broad, affecting social services, the health care system, communities and the economy. Health plans recognize this far-reaching impact, and are working to provide access to evidence-based treatment and recovery services for patients in need. Health plan case management programs provide ongoing services, support and education to treat people with, or at risk of developing, opioid and other substance use disorders, as well as their caregivers and families.

Key Health Plan Recovery Strategies to Treat Opioid Addiction & Substance Use Disorder

STRATEGY 3.1
Providing patients struggling with opioid use disorder access to evidence-based treatment including medication assisted treatment (MAT), counseling, and recovery support.

Health plans are committed to providing access to evidence-based medication assisted treatment (MAT) to help a person overcome their substance use disorder, including medications like buprenorphine and naltrexone, along with services such as counseling, peer support services and community based support groups. In recent months, several plans have lifted prior authorization requirements to ensure streamlined access to MAT for patients suffering from a substance abuse disorder.

However, provider shortages often impact a patient’s ability to access these services. A 2015 article¹⁴ in the Annals of Family Medicine found that only 3% of primary care physicians had received waivers from the Drug Enforcement Agency (DEA) to prescribe buprenorphine, the main drug used in MAT. As a result, more than 30 million Americans live in counties where there is no physician available who is certified to prescribe buprenorphine.
In addition to MAT, health plans offer comprehensive substance use treatment programs to members, including cognitive behavioral health counseling, peer support services, community-based support groups, rehabilitation/detoxification, and recovery support. Because individuals struggling with addiction often have other chronic medical and behavioral health conditions, treatment for opioid use disorder must be customized and coordinated to ensure the best possible opportunity for recovery. Once patients have entered a withdrawal management program, plans work closely with these patients and their providers to ensure ongoing engagement in their care and to help prevent relapses.

**STRATEGY 3.2**

*Improving access to treatment services such as counseling, peer support services, and community-based support groups.*

Health plans engage their members to provide them with support programs, such as substance use disorder coaching and Pharmacy Home programs to coordinate care and medication access. AHIP supports the protections established by the federal Mental Health Parity and Addiction Equity Act (MHPAEA), and health insurance providers have been working diligently to implement them.

Additionally, plans work with state and federal agencies and other stakeholders to promote rapid and effective access to evidence-based treatment for people at increased risk of overdose and death, such as individuals re-entering the community after serving prison or jail time. Efforts may include pre-release Medicaid enrollment, enhanced care coordination efforts to ensure linkage to community treatment providers, and recovery services to support stability during the transition home.

**STRATEGY 3.3**

*Partnering with other community organizations to increase access to treatment for patients with opioid use disorder.*

Often, health care resources are limited, particularly in rural areas, for patients seeking treatment for an opioid use disorder. Plans are actively collaborating with community non-profits, criminal justice organizations, local law enforcement, and maternity care centers to connect patients in need with treatment.
Many plans are also seeking to extend availability of care and treatment through telehealth services. Telehealth would allow individuals to access a physician more conveniently, and would provide much needed access particularly in rural regions and for chronically underserved populations.

**Ways to Improve Treatment and Recovery Strategies**

AHIP’s health plan members work together to share best practices and identify potential policy solutions to combat this crisis. Some policy solutions that have been discussed pertaining to treatment and recovery include:

- Expand access to evidence-based medication assisted treatment (MAT) and recovery services for patient and family-centered care. This can include expanding and strengthening the workforce by supporting those authorized to prescribe MAT to care for more patients, and improving the quality infrastructure (e.g., quality/outcome measures, validated standards, accreditation for behavioral health facilities and providers).

- Encourage adoption of a comprehensive opioid management program in Medicaid and other state-run health programs, with greater flexibility and an emphasis on patient and family-centered care.

- Encourage coordination and collaboration with the legal system, such as drug treatment courts through pre-trial drug diversion programs, in the rehabilitation of members with drug-related offenses and underlying substance use disorders.

- Encourage all pharmacies to dispense naloxone.

- Enact “Good Samaritan” legislation to provide legal protection for individuals that assist someone who experiences an opiate-related overdose.

- Increase oversight of fraudulent programs exploiting patients and targeting health insurance revenue (e.g., sober homes that do not provide evidence-based care, excessive billing for urine drug screening tests).

*This report was prepared for publication by AHIP’s Clinical Affairs. For further information, please contact Kate Berry, Senior Vice President, at kberry@ahip.org*
The STOP Measure
Safe and Transparent Opioid Prescribing to Promote Patient Safety and Reduced Risk of Opioid Misuse

FEBRUARY 2018

AHIP’s Safe, Transparent Opioid Prescribing (STOP) Initiative
**Methodology & Establishment of a Baseline**

Opioid misuse and addiction is an urgent public health crisis in America. As leading researchers have noted, the number of prescriptions for opioids (e.g., hydrocodone and oxycodone products such as Vicodin and Percocet, respectively) have escalated from approximately 76 million in 1991 to nearly 207 million in 2013. The United States is the biggest consumer, accounting for almost 100 percent of the world total for hydrocodone and 81 percent of oxycodone use, as a result, approximately 142 Americans die every day from an opioid overdose.² The impact is broad, affecting individuals and families, social services, the health care system, communities, and the economy.

The opioid crisis must be addressed comprehensively by all stakeholders – from law enforcement and the justice system, to social services agencies, community housing programs, and Medicaid programs, to physicians and other health care providers, pharmacists, health insurance providers, and pharmaceutical companies. Health insurance providers have been part of the solution by embracing a comprehensive approach encompassing prevention, early intervention, and substance use disorder treatment and recovery. America’s Health Insurance Plans (AHIP) and its members recently launched the Safe, Transparent, Opioid Prescribing (STOP) Measure – a robust, evidence-based methodology that health insurance providers can use to assess how provider practices compare to the federal recommendations for prescribing opioids.

**The STOP Measure – Methodology**

The STOP Measure is designed to assess adherence with the Centers for Disease Control and Prevention (CDC) *Guideline for Prescribing Opioids for Chronic Pain* for primary care physicians. Issued in 2016, the *Guideline* consists of twelve recommendations to help medical decision-makers determine when to initiate or continue opioids for pain.

The STOP Measure focuses on six of the twelve recommendations included in the CDC *Guideline* that can be measured using health insurance claims data.
To develop the methodology, AHIP was advised by an Expert Panel of clinical leaders from health insurance plans with experience in pain management and opioid prescribing. Together, AHIP and the Expert Panel developed the following specific measures to align with the CDC recommendations:

- Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for chronic pain.
- Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for acute pain.
- Morphine milligram equivalent (MME) of initial opioid prescription for chronic pain.
- Days’ supply of initial opioid prescription for acute pain.
- Proportion of patients with a follow-up visit (based on E&M CPT codes) within 30 days after the initial opioid prescription for chronic pain.
- Proportion of patients who received a urine drug test within 30 days before initial opioid prescription (initial screening) and within 365 days after initial opioid prescription (annual screening) for chronic pain.
- Proportion of patients who had an overlapping benzodiazepine prescription filled during opioid treatment for chronic pain.

A more detailed description of the measures are in to Appendix A.

Data from the Truven MarketScan® Commercial Claims and Encounters Database was used to assess the feasibility of operationalizing the CDC recommendations using claims data and to conduct an initial retrospective assessment of adherence to the six CDC recommendations.

Enrollees undergoing active cancer treatment, receiving palliative or end-of-life care, were excluded per the CDC Guideline. Enrollees diagnosed with human immunodeficiency virus (HIV), end-stage renal disease (ESRD), or sickle cell anemia were also excluded based on input from the Expert Panel, who noted that patients with these diseases are often treated by specialists (who were explicitly outside of the scope of the CDC Guideline).
Analysis included data from 2009 – 2013, before the 2016 dissemination of the CDC Guideline, and thus illustrates an industry-wide baseline prior to their adoption.

The STOP Measure – Results

Below are the initial results of the retrospective assessment.

Based on this analysis, current practice is closely aligned with the guideline of prescribing immediate release opioids rather than extended-release opioids. For the other CDC recommendations, there is room for improvement to better align practices with the Guideline. This includes: opioid prescription dosages, opioid prescription duration for acute pain, follow-up visits within 30 days of initial opioid prescription, initial urine drug testing and annual urine drug testing while on chronic opioid therapy, and overlapping prescriptions for benzodiazepines with opioids.

**Extended-release opioid prescriptions as a proportion of all initial opioid therapy prescriptions (Recommendation #4).** CDC Recommendation #4 states that when starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

Results show that the great majority of initial opioid prescriptions for chronic pain were for immediate-release opioids; about 97% throughout 2009-2013. The results indicate strong compliance with this recommendation.

<table>
<thead>
<tr>
<th>Year</th>
<th>Immediate-Release Initial Opioid Prescriptions (%)</th>
<th>Extended-Release Initial Opioid Prescriptions (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>96.7</td>
<td>3.3</td>
</tr>
<tr>
<td>2010</td>
<td>97.7</td>
<td>2.3</td>
</tr>
<tr>
<td>2011</td>
<td>97.8</td>
<td>2.2</td>
</tr>
<tr>
<td>2012</td>
<td>97.7</td>
<td>2.3</td>
</tr>
<tr>
<td>2013</td>
<td>97.4</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Morphine milligram equivalent (MME) of initial opioid prescription for chronic pain (Recommendation #5).

CDC Recommendation #5 states that when opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to >= 50 MME/day, and should avoid increasing dosage to >= 90 MME/day or carefully justify a decision to titrate dosage to >=90 MME/day.

Results show that about 25 percent of initial prescriptions for opioids exceed 50 MME, indicating there is room for improvement to reduce dosages.
Days’ supply of initial opioid prescription for acute pain (Recommendation #6).

CDC Recommendation #6 states that long-term opioid use often begins with treatment of 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 show 57% of opioid prescriptions for acute pain are for 4 or more days, indicating there is room for improvement to reduce the duration of opioid prescriptions for acute pain.
Clinician follow-up visits with patients to evaluate benefits and harms of continued opioid therapy (Recommendation #7). CDC Recommendation #7 states that clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 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 to discontinue opioids.

The calculation to measure this recommendation identifies the proportion of patients with a possible follow-up visit (based on the presence of medical claims for evaluation and management office visits) within 30 days after the initial opioid prescription for chronic pain.

Results show that about 52–57 percent of patients did not have an evaluation and management code in their medical claims within 30 days of their initial opioid prescription, indicating there is room for improvement regarding this recommendation.

<table>
<thead>
<tr>
<th>Year</th>
<th>Evaluation and management within 30 days after first opioid prescription</th>
<th>Evaluation and management within 30 days after first opioid prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DID NOT OCCUR (%)</td>
<td>OCCURRED (%)</td>
</tr>
<tr>
<td>2009</td>
<td>57.4</td>
<td>42.6</td>
</tr>
<tr>
<td>2010</td>
<td>57.7</td>
<td>42.3</td>
</tr>
<tr>
<td>2011</td>
<td>56.0</td>
<td>44.0</td>
</tr>
<tr>
<td>2012</td>
<td>54.3</td>
<td>45.7</td>
</tr>
<tr>
<td>2013</td>
<td>51.9</td>
<td>48.1</td>
</tr>
</tbody>
</table>
Proportion of patients who underwent urine drug testing within 30 days before initial opioid prescription (initial screening) and within 365 days after initial opioid prescription (annual screening) (Recommendation #10). CDC Recommendation #10 states that 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 show that only about 1 percent of patients received a urine drug test before being prescribed an opioid and 6 to 15 percent received annual urine drug tests while on chronic opioid therapy, indicating there is room for improvement regarding this recommendation.

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL TEST (%)</strong></td>
<td>0.5</td>
<td>0.6</td>
<td>0.8</td>
<td>1.1</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>ANNUAL TEST (%)</strong></td>
<td>6.7</td>
<td>8.0</td>
<td>10.4</td>
<td>12.2</td>
<td>14.9</td>
</tr>
</tbody>
</table>

Proportion of patients with overlapping prescriptions for opioids and benzodiazepines. (Recommendation #11). CDC Recommendation #11 states that clinicians should avoid prescribing opioid pain medications and benzodiazepines concurrently whenever possible.

Results show that over 40 percent of chronic pain patients were prescribed benzodiazepines during their opioid treatment, indicating there is room for improvement with regard to this recommendation.
The STOP Measure – Outlook

A growing number of health insurance providers are beginning to use the STOP Measure methodology to understand how practices perform compared with select CDC recommendations. The value of this methodology is two-fold: first, to demonstrate the feasibility of operationalizing the CDC Guideline using administrative claims data; and second, to provide an initial baseline to measure progress over time in improved adherence with the CDC Guideline. Health insurance providers will share information with their contracted providers and collaborate with them to improve adherence with evidence-based guidelines and to improve patient safety.

*This report was prepared for publication by AHIP’s Clinical Affairs. For further information, please contact Kate Berry, Senior Vice President, at kberry@ahip.org*
Appendix A: Specification for Measuring Adherence to CDC Opioid Guidelines

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DENOMINATOR INCLUSION</th>
<th>DENOMINATOR EXCLUSION</th>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC Recommendation 4</td>
<td>A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year</td>
<td>C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia.</td>
<td>Count of enrollees having an index opioid prescription for the denominator population</td>
<td>Count of enrollees having an index opioid prescription for an extended-release/long-acting opioid formulation</td>
</tr>
<tr>
<td></td>
<td>B. Enrollees undergoing chronic pain treatment</td>
<td>D. Enrollees receiving palliative or end-of-life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDC Recommendation 5</td>
<td>A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year</td>
<td>C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia.</td>
<td>Count of enrollees having an index opioid prescription for the denominator population</td>
<td>Count of enrollees whose index opioid prescription was one of the following MME equivalent dosage levels: 1. &lt;50 MME/day 2. 50 - 89 MME/day 3. ≥ 90 MME/day</td>
</tr>
<tr>
<td></td>
<td>B. Enrollees undergoing chronic pain treatment</td>
<td>D. Enrollees receiving palliative or end-of-life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDC Recommendation 6</td>
<td>A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year</td>
<td>C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia.</td>
<td>Count of enrollees having an index opioid prescription for the denominator population</td>
<td>Count of enrollees whose index opioid prescription was for one of the following days supply levels: 1. ≤3 days 2. 4-7 days 3. &gt;7 days</td>
</tr>
<tr>
<td></td>
<td>B. Enrollees undergoing chronic pain treatment</td>
<td>D. Enrollees receiving palliative or end-of-life care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix A: Specification for Measuring Adherence to CDC Opioid Guidelines

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DENOMINATOR INCLUSION</th>
<th>DENOMINATOR EXCLUSION</th>
<th>DENOMINATOR</th>
<th>NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC Recommendation 7 (any physician)</td>
<td>A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year</td>
<td>C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia.</td>
<td>Count of enrollees having an index opioid prescription for the denominator population</td>
<td>Count of enrollees who had an outpatient visit (with the physician who prescribed the first opioid prescription OR any other physician) that included evaluation and management services within 30 days of the initial opioid prescription.</td>
</tr>
</tbody>
</table>

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.

| CDC Recommendation 7 (same physician) | A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year | C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia. | Count of enrollees having an index opioid prescription for the denominator population | Count of enrollees who had an outpatient visit (with the same physician who prescribed the first opioid prescription) that included evaluation and management services within 30 days of the initial opioid prescription. |

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.

| CDC Recommendation 10 (any physician) | A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year | C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia. | Count of enrollees having an index opioid prescription for the denominator population | 1. Initial screening: count of enrollees who had a urine drug test (ordered by the physician who prescribed the first opioid prescription OR ordered by any other physician) within 30 days before the initial opioid prescription. |

- 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.

| | | | 2. Annual screening: count of enrollees who had a urine drug test (ordered by the physician who prescribed the first opioid prescription OR ordered by any other physician) within 365 days after the initial opioid prescription. | |
# Appendix A: Specification for Measuring Adherence to CDC Opioid Guidelines

## MEASURE

<table>
<thead>
<tr>
<th>DENOMINATOR INCLUSION</th>
<th>DENOMINATOR EXCLUSION</th>
<th>DENOMINATOR NUMERATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CDC Recommendation 10</strong> (same physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Enrollees undergoing chronic pain treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Enrollees receiving palliative or end-of-life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Count of enrollees having an index opioid prescription for the denominator population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Initial screening: count of enrollees who had a urine drug test (ordered by the same physician who prescribed the first opioid prescription) within 30 days before the initial opioid prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Annual screening: count of enrollees who had a urine drug test (ordered by the same physician who prescribed the first opioid prescription) within 365 days after the initial opioid prescription.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **CDC Recommendation 11** (any physician) |
|Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. |
| A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year |
| B. Enrollees undergoing chronic pain treatment |
| C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia. |
| D. Enrollees receiving palliative or end-of-life care |
| Count of enrollees who filled benzodiazepine prescriptions with prescription service dates falling between the start date and the end date of their opioid treatment (the benzodiazepine prescription could have been prescribed by the same physician who prescribed the first opioid prescription OR any other physician). |

| **CDC Recommendation 11** (same physician) |
|Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. |
| A. Commercial enrollees age 18 and over with continuous coverage who have at least one opioid prescription during the measurement year |
| B. Enrollees undergoing chronic pain treatment |
| C. Enrollees undergoing active cancer treatment, having a recent diagnosis of ESRD, HIV, or sickle cell anemia. |
| D. Enrollees receiving palliative or end-of-life care |
| Count of enrollees who filled benzodiazepine prescriptions with prescription service dates falling between the start date and the end date of their opioid treatment (the benzodiazepine prescription having been prescribed by the same physician who prescribed the first opioid prescription). |
## Table B.1 List of Identifying Codes for Medical Conditions

<table>
<thead>
<tr>
<th>MEDICAL CONDITION</th>
<th>ICD-9-CM CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>140.0 – 239.9</td>
</tr>
<tr>
<td>HIV</td>
<td>042</td>
</tr>
<tr>
<td>ESRD</td>
<td>585.5, 585.6</td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
<td>282.60 – 282.69</td>
</tr>
</tbody>
</table>

## Table B.2 List of Identifying Codes for Medical Procedures

<table>
<thead>
<tr>
<th>MEDICAL PROCEDURE</th>
<th>HCPCS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Assessment</td>
<td>G8730, G8731, G8509, G8939</td>
</tr>
<tr>
<td>Drug Test Urinalysis</td>
<td>G0430, G0431, G0434</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL PROCEDURE</th>
<th>CPT CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>99211, 99212, 99213, 99214, 99215</td>
</tr>
<tr>
<td>Drug Test Urinalysis</td>
<td>80100, 80101, 80102, 80103, 80104, 80150, 80152, 80154, 80156, 80157, 80158, 80160, 80162, 80164, 80166, 80168, 80170, 80172, 80173, 80174, 80176, 80178, 80182, 80184, 80185, 80186, 80188, 80190, 80192, 80194, 80195, 80196, 80197, 80198, 80200, 80201, 80202, 80209, 82003, 82055, 82101, 82145, 82205, 82415, 82520, 82638, 82646, 82649, 82654, 82742, 83840, 83925, 83992, 84022</td>
</tr>
</tbody>
</table>
Opioid use and chronic vs. acute pain definitions were based on the paper by Von Korff et al as follows:

**Opioid treatment – opioid use episode**

- Index opioid prescription (start of episode date) – no previous prescriptions in 180 days
- End of episode date = end of opioid treatment date + days’ supply
- All prescription with less than 180 days’ gap are considered part of the same opioid treatment

**Chronic vs Acute Pain Treatment**

**Acute pain treatment:**
- Treatment duration <= 90 days

**Chronic pain treatment:**
- Treatment duration > 90 days
- Total day supply > 180 or number of prescriptions > 10
Data Base Details

- The Truven MarketScan® Database contains de-identified administrative data from large employers and health plans across the U.S. who provided private health care coverage for 44 million - 53 million individuals in 2008-2014; about a quarter of the U.S. commercially insured population.

- In addition, the Truven Red Book 2017 dataset was used to construct a list of pharmacological treatments.

- The analyses included patients aged 18 to 64, continuously enrolled for at least 3 years between 2008 and 2014, and with at least one prescription for an opioid.

Study Limitations

Limitations of this study include the absence of well-populated provider identifiers in the Truven MarketScan® data, which makes the measures for Recommendations 7 (evaluation of opioid therapy in follow-up visits) and 10 (urine drug testing) somewhat less precise since we are not able to ascertain with certainty that this testing or evaluation and management procedures were related specifically to opioid management of chronic pain. Another study limitation was the definition of the initiation of opioid therapy for chronic pain based on the subsequent opioid use prescription patterns. Some of these therapies could have been started as an episode of acute pain opioid management and later became chronic pain management, however, this type of information may be captured in electronic medical records but not in the administrative data.