



Role of Managed Care Pharmacy in Managing Controlled Substances for Medicare Part D Beneficiaries

Managed care organizations have well-established techniques for preventing the abuse or diversion of opiates or other controlled substances for patients who have a history or suspicion of inappropriate utilization, diversion, or abuse of these agents. AMCP supports the following additional tools:

Amend Medicare Part D to allow prescriber and pharmacy lock-in programs.

Currently, the Medicare Part D program does not permit prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PD) to limit patients with a history of abuse to a single prescriber and/or pharmacy (or chain of pharmacies), a practice common in the private market and Medicaid. Congress, the Centers for Medicare and Medicaid Services (CMS), and the Drug Enforcement Administration (DEA), and the Department of Health and Human Services Office of Inspector General have all recently expressed support for this concept.

Prescriber and pharmacy restricted access programs help to mitigate the issues associated with doctor or pharmacy shopping and may reduce the number of inappropriate controlled substance prescriptions.¹ Most states have implemented lock-in programs for Medicaid programs. In 2009, the Oklahoma Medicaid department found that its lock-in program reduced doctor shopping, utilization rates of controlled substances, and emergency room visits with a savings of \$600 per person in costs.² As demonstrated in Medicaid and other programs and recommended by the General Accountability Office in 2011, to reduce incidence of doctor or pharmacy shopping, a common way that Medicare beneficiaries obtain inappropriate controlled substances, CMS should consider restricted access to certain prescribers and pharmacies for Medicare beneficiaries who have a history of inappropriate controlled substance utilization or diversion.³

Permit real time data sharing of information compiled in prescription monitoring programs (PMPs) with prescribers, pharmacies, managed care organizations, and pharmacy benefit management companies (PBMs). Currently, access to data in PMPs is generally available to prescribers, pharmacists and pharmacies, other health care providers, and law enforcement personnel, but not PBMs, PDPs, and MA-PDs. Congress may increase uptake of PMP data sharing by passing legislation to require states to adopt this practice and increase funding of existing PMP programs.

¹ Hendrickson H. *The Burden of Prescription Drug Overdoses on Medicaid*. National Conference of State Legislatures Legisbrief. 10(1). January 2012. <http://www.ncsl.org/portals/1/documents/health/2001.pdf>. Accessed August 7, 2013.

² SoonerCare Pharmacy Lock-in Program Promotes Appropriate Use of Medications. September 9, 2009 [press release]. <http://okhca.org/about.aspx?id=10973>. Accessed August 7, 2013.

³ General Accountability Office. Medicare Part D: Instances of Questionable Access to Prescription Drugs. October 4, 2011. <http://www.gao.gov/products/GAO-12-104T>. Accessed August 7, 2013.

Many inappropriate controlled substance prescriptions are purchased through cash-based transactions and not adjudicated to a private insurance plans, Medicare Part D, or Medicaid.⁴ This means that PBMs, PDPs, or MA-PDs may be unaware of certain controlled substance prescriptions for some individuals and thus do not have all the information necessary to establish a basis for inappropriate utilization or abuse. Allowing access by PBMs, PDPs, and MA-PDs could help to reduce inappropriate utilization or abuse by implementing systems to flag inappropriate utilization and provide other interventions to ensure appropriateness of the prescription prior to dispensing.

Federal and state governments should develop better coordination efforts to encourage and establish interoperable communication among PMPs among states.

Currently, most state PMPs are accessible only to designated individuals in that state with limited availability of interstate communication and interoperability.⁵ Currently, under the National Association of Boards of Pharmacy PMP Interconnect program, 26 states (Arizona, Arkansas, Colorado, Connecticut, Delaware, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia and Wisconsin) securely interchange prescription data.⁶ Funding and policy initiatives on a federal basis would greatly assist the ability of everyone involved with prescribing and dispensing of controlled substances, reduce inappropriate utilization, and reduce cases of abuse.

Additional AMCP Reference Documents

Where We Stand on the Management of Opioids. Approved by the AMCP Board of Directors June 2013. <http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=16926>

Where We Stand on Fraud, Waste, and Abuse in Prescription Drug Benefits. Approved by the AMCP Board of Directors October 2011. <http://www.amcp.org/Tertiary.aspx?id=14212>

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The Academy of Managed Care Pharmacy (AMCP) is a national professional association of pharmacists and other health care practitioners who serve society by the application of sound medication management principles and strategies to assist patients in achieving positive therapeutic outcomes. The Academy's nearly 7,000 members develop and provide a diversified range of clinical, educational and business management services and strategies on behalf of the more than 200 million Americans covered by a managed care pharmacy benefit. More news and information about AMCP can be obtained on its website, at www.amcp.org.

⁴ Peirce GL, Smith MJ, Abate MA, Halverson J (2012) Doctor and Pharmacy Shopping for Controlled Substances. *Medical Care* 50:7. doi: [10.1097/mlr.0b013e31824ebd81](https://doi.org/10.1097/mlr.0b013e31824ebd81).

⁵ NABP PMP Interconnect. <http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect>. Accessed August 7, 2013.

⁶ *Ibid.*