Changes to the Arizona Health Care Cost Containment System (AHCCCS) Pharmacy Program

Marc Leib, M.D., J.D.
Chief Medical Officer
NAMD October 30, 2012
Historical Prospective

- In 1982, Arizona was the last state to adopt Medicaid, 17 years after its inception.
- Designed almost exclusively as a managed care program under the first waiver of its kind.
- Drugs provided through MCOs were not eligible for rebates, which resulted in AZ being the only state that did not participate in the Medicaid Drug Rebate Program.
Cost-Effectiveness of Program

- To determine whether MCO oversight of pharmacy benefits was cost effective vs. Agency oversight with rebates, the Lewin Group conducted a study of AHCCCS vs. other state Medicaid programs.

- This study showed that in spite of forgoing the 15.1% federal rebates, AZ was the least costly Medicaid pharmacy program on a pmpm basis, with the next most cost-effective program costing 11% more.
Reasons for Cost Effectiveness

- Pharmacy benefits administered by MCOs, with all medically necessary drugs covered, BUT
  - Generics-first mandated as cost-effective therapy
  - Brand name drugs covered only if generic drugs were ineffective or otherwise contra-indicated
  - Extensive MCO step-therapy and coverage guidelines to discourage use of more expensive drugs before less-costly alternatives have failed
  - Drug costs directly affect MCO bottom lines
Changes to Pharmacy Program

- AHCCCS now participates in the Medicaid Drug Rebate Program
- Physician administered drugs requirements
- 340B Pricing requirements
- No state-wide Preferred Drug List (PDL), each MCO administers its own pharmacy program
- Recently developed a Minimum Required Prescription Drug List (MRPDL) for all plans
Medicaid Drug Rebate Program

- PPACA extended rebates to drugs paid for by Medicaid Managed Care Organizations
- Rebates available to State for prescription drugs
- Physician-administered drugs in an office or outpatient hospital setting are reported with NDC codes for rebate reporting purposes
- These changes result in significant savings
340B Pricing

- Although AZ now eligible for rebates, drugs purchased by 340B entities are not eligible because the discount is at the front end, not through rebates.

- AHCCCS and its MCOs now pay FQHCs and other non-hospital 340B eligible entities at the lesser of the 340B price or actual acquisition cost.

- These entities receive an enhanced dispensing fee since there is no markup on the drugs to cover indirect costs of the entity.
340B Pricing

- As expected, the FQHCs and FQHC look-alikes initially resisted this change.
- Alternative was to require AHCCCS members to obtain prescription drugs at network pharmacies, which would make them eligible for rebates.
- Instead, the enhanced dispensing fee allows these entities to cover the costs of dispensing drugs and results in savings to the State.
Preferred Drug Lists

- AHCCCS does not have a PDL for purposes of claiming Supplemental Rebates
- Instead, contracted MCOs and their PBMs negotiate discounts with savings directly benefitting the MCOs
- MCO savings result in lower capitation rates, saving the State money overall
Minimum Required Prescription Drug List

- Prescribers complained about inconsistent coverage among MCOs
- Providers wanted more coverage consistency, because to them, a Medicaid member is a Medicaid member
- AHCCCS and its Contractors developed the MRPDL over a three-year collaborative effort
Minimum Required Prescription Drug List

☐ This is NOT a PDL or equivalent
☐ This is NOT a Medicaid formulary
☐ This is NOT sufficient coverage by an MCO
☐ Drugs listed on the MRPDL are available from ALL MCOs with either no PA or only minimal PA requirements that must be met for approval
☐ Initial response from prescribers is positive
Use of Psychotropic Medications in Foster Care and Other Children

- Foster children in AZ enrolled in a dedicated MCO with a broad network administered through another state Agency
- Medicaid members, including foster children, receive behavioral health care through behavioral health MCOs contracted though a separate Agency
Use of Psychotropic Medications in Foster Care and Other Children

- Use of psychotropic medications in foster children in AZ compares favorably to other states according to data collected through the Medicaid Medical Directors Learning Network.

- But, like most states, use of psychotropic medications is greater in foster children than in other Medicaid enrolled children receiving behavioral health services.
Use of Psychotropic Medications in Foster Care and Other Children

- AHCCCS is looking for opportunities to appropriately reduce use of psychotropic medications in foster children

- Difficult to reduce use to the same level as other Medicaid enrolled children receiving BH services because foster children seem to have more severe BH issues than other Medicaid enrolled children in the BH system
Drug Abuse/Overuse

- MCOs ideally monitor for excessive drug use or abuse by members
- Providers ideally utilize the state prescription drug database to know what has been prescribed and filled
- Identify members who abuse drugs by doctor shopping, seeing multiple providers, or going to the ED for severe pain
Member Lockdown

- When misuse/abuse is identified:
  - Member is locked down to a single prescriber
  - Member is locked down to a single pharmacy
  - Cannot deny ED visits for an “emergency” but can deny prescription provided in the ED and deny payment for any narcotics dispensed in ED
  - EDs notified and cooperate by not administering drugs or giving prescriptions
Addressing the Challenges of Safe and Effective Psychotropic Use and Mental Health Services in Medicaid Programs: Improving Care Through Metric-Driven CQI

Stephen Crystal

Center for Health Services Research on Pharmacotherapy, Chronic Disease Management, and Outcomes
Rutgers University

Panel on The Future of Medicaid Drug Policy
National Association of Medicaid Directors
Fall 2012 Conference -- October 30, 2012
Arlington, VA
The Problem

• MH conditions account for large share of overall illness burden and expenditure -- directly and via impact on treatment and course of co-occurring medical conditions.

• For publicly insured, responsibility for and data on MH tx often fragmented between multiple systems; care processes and outcomes often fall short. Prescription pad often easier to access than appropriate, coordinated, evidence-based services.

• Appropriate, safe and effective use of antipsychotic (AP) and other psychotropic medications identified by states and other stakeholders as high-priority QI issue. High rates of off-label AP use, often without adequate psychosocial mental health services, are a concern.

• Use patterns vary widely; uptake of evidence based practices highly uneven. Need for more effective monitoring and management of these powerful but not risk-free treatments.

• Recent developments such as GAO report on prescribing in foster care and IG report on prescribing in nursing homes reinforce the need.

• States need tools to address these needs.
Key Concerns

- Within-class and between-class polypharmacy; dosage; use in children under 6: “too many, too young, too much.”
- High psychotropic use and polypharmacy in foster youth.
- Use in nursing home (and community) elderly with dementia, despite significant safety concerns and FDA black box warning.
- New national concerns sparked by GAO reports on psychotropics in foster youth, and IG report on antipsychotics in nursing home elderly. New ACYF requirements for foster youth; CMS goal of reduction in AP use in nursing homes.
- Monitoring and managing metabolic risks of antipsychotics.
- Monitoring and improving adherence (adult quality measure on consistent use of AP meds in benes with schizophrenia is a good place to start).
- MH assessment and services consistent with treatment.
- Inconsistent access to some treatments (e.g., evidence-based psychosocial interventions, trauma-informed treatments, clozapine).
Critical Issues for Medicaid Programs

– Which quality measures to focus on; how to use them most effectively to drive CQI and assess impact of the many new initiatives and structural changes underway in Medicaid, as close to real-time as possible.

– Need to add additional metrics related to psychotropics and mental health treatment to existing “official” child and adult quality measures.

– Integration of “siloed” data streams to support quality measurement. Feeding back needed data to appropriate users (e.g., addressing multiple prescriber problem).
Critical Issues for Medicaid Programs

- Integrated quality measurement and QI across FFS and managed care sectors; incentives for quality improvement on safe and effective use of psychotropics, and for use of evidence-based mental health services prior to or concurrent with use of antipsychotics.
- Appropriate contractual standards and network adequacy. Aligning incentives (e.g., misalignments that result from plans being at risk for some treatment modalities and not others).
- Appropriate use of metrics-based QI initiatives and policies to improve quality, including second opinions, provider feedback, prior auths while minimizing hassle factor for clinicians.
- Managing medication shifts during transitions, as important component of interventions to improve transitions and reduce mental health rehospitalization.
### Annual Antipsychotic Use Rates by Foster Care Medicaid FFS Youth*
#### Ages 6-17, 2001 - 2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Foster Care</th>
<th>Non-Foster Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>9.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>2002</td>
<td>10.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>2003</td>
<td>12.1%</td>
<td>2.94%</td>
</tr>
<tr>
<td>2004</td>
<td>13.2%</td>
<td>3.3%</td>
</tr>
<tr>
<td>2005</td>
<td>13.6%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

*MAX all states except AZ, DE, DC, OR, NV, RI, NJ, ME*
Data Driven State QI Strategies: Metrics are Fundamental

“If you can’t measure it, it’s hard to improve it”

Use of Metrics at State Level

– Decision support for data-informed policymaking/planning.
– Assessing treatment rates, patterns, trends, guideline consistency, comparison to cross-state and other benchmarks, variation across geog. Areas/provider type.
– Support communication/collaboration with state stakeholders on identification of needs and improvement strategies.
– Turning data into information: maps, graphics, trend analysis to support CQI and a “learning care system” for children.
– Tracking progress toward desired outcomes. Toward integration of treatment and outcome data as framework for tracking progress.
Use of Metrics at Provider Level

• Feedback to clinical providers on treatment patterns; comparison of patterns to treatment recommendations, benchmarking vs. other providers.

• Identifying outlier providers, prioritizing provider-level interventions, informing incentives.

• Implementation challenges for states include:
  – Accurate attribution of children to providers; dealing with multiple-prescriber situations.
  – Collaboration with provider community; achieving provider buy-in.
  – Debates about measurement, validity, risk adjustment. “My patients are sicker than other providers”—i.e., “all the children are below average!”
Use of Metrics at Provider Level

- Need to balance a clear vision of intended change and willingness to take risks with commitment to listen and make appropriate adjustments.
- Not an “autopilot” process but requires ongoing assessment and adjustment.
- Effective QI through provider feedback facilitated by:
  - Long-term commitment
  - Stable leadership
  - Ongoing assessment and adaptation based on data (CQI approach)
  - Good communication and trust-building with provider community
- Incentives for prescribers with best practices used in some states—e.g., TN Best Practice Provider (BPN) network. Referrals, exemption from PA requirements, CME access, etc. can serve as incentives.
Use of Metrics at Patient Level

- “Review flags” for second opinions and other interventions.
- Second opinion programs (voluntary or required based on metrics) are important tool.
- Other applications of person-level metrics include identifying nonadherence; monitoring receipt of appropriate mental health services and evaluations; supporting communication among participants in decisionmaking and care for child (eg multiple prescribers and other clinicians; casework and agency staff; judges; foster care providers; parents.)
DATA SOURCES

- Medicaid FFS Claims
- Medicaid Eligibility Files
- Medicaid MC Encounter Data
- Medicare (A, B, D)
- State Children Services Data (CWIS)
- Mental Health Carveouts (Managed Care, county, etc)
- Other Sources and Providers

DATA INTEGRATION

DATA USERS

- Policymakers/Planners
- Mental Health Prescribers/Providers
- Child Welfare Staff
- Caregivers/Reviewers/Consenters
- Consumers
- Primary Care and Other Providers/Prescribers

- Mental Health Prescribers/Providers
- Child Welfare Staff
- Caregivers/Reviewers/Consenters
- Consumers
- Primary Care and Other Providers/Prescribers
Background: The MMDLN ACP Project

• MEDNET builds on a joint project between AHRQ’s Rutgers CERTs and Medicaid Medical Directors Learning Network (MMDLN) – 2007
  — MMDs identified the issue of antipsychotic prescribing in youth as top priority for a collaborative project, which became the Antipsychotics in Children Project (ACP)
• MEDNET invited the original 16 states to participate, six joined the MEDNET learning collaborative
  — CA, ME, MO, OK, TX, WA
• MEDNET Multi-state collaborative vision includes:
  — Benchmarking of AP prescribing practices across states
  — Documentation/sharing of promising practices
  — States implement new and promising practices
  — Provider level reporting
Lessons Learned from ACP Project

• States have strong levers, potentially, to influence adoption of evidence-based practices.
• Multi-state QI initiatives in partnership with researchers have promise but must address:
  – Development of appropriate metrics and need for substantial TA in analysis, implementation and utilization of metrics.
  – Fragmented responsibilities and data systems; need to support within-state collaboration across agencies.
  – Identification of service delivery system innovations that are effective in increasing use of evidence-based clinical practices.
  – Need to further engage providers and stakeholders.
Six states collaborated with Rutgers and other partners to improve prescribing of antipsychotics

- Plan for a systematic, collaborative, multi-state initiative
- Accelerate the implementation of CE findings in Medicaid funded mental health care
  - Findings on effectiveness and safety of specific clinical practices.
  - Findings on effectiveness of organizational practices, strategies and policies related to management of these treatments and of risks associated with treatments across subpopulations.
- Address treatment challenges for adults and kids
- Use common metrics to support data driven QI
  - Problem identification
  - Monitoring
  - Provider feedback interventions
Targeted Clinical Practices

MEDNET EBP Focus

- Psychotropic polypharmacy
- Safe dosing
- Managing metabolic risks of antipsychotics
- Improving treatment adherence for adults with SMI
- Alternatives/complement to medication
- Special populations
- Assessing and addressing variations in treatment practices
- Consistency of treatments and diagnoses
Measuring and Acting on Dimensions of Quality

- Antipsychotic use rates.
- Too Young: Retrospective and prospective reviews for antipsychotic treatment of very young children.
- Too Many
  - Antipsychotic Polypharmacy
  - Cross-Class Polypharmacy
  - Importance of Concurrent Use Measures
- Too Much—Dosage Parameters and Reviews
- Managing Metabolic Risk
  - Monitoring metabolic parameters, prior to and during treatment.
  - Appropriate use of agents with lower metabolic burden.
- Mental health evaluation; psychosocial treatment prior to/concurrent with pharmacological treatment.
MEDNET Consortium

- **MO**
  - Reduce unnecessary psychotropic prescribing and associated costs
  - Use multiple indicators to track
    - AP and cross class polypharmacy, safe dosing, and adherence
  - Strategies
    - Quarterly benchmark reports and educational newsletters
    - Developing a second opinion program for case review
    - Targets providers based on outlier prescription count
• OK

– Educate pediatric providers to improve psychotropic prescribing (targets children 5-14)
– Indicators of concern include safe dosing standards and diagnostic indication consistent with treatment
– Strategies
  • Statewide quarterly “enhanced” DUR letters and with peer provider benchmarks and educational materials
  • Second opinion for any case exceeding FDA dosage recommendations
  • Very engaged stakeholder group that has encouraged work to expand to monitoring children in foster care
• TX
  – Expand existing foster care monitoring strategies to other Medicaid populations
  – Current measurement follows state foster care prescribing parameters
    • Updated parameters; Annual prescribing reports published on line
  – Strategies
    • Flags children at risk for *immediate* prescriber intervention
    • Individual outreach to any and all outlier prescribers
      – Direct consultation and second opinions required
      – Face to face academic detailing for “high” opportunity providers (slow to change)
    – Leverages MCOs contract to ensure quality
MEDNET Consortium

• WA

– Reduce unnecessary psychotropic prescribing, increase adherence to EBP, reduce associated costs of acute care treatment
– Use multiple indicators to track
  • Adherence, AP and cross-class polypharmacy, dosage
  • Email monthly performance reports to clinics and prescribers
  • 12 Pilot clinics enrolled in CMHC based “Learning Congress”
    – Monthly webinars and additional TA for pilot clinics
    – Responsive feedback loop with prescribers
  • Leverages other state initiatives
    – Peer review and second opinion help line
MEDNET Approach

• Each state is unique
  – Specific organizational structures, Medicaid eligibility criteria, benefit arrays, financing structures
  – Different administrative and policy levers employed
  – Individual processes for development of DUAs and sharing data
  – Political environments are ever changing

• State Data
  – Claims and eligibility data for its Medicaid population
  – Rutgers supports development and estimation of quality measures
  – Analyses will provide clearer understanding of prescribing trends
  – Core Metrics
    • Treatment patterns
    • Issues and outcomes associated with measures
MEDNET Approach

• Barriers and Creative Solutions

  - States are critical players for adoption of evidence based practices and QI interventions, but face distinctive challenges in implementation—thin staffs, competing demands, limited data infrastructure, complex decisionmaking processes, and more.

  - Sustained effort and consistent leadership critical for QI, but state level health services leadership has been undergoing a period of considerable turnover and organizational change.

  - E.g., CA MEDNET plan developed as initiative led by State Dept. of Mental Health—soon after project start, a state reorganization eliminated DMH as a separate state agency, with many of its responsibilities devolved to the counties.

  - New state administrations and Medicaid leadership in several of the states complicated implementation. Shifts to managed care also impacted plans.

  - Reorganizations changed or eliminated the positions of several key state MEDNET leaders.

  - In several instances, creative adjustments to project strategies were needed to address changing state priorities and organizational structures. Solutions were required. E.g., CA MEDNET was implemented at the county level via a county managed care plan (CalOptima), bringing MC perspective to project.
MEDNET Approach

• Each state is unique
  – Specific organizational structures, Medicaid eligibility criteria, benefit arrays, financing structures
  – Different administrative and policy levers employed
  – Individual processes for development of DUAs and sharing data
  – Political environments are ever changing

• State Data
  – Claims and eligibility data for its Medicaid population
  – Rutgers supports development and estimation of quality measures
  – Analyses will provide clearer understanding of prescribing trends

  • Core Metrics
    • Treatment patterns
    • Issues and outcomes associated with measures
MEDNET Approach

- **Barriers and Creative Solutions**
  - States are critical players for adoption of evidence based practices and QI interventions, but face distinctive challenges in implementation—thin staffs, competing demands, limited data infrastructure, complex decisionmaking processes, and more.
  - Sustained effort and consistent leadership critical for QI, but state level health services leadership has been undergoing a period of considerable turnover and organizational change.
  - E.g., CA MEDNET plan developed as initiative led by State Dept. of Mental Health—soon after project start, a state reorganization eliminated DMH as a separate state agency, with many of its responsibilities devolved to the counties.
  - New state administrations and Medicaid leadership in several of the states complicated implementation. Shifts to managed care also impacted plans.
  - In several instances, creative adjustments to project strategies were needed to address changing state priorities and organizational structures. Solutions were required. E.g., CA MEDNET was implemented at the county level via a county managed care plan (CalOptima), bringing MC perspective to project.
“Take Aways”

• States have great potential for QI interventions with great public health impact, affecting large populations with millions of vulnerable beneficiaries. Strong interest in cross-state collaboration to avoid having to re-invent the wheel.
• Effective mental health care requires multiple state systems to work effectively together, but programs and policies as well as data are often “siloed”.
• Changing state systems is like turning a battleship (Newton’s Second Law).
• These interventions are high-risk/high-reward; challenging because of the many players involved and competition for state attention and resources, especially at times of large state financial cutbacks.
• State-level QI initiatives compete for limited state resources/attention with more immediate concerns.
• Sustained support working with within-state quality champions is key to keep quality on the radar screen.
“Take Aways”

• Sustained engagement and persistence is vital. Building partnerships and trust takes time, as does implementing and using metrics and other QI tools. Not a moon-shot but a cumulative process; as states begin to monitor and utilize metrics, and drill-down on problem areas, additional applications emerge and impact grows.

• Initial provider push-back common but MEDNET initiatives are making good headway in working with provider communities to mutually address quality issues.

• Within-state collaboration across agencies and with stakeholders is vital.

• States have strong interest in learning from one another; mechanisms needed for continuing collaboration.

• More effective deployment of metrics will require substantial work and TA to integrate data streams, turn raw data into useful quality information, distribute to needed users, and build feedback systems to support CQI as a standard operating practice.
Building Metric-Based CQI Processes into Medicaid Mental Health Care: Turning the Battleship

• States have great potential for QI interventions with great public health impact, affecting large populations with millions of vulnerable beneficiaries. Strong interest in cross-state collaboration in collaboration with researchers to make better use of data to drive quality.

• Effective mental health care requires multiple state systems to work effectively together, but programs and policies as well as data are often “siloed”. Sustained engagement is vital to maintain momentum in the face of state challenges including budget cuts, competing demands, limited data infrastructure, complex decisionmaking processes, etc.

• Changing state systems is like turning a battleship. Newton’s Second Law: body at rest tends to remain at rest until significant force applied; body in motion may remain in motion (if continued support provided to overcome frictional forces).
“Ask your doctor if taking a pill to solve all your problems is right for you.”
Presentations from Speakers Unable to Attend Session

The Future of Medicaid Drug Policy
October 30, 2012
Prescription Drug Use and Abuse in the Medicaid Population

Len Paulozzi, MD, MPH
Division of Unintentional Injury Prevention
National Center for Injury Prevention and Control

2012 Fall NAMD Meeting
October 30, 2012
Outline

- Background on the problem nationally
- Increased risk of overdose and other health outcomes in the Medicaid population
- Patterns of prescribing opioids in Medicaid
- Focus on prescribers
- Remedies
Motor vehicle traffic, poisoning, and drug poisoning (overdose) death rates
United States, 1980-2010

NCHS Data Brief, December, 2011, Updated with 2009 and 2010 mortality data
Drug overdose deaths by major drug type, US, 1999-2010

Distribution of drug overdose deaths by age group, U.S., 2009

Source: National Vital Statistics System
Age Distribution of Medicaid and Private Insurance Populations, U.S., 2010

Source: U.S. Census 2010
Proportion of Fatal Drug Overdoses Involving Current Medicaid Enrollees, Two States

Sources: MMWR 2009;58:1171 and Whitmire, North Carolina Center for Health Statistics, 2010
### Number and Rate of Deaths Attributed to Overdoses of Prescription Opioid Drugs, by Insurance Type — Washington State, 2004-2007

<table>
<thead>
<tr>
<th>Insurance Program</th>
<th>No. of Deaths</th>
<th>Crude Rate per 100,000</th>
<th>Age-adjusted Rate per 100,000</th>
<th>Age-adjusted RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>758</td>
<td>14.8</td>
<td>30.8</td>
<td>5.7 (5.3-6.1)</td>
</tr>
<tr>
<td>Non-Medicaid</td>
<td>910</td>
<td>4.5</td>
<td>4.0</td>
<td>Referent</td>
</tr>
</tbody>
</table>

Source: MMWR 2009;58:1171
Rate of Hospitalization for Poisoning by Opiates and Related Narcotics by Payer, 18+ years old, U.S., 2010

Source: HCUPnet
Opiate and related narcotics poisoning is defined as a first-listed diagnosis of ICD9-CM 965.0
Rate of ED Visits for Drug Poisoning by Payer, U.S., 2009

Source: NEDS of AHRQ.
Drug poisoning is defined as a first-listed diagnosis of ICD9-CM 960-979

<table>
<thead>
<tr>
<th>Payer</th>
<th>Pct. Of Unexposed Neonates</th>
<th>Pct. Of Drug-Exposed Neonates</th>
<th>OR (95% CI)</th>
<th>Pct. Of Neonatal Abstinence Cases</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>39.9</td>
<td>79.5</td>
<td>1.0</td>
<td>80.3</td>
<td>1.0</td>
</tr>
<tr>
<td>HMO or third party</td>
<td>59.2</td>
<td>17.5</td>
<td>0.3 (0.3-0.3)</td>
<td>17.1</td>
<td>0.2 (0.2-0.2)</td>
</tr>
<tr>
<td>Self-pay</td>
<td>0.9</td>
<td>3.0</td>
<td>1.3 (1.2-1.5)</td>
<td>2.6</td>
<td>1.0 (0.7-1.3)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>100.0</td>
<td>NA</td>
<td>100.0</td>
<td>NA</td>
</tr>
</tbody>
</table>

Rate of Opioid Prescriptions per 1,000 Persons by Payer, U.S., 2003-2004

Percentile Values of Days Supply of Opioids for Chronic Noncancer Pain, by Insurance Type, 2005

- Private
- Arkansas Medicaid

Private Insurance data is from Health Core.
High Risk Patients: Percentage of Total Opioids Consumed by Patient Daily Dosage Level, Arkansas Medicaid, 2005

High-Risk Prescribers: Percentage of CSII Opioid Prescriptions Written by Prescribers Ranked by Volume, CA Workers Compensation, 2005-2009

Swedlow et al. Prescribing patterns of schedule II opioids in California Workers’ Compensation, CWCI Institute, 2011
Percent of CS II-V Prescriptions by Prescriber Decile by Year, Kentucky, 2009

Top 20% of prescribers accounted for 82.2% of all prescriptions.

Blumenschein, K. et al. Independent Evaluation of the Impact and Effectiveness of the Kentucky All Schedule Prescription Electronic Reporting Program (KASPER) Institute for Pharmaceutical Outcomes and Policy, Univ of Kentucky, 2010
Average Prescription Size for Prescribers Ranked by Volume, CA Workers Compensation, 2005-2009

Swedlow et al. Prescribing patterns of schedule II opioids in California Workers’ Compensation, CWCI Institute, 2011
During 2001-2003, Florida Medicaid paid $347 million for controlled prescription drugs.

<3% of physicians prescribed two thirds of these drugs.

Two physicians earned $1 million each for prescribing drugs that cost Medicaid an addition $3 million.

Report notes that some physicians drop out of the Medicaid system and take cash, but their patients continue to bill Medicaid.

Schulte, F. Medicaid abuse is rampant. Sun Sentinel, November 30, 2003
Distributions of Patients and Opioid-related Deaths by Prescribing Volume, Ontario Public Drug Program, 2006

Adapted from data from Dhalla et al. Can Fam Physician 2011;57:e92-e96
Prescribers Have Not Been the Focus of the Conversation About Drug Diversion

- Prescribers do not appear as statistics in medical examiner or emergency department files
- Prescribers are not the target of substance abuse surveys
- With the exception of “pill mill” bills, most of the recent legislative concern has been with doctor shopping, not patient recruitment.
Reasons to Focus on Prescribers

- **Cost-effectiveness**
  - Many fewer prescribers than patients.
    - ~100 patients prescribed controlled substances for every doctor prescribing them
  - 10-20% of doctors prescribe 80% of controlled substances.
    - Warnings to providers about high-usage clients will go to the doctors prescribing most in 80% of cases. They may be less easily influenced as a result than other prescribers.
Other Reasons to Focus on Prescribers

- "High-volume" prescribers are currently targeted by pharmaceutical industry for aggressive marketing.
- Patients are physiologically dependent, so behavioral change may be more difficult than for high-volume providers, who are only financially dependent.
- Adverse publicity about prescribers can be damaging to payers.
Provider Intervention Is Primary Prevention:

“It is better to build a fence at the top of the cliff than to station an ambulance at the bottom.”

--Sir Frederic Truby King
Senator Grassley’s Investigation:
Top Prescribers in Medicaid Programs, Texas, 2009

- Top 72 prescribers wrote >25 rx/week to Medicaid clients for antipsychotics and sedatives
  - Top prescriber wrote 260/week, 6-7 per hour
- ~40% of the top 72 had been disciplined by the Texas Medical Board
- By comparison, the Board disciplines fewer than 1% of state physicians each year.
- Suggests that top prescribers are more likely to be engaged in inappropriate prescribing.

Barbee, D. Some doctors handing out prescriptions to kids for potent medications. Fort Worth Star-Telegram, Dec. 11, 2010
Top Prescribers in Medicaid Program, New York, 2011

- Top 10 prescribers of Oxycontin or other extended-release (ER) oxycodone products
  - Two facing trial
  - One arrested by federal agents
  - One who lost his license
  - One under investigation by the DEA

- One wrote 2,155 ER oxycodone, 988 oxymorphone, and 671 hydromorphone scripts to Medicaid clients in 2011, about 15 per day.

Dr. Joseph Hernandez had his medical license revoked in Illinois and in DC in 2007 and 2008.

He was Florida Medicaid’s top prescriber of oxycodone in 2009.

He was arrested in 2010 in Florida for trafficking in narcotics.

He continued to rank among Florida’s top Medicaid prescribers.

In July of 2012, the State suspended his medical license.

http://www.propublica.org/article/florida-sanctions-top-medicaid-prescribers-but-only-after-a-shove
GAO Report on Fraud and Abuse of Controlled Substances (CS) in Medicaid, 2009

In the 5 states studied, the GAO found

- 65 prescribers/pharmacies who had been barred/excluded from federal health care programs when they wrote/filled Medicaid prescriptions for CS worth $2.3 million.
- Medicaid paid $500,000 for CS prescriptions “written” by over 1,200 physicians after they died.

Summary

- Medicaid clients are at substantially increased risk of prescription drug overdose, both fatal and nonfatal, and other health effects.
- Medicaid clients are more likely to be prescribed opioid analgesics and to be using them more days/year.
- 10% of clients prescribed opioids for chronic pain are at a risky daily dose of 100+ MME/day
  - These clients consume most of the opioid prescribed in Medicaid.
- Heavy opioid users account for a large portion of overdoses in Medicaid.
- Heavy opioid prescribers account for a large portion of overdoses in Medicaid.
Remedies with Some Evidence of Effectiveness

- **Health plan risk mitigation initiatives focused on providers**
  - Group Health in Seattle increased screening and decreased daily dosage*

- **Opioid Use Guidelines**
  - Washington and Utah State Health Departments**

- **State legislation prohibiting “pill mills”***

- **Medicaid patient review and restriction (“lock-in”) programs report substantial savings.**

---


**Franklin, AMERICAN JOURNAL OF INDUSTRIAL MEDICINE 55:325–331 (2012)

Other Suggested Remedies

- **Reimbursement and formulary strategies**
  - covering nonpharmacologic therapies for pain
  - not listing methadone as a preferred analgesic
  - quantity and dose limits for opioids*
  - prior authorizations, e.g., requiring demonstrated benefit from opioids prior to continuing coverage beyond 90 days
  - reimbursement for checking prescription monitoring program

- **Using claims analysis to identify inappropriate prescribers and dispensers**

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.