Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter

Comments due: March 2, 2018

Feedback in red:

- Enhancing the OMS by such that it identifies high risk beneficiaries who use "potentiator" drugs (such as gabapentin and pregabalin) in combination with prescription opioids to ensure that plans provide appropriate case management. Potentiators are drugs that when taken with an opioid increase the risk of an adverse event.

  OMS already flags concurrent benzodiazepine use by plan enrollees.

  This is concerning as the gabapentinoid class of medications are extremely useful for pain management, including pain other than neuropathic with not nearly as much concern in combination with opioids as benzos/z drugs/soma. This is a cornerstone medication that has allowed many providers to reduce opioid use and has sufficient evidence to support its continued use. I would remove the concern for these medications at this time, as there are not very many options for alternatives to opioids for pain management, but rather add soma and z drugs to the list of concerns with opioid medications and the already listed benzodiazepines.

- Implementing technical revisions to the Pharmacy Quality Alliance (PQA) measures used by CMS to evaluate Part D sponsors' progress in combatting the opioid crisis, and consideration of a new PQA measure, Concurrent Use of Opioids and Benzodiazepines. Given the danger of combining opioids and benzodiazepines, we seek feedback in the Call Letter on starting to track a new measure to address this issue. This measure assesses the percentage of individuals 18 years and older with concurrent use of opioids and benzodiazepines.

  Again, I would add soma and z drugs to this list; this has also been outlined in the CDC guidelines as medications of concern when used in combination with opioids.

- Expecting all sponsors to implement hard formulary-level cumulative opioid safety edits at point-of-sale (POS) at the pharmacy (which can only be overridden by the sponsor) at 90 morphine milligram equivalent (MME), with a 7-day supply allowance.

  Is this for acute pain or chronic pain or both? If for chronic pain-the 7 day supply, this is not feasible. If for acute pain-these are reasonable measures, however would take into consideration patients with acute on chronic pain that may end up on >90MED more than their baseline due to a new injury/surgery/trauma/etc.

- Implementing a supply limit for initial fills of prescription opioids (e.g., 7 days) for the treatment of acute pain with or without a daily dose maximum (e.g., 50 MME).

  Avoid using a daily dose maximum, however the 7 day supply is in alignment with many guidelines and with the direction of new upcoming guidelines.

- Expecting all sponsors to implement soft POS safety edits (which can be overridden by a pharmacist) based on duplicative therapy of multiple long-acting opioids, and request feedback on concurrent prescription opioid and benzodiazepine soft edits.

  Add soma and z drugs to the list. Also consider adding multiple short acting opioid medications to this list.