



## **Monitoring the use of Controlled Substances in Medicaid: KHPA Current Practice**

Currently, several schedule II-IV narcotics have upper dosage limits which require beneficiaries to obtain a prior authorization in order to exceed that dosage. Short-acting opioids were presented at the January 2010 Drug Utilization Review (DUR) Board meeting for continued evaluation of adding several additional dosage limits, finalizing a process that began in July 2009 with the DUR Board's initial discussion of additional narcotic limitations. Board discussion resulted in establishment of dosage limitations for six short-acting opioids.

In preparation for the DUR board meeting, six months of narcotic utilization was examined to identify claims for narcotic doses higher than limits suggested in guidelines issued by the American Pain Society. Expenditures on claims exceeding the American Pain Society's high dose limit for these narcotics were less than \$50,000. Though in comparison to the approximately \$90 million of pharmacy expenditures in the same timeframe this is a relatively small sum, closer monitoring of narcotic use will decrease fraud and abuse in the Medicaid population, as well as alerting providers to potential narcotic abusers via alerts and prior authorization requirements implemented through pharmacy point of sale transactions.

The DUR board reviews narcotic utilization and prescribing on average one or two times each year and the Retrospective DUR subcontractor reviewed controlled substance utilization data in June 2009.

The dosage limitations approved by the DUR Board in January will likely result in additional referrals to lock-in. While the new limitations will not result in additional claims appearing on the standard SURS report, we anticipate that referrals received from pharmacy providers will increase as they are alerted to beneficiaries exceeding acceptable dosage limitations at the point of sale. Additionally, the prior authorization unit may refer more beneficiaries as they receive requests to exceed the high dose limits.

For specific beneficiaries identified as participating in suspect use of Medicaid coverage, lock-in programs (denying use of Medicaid funding to any provider other than the one specified for the beneficiary) can be implemented. Beneficiaries can be "locked-in" to a single physician, single pharmacy, single emergency room, or any combination of those three. Important to note is that beneficiaries could potentially skirt these restrictions by paying out of pocket for services.

The Surveillance and Utilization Review/Fraud and Abuse (SURS/FADS) unit generates reports quarterly which monitor beneficiaries' utilization of controlled substances against established "norms", adjusted by age, gender and morbidity. Those beneficiaries that fall outside of the norm are evaluated for our lock-in program. Beneficiaries suspected of abuse of their medical coverage, including overuse of schedule II-IV narcotics, can also be identified through referrals from prescribers, pharmacies, anonymous reports, or other fiscal agent units, such as the pharmacy unit.

Once identified for suspect behavior, the beneficiary is reviewed by one of the 13 utilization review nurses in the SURS/FADS unit. The time required to complete each beneficiary review is estimated to be approximately 40 hours, and the total administrative costs to establish each lock-in participant is about \$2,000. There are 362 beneficiaries in the lock-in program at this time with an active eligibility status and an additional 285 beneficiaries who have lost their eligibility but still meet lock-in criteria that we continue to monitor. Once eligibility is regained they will automatically be placed back in the Lock-In Program.

In addition to beneficiary reviews, the utilization review nurses also perform reviews and generate quarterly reports of providers prescribing and dispensing practices (physicians, pharmacies) to ensure compliance with Medicaid regulation, and recoup payments from those providers if inappropriate payments are identified. Providers who are suspected of inappropriate prescribing or dispensing of controlled substances are referred to the Peer Education Resource Committee (an advisory board comprised of physicians, a pharmacist, and a mid-level provider that reviews provider practices to ensure quality and adherence to current standards of care) and possibly their licensing and oversight board.

### **Activities in other States**

Medicaid programs in most other states have mechanisms in place to prevent fraud, abuse and diversion of controlled substances that are similar to those in Kansas. These include point of sale edits, dosage limitations, prior-authorization of controlled substances above the recommend dosing level and lock-in programs.

As of September 2009, 33 states have operational Prescription Drug Monitoring Programs (PDMP) that have the capacity to receive and distribute controlled substance prescription information to authorized users. States with operational programs include: Alabama, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Vermont, West Virginia, and Wyoming.

Seven states (Alaska, Florida, Kansas, Minnesota, Oregon, New Jersey and Wisconsin) and one U.S. territory (Guam) have enacted legislation to establish a PDMP, but are not fully operational.

The Kansas Board of Pharmacy was awarded two grants in 2009 to implement the Kansas Prescription Drug Monitoring Program. These were the Harold Rogers grant from the federal Bureau of Justice Assistance in the amount of \$400,000 over two years, and the Substance Abuse and Mental Health Services Administration (SAMHSA) National All Schedules Prescription Electronic Reporting Act (NASPER) formula grant totaling \$66,407 over one year. No money has been appropriated by the legislature to support this program. The Medicaid Pharmacy Director sits on the steering committee for the Prescription Drug Monitoring Program and is working with the committee to prevent fraud, abuse, and diversion of controlled substances.

### **KHPA Future Plans**

Data-driven, cost-effective management of the Medicaid Pharmacy Program has been an area of focus in recent years and continues to be for FY11. Enhanced management of pharmacy expenditures through

mechanisms such as pricing initiatives related to generically available drugs, internal development of an automated prior authorization system, and expansion of the preferred drug list occurred in State Fiscal Years 2009 and 2010.

Fiscal Years 2011 initiatives include requests for legislative funding of an enhanced automated prior authorization system, which will greatly expand the prior authorizations currently employed by Kansas Medicaid, and repealing of the statute that prevents industry-standard management of mental health drugs such as utilization edits and prior authorizations to ensure safe and appropriate use of mental health medications, placement of mental health drugs on the preferred drug list, and allowing market competition to provide cost savings. The enhanced prior authorization system would allow Medicaid to better monitor the use of controlled substances as well.

Finally, the Medicaid Pharmacy Program is developing new point of sale edits to reinforce current dosage limitations on the use of large quantities of Oxycontin and other controlled substances. Medicaid will continue to generate the quarterly beneficiary utilization, and provider prescribing and dispensing reports. These reports will be distributed to the DUR board and PERC committee as needed. Aggregate data will be shared with providers through our newsletter.