North Carolina Medicaid Update

Objectives:
1. Discuss the reasons behind the changes to the North Carolina Medicaid Preferred Drug List (PDL)
2. Review the NC Medicaid Outpatient Pharmacy Program
3. Educate pharmacists on upcoming changes to the NC Medicaid Outpatient Pharmacy Program
4. Review the NC Controlled Substances reporting system and provide details to how pharmacists can sign up

Our Vision and Key Principles
- Develop a better healthcare system for NC starting with public payers (Medicaid)
- Strong primary care is foundational to a high performing system
- Additional resources needed to help primary care manage populations
- Timely data is essential to success
- Build better local healthcare systems (public-private partnership)
- Physician leadership is critical
- Improve the quality of the care provided and cost will come down
- A risk model is not essential to success- shared accountability is!
Primary Goals of CCNC

- Improve the care of the enrolled Medicaid population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings

Medicaid challenges

- Lowering reimbursement reduces access and increases ER use
- Reducing eligibility or benefits limited by federal “maintenance of effort”, raises burden of uninsured on community and providers
- The highest cost patients are hardest to manage (disabled, mentally ill, etc.) – Community Care has proven ability to address this challenge
- Utilization control and clinical management only successful strategies to reining in costs overall
- Designing systems that work in urban and rural communities

Community Care of NC – Now in 2011

- Focused on improved quality, utilization and cost effectiveness of chronic illness care
- 14 Networks with more than 4500 Primary Care Physicians (1360 medical homes – representing 94% of primary care providers)
- Serving 1.3 million Medicaid enrollees
Does CCNC Work?

- Saved $568 million and $400 million in the Families with Dependent Children and ABD populations between 2003-2007 (Mercer, 2003-2007)
- CCNC saved between $187 and $195 million!
  - Mercer Report SFY 2009

Still Skeptical?
CCNC’s Impact

- Independent analysis of data by Milliman, one of world’s largest consulting practices
  - Contracted by DMA to calculate Medicaid savings attributable to CCNC initiatives and actions
  - 2010 estimated total savings: $383 million

But wait! There’s more!

CCNC’s Cost Impact

- Separate analysis by Treo Solutions, a health care business intelligence company
  - Contracted by CCNC to analyze and report Medicaid data on a risk-adjusted basis.
  - Estimated three-year savings (2007-2009): nearly $1.5 billion dollars – all directly back to the state
Treo’s savings estimate

Using the unenrolled fee-for-service population, with adjustments made by creating a total cost of care (PMPM) set of weights by Clinical Risk Group (CRG), risk and gender adjustments, this weight set was then applied to the entire NC Medicaid Population. Using the FFS weight set and base PMPM, expected costs were calculated. This FFS expected amount was compared to the actual Medicaid spend for 2007, 2008, 2009. The difference between actual and expected spend was considered savings attributable to CCNC. Treo Solutions, Inc., June 2011.

Annual Percent Change in Medicaid Expenditures: 2002 - 2010

CCNC expands across North Carolina starting in 1998. Between 2002 and 2005 expansion increased from 17 to 93 counties. By 2007, all 100 counties were under the CCNC umbrella organization.

No compromise on quality (in fact top 10% nationally)
Something We All Can Agree Upon!

New Budget Challenge

- CCNC’s significant savings have come from pilots that were tested, then expanded statewide – a process that takes time.
- In addition to ongoing efforts, NCGA directed CCNC to find additional savings of $270 million (90 million in state dollars SFY 2012 and 2013)
- Current estimate of state savings from enrollment/special initiatives = $51 million (SFY2012) & $150 million (SFY2013)
  - SFY 2012 shortfall due to delays in implementation

Medicaid Basics

http://www.ncdhhs.gov/DMA/
What is Medicaid?

- In 1965 Medicare and Medicaid were enacted through Title XVIII and Title XIX of the Social Security Act
- Medicaid is a Federal entitlement program
  - Eligible individuals cannot be legally denied service
- Medicaid is administered by States
  - For SFY 2010-2011, total cost is about $12 Billion
  - Federal government supplies about 65-75% of the funding ("FMAP") so ~$8 billion for SFY 2010-2011
  - State participation is optional; all 50 states participate

Who is on Medicaid?

- About 1.5 million North Carolinians qualify for Medicaid
  - Approximately 50% are children
  - About 1 in 4 children in NC are on Medicaid
  - Medicaid pays for about ½ of all births in NC
  - Must be a US citizen or prove eligible immigration status
- "Mandatory Eligibles"
  - Aged/Blind/Disabled ("ABD") receiving SSI
  - Foster/Adoptive children and certain Medicare recipients
  - Low income pregnant women/infants
    - $14,400 for a single parent/ $29,327 for a family of 4
  - Low income children through age 18

Who is on Medicaid?

- "Optional Eligibles"
  - Aged/Blind/Disabled ("ABD") NOT receiving SSI
  - "Medically needy" people with extensive health care needs
  - Other classifications of low income women/infants/children
  - Family planning for adults up to 185% of federal poverty
  - Women In NC Breast and Cervical Cancer Control Program
Mandatory Services

- Ambulance
- Durable Medical Equipment
- Family planning
- FQHCs
- Health Check (EPSDT)
- Hearing aids (children)
- Hospital Inpatient/Outpatient
- Nurse midwife/Nurse practitioner
- Nursing facility
- Labs/X-rays
- Physician
- Psychiatric residential treatment and residential services
- Routine eye exams
- Visual aids (children)

Optional Services

- Case management
- Chiropractor
- Community Alternatives Program (CAP)
- Dental and dentures
- Eye care (adults)
- Home infusion therapy
- Hospice
- Intermediate care facilities for MR pts
- Mental health services
- Orthotics and prosthetics
- Personal care services
- Physical, occupational, and speech therapies
- Podiatrist
- Prescription drugs
- Preventive care
- Private duty nursing
- Rehabilitative services
- Transportation

Who Pays for Medicaid

- For SFY 2010-2011, total cost is about $12 Billion
  - Federal (FMAP) ~73.1%
  - State (SMAP) ~26.9%
- American Recovery and Reinvestment Act
  - Increased Federal assistance (6.2% all states)
  - Increased additionally based on unemployment
  - Extended through June 2011
Medicaid Economic Impact

According to a 2008 study conducted by economists at UNC Wilmington, North Carolina state Medicaid expenditures of $2.36 billion resulted in:

- $3,941,000,000.00 in federal dollars
- 182,000 jobs (including both full-time and part-time positions)
- $6.11 billion in wages, salaries and sole proprietorship/partnership profits
- $1.892 billion in rents, interest and corporate dividend payments to NC citizens
- $2.2 billion in government tax revenues

According to Families USA, every $1 million in state funds invested in Medicaid in NC results in more than $3.8 million in business activity, 36 jobs and $1.4 million in salaries and wages.

The Pharmacists’ Role in CCNC
So much to talk about, so little time.....

www.communitycarenc.org

North Carolina Pharmacist

From Soup to Nuts:
The CCNC Model of Transitional Care

Dr. Judy S. Codner, PharmD
Global Pharmacist
Community Care PCC of Eastern Carolina/Memorial Hospital

Nadine Roberts, PharmD, BCPS
Medical Pharmacists
National Community Care Network

Gavalin L. Teng, Pharm D
Clinical Pharmacist
Atrium Health
Global Network
UAB School of Medicine, Department of Family Medicine
NCCN Pharmacist’s Role: Two Broad Areas of Focus

Pharmacy Administration
1. Pharmacy Drug Coverage Support
2. Prescriber Drug Coverage Support
3. Patient Drug Coverage Support
4. Education of Policy and Cost-Effective Prescribing
5. HIT Support/Adoption

Goals:
1. Minimize Patient Disruption and Attrition from Therapy
2. Minimize Prescriber Disruption
3. Minimize Pharmacy Disruption

Clinical Pharmacy Programs
1. Medication Reconciliation Plus
2. Medication Review
3. Curbside Consult

Goals:
1. More well-informed and effective prescribing and care delivery
2. More well-informed and effective care management
3. Reduction in Hospitalizations and Re-Hospitalizations

NCCN Pharmacist’s Role

- Administrative
  - Academic detailing
  - Provider education
  - Project management
  - Staff continuing education
  - Data
  - Research
  - Patient access issues
  - Community pharmacy engagement and education
  - Community involvement
  - E-prescribing promotion

North Carolina Medicaid Mean Amount Paid by Brand and Generic Status (2006-10)

North Carolina Medicaid Mean Amount Paid and Generic Market Share (%) (2006-10)
NCCN Pharmacist’s Role

- Clinical
  - Inpatient readmission project
  - Medication reconciliation
  - Medication review
  - Formulary (PDL) recommendations
  - Collaboration with other pharmacists
  - Chronic disease management
  - Member of a Medical Home

Transitional Care Program

- Goal of reducing hospital readmissions
- Focuses on the hospital transition process
  - Real time data from all 8 hospitals
  - Complete comprehensive health assessment on targeted patients at bedside in all 8 hospitals
  - Work with hospital physicians, case managers and staff to identify barriers and coordinate plan care.
  - Conduct post-hospitalization home visit to complete Medication Reconciliation for patients meeting screening criteria.
  - Communicating and coordinating follow up care with PCP, specialists, home health, etc.

NCCN Pharmacist’s Role in Transitional Care:
A “Discontiguous Set” of Care Delivery Settings
Capable Providers in an Incapable System

Pharmacy Hospital HH/Rehab/SNF Clinic

MTM ← Comprehensive Med Rec ← MTM ← Fully Informed Prescribing

Inadequate, Misaligned or Non-Existent Payment Systems for Pharmaceutical Care
*Also incredibly cost-inefficient in Today’s HIT/HIE Environment*

NCCN Pharmacist’s Role in Transitional Care: A “Contiguous Set” of Care Delivery Settings

Pharmacy Hospital HH/Rehab/SNF Clinic

MTM ← Comprehensive Med Rec ← MTM ← Fully Informed Prescribing

Goal: Coordinated, goal-oriented, re-enforced drug use plan

Transitional Care
NCCN/CCNC Transitional Care Process
(Patient Discharged from UNC, but lives in Onslow county - Medication Management)

Hospital
Transitional Care Manager (TCM)
Meets with Patient, Gathers Discharge Instructions, Counsels and Refers to PCM

Home
Primary Care Manager (PCM)
Meets with Patient at Home, Gathers Drug Use Inventory, Assessment and Self-Management

Network
Network Pharmacist (PharmD)
Reviews All Medication Lists (Discharge, Home, Claims) for Discrepancies

Clinic
CCNC Physician (PCP)
Visit Scheduled, PCP Receives Problem List and Care Coordination Plan

Med Wrecks

Medication Discrepancies

Count of Discrepancies/Potential Problems Per Patient

- Drug Allergy
  - Unclassified
- Adverse Event/Toxicity Reported
- Absolute Contraindication
- Discontinued Med Per Discharge Instructions
- Interaction Non-Absolute
- Potential Transcription Error
- Therapeutic Duplication
- Poor Adherence to Chronic Meds
- Non-Taking Prescribed Discharge
- Medication Dose/Frequency/Duration
- Unconfirmed Discontinuation

Requires Patient Education/Clarifying
Requires Regimen Change/Clarifying
Unvarified Prescription
Total Discrepancies (PDMs)
The Big Problem: Pharmacy Opportunity

- Medicare
  - $34 Trillion underfunding
  - Stated another way...
    - 34,000,000,000,000
    - 34 Million, Million

- NEJM article (Jenks et al...)
  - Roughly 1 in 5 Medicare enrollees re-admitted to hospital
  - Roughly 50% never had an outpatient visit between admissions
  - Some have suggested that up to 50% of re-admits are related to drug therapy problems

- NEHI estimate
  - Non-Adherence costs $290 Billion a year

Halftime!

NC Medicaid Outpatient Pharmacy Program
http://www.ncdhhs.gov/dma/pharmacy/index.htm
Coverage of Prescription Drugs

- Covered Medications:
  - Must have FDA approved indication
  - Must bear federal legend statement
  - Manufacturer must sign National Drug Rebate Agreement with CMS
  - Insulin and selected OTC are covered if pursuant to a lawful prescription and dispensed by a pharmacist
    - Prilosec OTC
    - Zyrtec OTC
    - Claritin OTC

- Not Covered:
  - OTC drugs and herbals (tylenol, herbs, vitamins, etc)
  - Drugs designated by the FDA on the Drug Efficacy Study Implementation (DESI) list
  - Non-rebateable drugs
  - Fertility drugs
  - ED drugs
  - Drugs for cosmetic indications
  - Prescription cough and cold medications

Medication Co-Payments

- All Medicaid recipients who receive prescription drugs are required to make a co-payment of $3.00 per RX
  - $3.00 Co-pay for 90 day supplies of some generics

- Exemptions
  - Pt less than 21 years of age
  - Pt resides in a nursing home facility
  - Pt is pregnant
  - Oral contraceptives

- Patient is unable to pay co-pay
  - Provider MAY NOT deny the prescription
  - Provider may open an account and try to collect at a later date

Prescription Limitations

- Initiated June 1, 2006
- Recipients are 21 and older
- Eight (8) prescriptions per recipient per month
- Pharmacist may override with three additional Rx per recipient per month
- Patients are locked into one pharmacy for continuity of care (11+ meds)
- May be going away in 2012
Drug Utilization Review (DUR)

- Federally mandated in 1990
- Assures that prescriptions:
  - Are appropriate
  - Are medically necessary
  - Are not likely to result in adverse events
- 3 Components
  - Prospective DUR
  - Retrospective DUR
  - DUR Board

Drug Utilization Review (DUR)

- U.S. Senator Charles Grassley, R-Iowa
- Investigating overprescribing of antipsychotics and narcotics
- Florida doctor wrote 96,685 prescriptions for mental health drugs in 21 months
  - ~153 per day including weekends!

90 Day Supply of Medication

- The maximum days supply for all drugs is a 34-day supply unless the medication meets the criteria described below to obtain a 90-day supply.
  - Generic
  - Non-controlled
  - Maintenance medication
  - Pt has had a previous 30-day fill of the same medication T
  - He claim must also pay at either the Federal or State Maximum Allowable Cost (MAC) rate
- Only one co-pay is collected and only one dispensing fee is paid for the 90-day supply.
- The MAC list can be found at: http://www.dhhs.state.nc.us/dma/pharmacy/index.htm
Diabetes Testing Supplies

- As of 11/15/11 AccuCheck is now the preferred diabetes testing supplies of NC Medicaid
  - AccuCheck Aviva
  - AccuCheck Compact
  - Strips
  - Lancets and lancing device
  - Control Solution
- 2-3 month transition from Prodigy products
- Handout in back of packet on billing for meters
- No preferred syringes

A+KIDS (Antipsychotics – Keeping It Documented for Safety)

- www.documentforsafety.org
- All antipsychotic prescriptions for children 17 and under must be registered
- Pharmacy rejection if not registered
  - “SAFETY DOCUMENTATION REQUIRED; PRESCRIBER GO TO WWW.DOCUMENTFORSAFETY.ORG OR CALL ACS 866-246-8505”
- Point of Sale Override (unlimited use)
  - A “1” in the PA field (461-EU) or a “2” in the submission clarification field (420-DK) will override the PA edit.

Synagis

- Specialty pharmacy item
- For the 2011-2012 season there is an online system
  - http://smartdur.com/synagis/pub/
  - Instant approval
NC Health Choice

- As of 10/1/11 the Division of Medical Assistance (DMA) and CCNC are now managing the NC Health Choice (NCHC) program
- Previously administered by BCBS of NC
- As of 11/15/11: Same PDL as NC Medicaid
- Process NCHC pharmacy claims just like NC Medicaid claims
- For children whose parents make too much money to qualify for Medicaid
- [http://www.ncdhhs.gov/dma/healthchoice/index.htm](http://www.ncdhhs.gov/dma/healthchoice/index.htm)

45 Day Comment Period

- Don’t like the changes in NC Medicaid, then let your voice be heard!
- [http://www.ncdhhs.gov/dma/mpproposed/index.htm](http://www.ncdhhs.gov/dma/mpproposed/index.htm)
- Big proposed changes to the pharmacy program are currently posted for comment until 12/5/11

The Medicaid Preferred Drug List (PDL)

[www.ncmedicaidpbm.com](http://www.ncmedicaidpbm.com)
Why a PDL?

- Growing population: 1.4 to 1.7 million eligible
- Estimated 400,000 to 600,000 additional eligible when health care reform is implemented
- Ballooning costs
  - Prescription drug expenditures approximately $1 Billion dollars annually
  - $1 billion=$1,000,000,000.00
  - Medications are about 10-12% of Medicaid’s budget
- Estimated to save at least $90 million annually
- Additional rebates on brand name drugs
- Updated November/October of each year
- PDL review panel

Medicaid State Preferred Drug Lists

Point of Sale (POS) Messaging

- The POS message for non-preferred medications will say “NON-PDL DRUG; MD CALL ACS: 1-866-246-8505” to indicate patient needs to be switched to Preferred agent.
- If a medication requires prior authorization, the POS message will be “PA REQ. PRESCRBR CALL ACS: 1-866-246-8505”.
- If a prescription exceeds the quantity limit, the POS message will be “CLAIM DENIED, PA LIMITS EXCEEDED”.
- If a medication is a non-preferred generic, you will receive the following POS message: “DISPENSE BRAND; GENERIC NON-PREFERRED”.

Data compiled by NCSC; updated March 2007. Operational status may vary, and is for general information only.

**PDL Changes 11/15/11**

<table>
<thead>
<tr>
<th>PDL Class / Drug</th>
<th>Primary Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NSAIDs</strong></td>
<td>Meloxicam (Generic) and Mobic (Brand) Non-Preferred</td>
</tr>
<tr>
<td><strong>ARBs and ARB combo</strong></td>
<td>Losartan and combo Preferred, Cozaar and Hyzaar Non-Preferred</td>
</tr>
<tr>
<td><strong>Statins</strong></td>
<td>Crestor Preferred; Lipitor only after trial and failure of Crestor</td>
</tr>
<tr>
<td><strong>GLP-1 Receptor Agonists</strong></td>
<td>Victoza Non-Preferred; Byetta still Preferred</td>
</tr>
<tr>
<td><strong>Anticoagulants</strong></td>
<td><strong>Non-Preferred</strong></td>
</tr>
<tr>
<td><strong>Narcotics</strong></td>
<td>All long acting narcotics require a prior authorization</td>
</tr>
</tbody>
</table>

**Non-Preferred Anticoagulants**

- For the first claim of a non-preferred oral anticoagulant (Pradaxa or Xarelto)
  - The POS message will say, “NON-PDL DRUG; MD CALL ACS: 1-866-246-8505”
  - If you enter a 1 in the submission clarification field, the claim will pay.
- For the second claim of non-preferred oral anticoagulant you will receive 2 messages:
  - “NON-PDL DRUG: MD CALL ACS: 1-866-246-8505”
  - “ONLY ONE OVERRIDE ALLOWED FOR ORAL ANTICOAGULANTS”
  - The prescriber must switch the patient to a preferred agent or submit for prior approval to receive a non-preferred product.

**Narcotics**

- All long acting narcotics require a prior authorization
- Affects preferred and non-preferred
- Short acting (percocet, vicodin, etc) not affected
- Preferred in this class
  - DuragesicR/Matrix
  - Kadian
  - Morphine sulfate SA (generic MS Contin)
  - Opana ER
  - Methadone
Suboxone/Subutex on DMA PA List

- Criteria for Use-Suboxone/Suboxone Film
  - Provider must have X-DEA number
  - Indication must be opioid dependence
  - Maximum dose of 24mg/day
  - Provider must review the CSRS registry for other therapies (benzodiazepines, narcotics)
  - PA approval for up to 12 months
  - Subutex/buprenorphine: must be intolerant of Suboxone

Generic products are considered preferred unless indicated

- Legislation changed to allow dispensing of brand when cost is less than generic
- Removing SMAC from these medications
- "Brand name medically necessary" does not need to be written on the Rx
- Point of sale messaging
  - “DISPENSE BRAND; GENERIC NON-PREFERRED”.

Brand Preferred Over Generic Alternative

- The following brand name products will be preferred over their generic alternatives or other products in their therapeutic class.

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accolate</td>
<td>Zafirlukast</td>
</tr>
<tr>
<td>Alphagan P</td>
<td>Brimonidine</td>
</tr>
<tr>
<td>Aricept</td>
<td>Donepezil</td>
</tr>
<tr>
<td>Azelastin/AstePro</td>
<td>Azelastine HCL</td>
</tr>
<tr>
<td>Baytril</td>
<td>Chloramphenicol/Benzo P/Peroxide</td>
</tr>
<tr>
<td>Differin</td>
<td>Adapalene</td>
</tr>
<tr>
<td>Edon</td>
<td>Rivastigmine</td>
</tr>
<tr>
<td>Lovenox</td>
<td>Enoxaparin</td>
</tr>
<tr>
<td>Ovide</td>
<td>Malathione</td>
</tr>
</tbody>
</table>
### Brand Name Medications Newly Designated as Non-Preferred

- The following brand name medications will be designated Non-Preferred agents as of November 15, 2011, after which you may dispense the generic product.
- If the prescriber indicated “Brand Name Medically Necessary” on the original prescription, authorization is needed from the prescriber to substitute the generic product.
- Alternatively, prior approval is needed using a NC Medicaid Standard Drug Request form to continue on the Non-Preferred brand drug.

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levobunolol</td>
<td>Betagan</td>
</tr>
<tr>
<td>Losartan</td>
<td>Cozaar</td>
</tr>
<tr>
<td>Cromolyn Sodium</td>
<td>Crolom</td>
</tr>
<tr>
<td>Dantrolene</td>
<td>Dantrium</td>
</tr>
<tr>
<td>Famciclovir</td>
<td>Famvir</td>
</tr>
<tr>
<td>Losartan/HCTZ</td>
<td>Hyzaar</td>
</tr>
<tr>
<td>Apraclonidine</td>
<td>Iopidine</td>
</tr>
<tr>
<td>Melipranolol</td>
<td>OptiPranolol</td>
</tr>
<tr>
<td>Timolol</td>
<td>Timoptic/Timoptic XE</td>
</tr>
<tr>
<td>Latanoprost</td>
<td>Xalatan</td>
</tr>
<tr>
<td>Acyclovir</td>
<td>Zovirax</td>
</tr>
</tbody>
</table>

### “Meets PA Criteria”

- Allows for POS override by Pharmacist
- Affected classes
  - Inhaled Corticosteroids/Combos
  - Leukotriene modifiers
  - Statins
  - Anticonvulsants (seizure dx ONLY!)
- The prescriber writes “Meets PA Criteria” on the face of the prescription in his or her own handwriting
  - This information may also be entered in the comment block on e-prescriptions.
- “Brand Name Medically Necessary” must also be written on the face of the prescription in the prescriber’s own handwriting in order to dispense the brand name drug if a generic is available.
  - Must be hand written on eRx too!
  - No typing in comment box!!!!!!!

### POS Override

- A “1” in the PA field (461-EU) or a “2” in the submission clarification field (420-DK) will override the PA edit.
- These overrides will be monitored by Program Integrity.
- Prescriptions must be compliant with the federally mandated Tamper Resistant Prescription Laws.
Board of Pharmacy Statements

- “…the pharmacist would not have to obtain a new prescription to dispense the vial-packaged insulin rather than a cartridge- or pen-packaged insulin.”

- “…on a prescription DuoNeb® for which substitution is authorized, the pharmacist may substitute equivalent strength individual nebulizer dosage forms of albuterol sulfate and ipratropium bromide.”

- “Careful counseling of the patient is paramount”

- ProAir, Proventil, and Ventolin HFA are interchangeable

- [http://www.ncbop.org/](http://www.ncbop.org/)

Pharmacist PDL Questions

Controlled Substances Reporting System

CSRS and its role in potential substance abuse issues

- Statewide controlled substance reporting system
- Established by North Carolina law to improve the state's ability to identify people who abuse and misuse prescription drugs classified as Schedule II-V controlled substances
- Assist clinicians in identifying and referring for treatment patients misusing controlled substances
- NC DMHDDSAS make rules and manage the program
- Percentage of utilization by practitioners
- State CS registry databases not linked at this time

CSRS Data Overview

- Weekly reporting began 01/02/10
- Over 53,500,000 prescriptions in the database (started July 1, 2007)
- Approx. 17 million per year
- Over 1,000,000 queries have been made of the system
- Over 7400 dispensers and practitioners currently registered to use the system
- Averaging 2200 queries per day

CSRS - Who has Access?

State Shall Release Data to:

- Persons authorized to prescribe or dispense for the purposes of providing medical care for THEIR patients
- A person requesting their own data
- The 21 Special Agents of the SBI pursuant to a bona fide investigation
- Licensing Boards with jurisdiction over health care professionals- pursuant to an ongoing investigation
CSRS - Who has Access? (cont)

- Division of Medical Assistance
- Primary Monitoring Authorities from other states pursuant to an ongoing investigation
- DHHS must report “Unusual Patterns of Prescribing” to the Attorney General – criteria set by a multidisciplinary advisory committee
- Anonymous data for research and statistics
- Medical Examiners (effective 8/9/09)
- Practitioners may share & document (8/9/09)

NC CSRS FAQ

- May a physician disclose information to law enforcement concerning suspected instances of prescription forgery or diversion based on patient information obtained from the CSRS?
  No. Physicians may not communicate information obtained from the CSRS regarding any patient to law enforcement authorities or anyone else unless the patient has executed a HIPAA compliant written authorization.

- What are the penalties for misuse of the CSRS?
  A person who intentionally, knowingly, or negligently releases, obtains, or attempts to obtain information from the system in violation of a provision of this section or a rule adopted pursuant to this section shall be assessed a civil penalty not to exceed five thousand dollars ($5,000) per violation.

  http://www.ncdhhs.gov/MHDDSAS/controlledsubstance/

Chronic Pain Initiative
NC Medicaid Narcotic and Anxiolytic Lock-in Program

www.projectlazarus.org/
What is the Lock-In Program?

- Program for Medicaid recipients who are filling multiple opiate or benzodiazepine/anxiolytic prescriptions (>6 in 2 consecutive months) or from >3 providers in 2 consecutive months
- Identified patients are locked in to one provider and pharmacy to obtain medications related to lock-in criteria
- Objective to prevent overutilization of Medicaid benefits

Chronic Pain Initiative:
The need is now.

[Misuse of Pain Relievers](http://www.hhs.gov/ash/testify/t040209.html)

*Oxycontin approved by the FDA on December 12, 1995*
Poisoning Deaths: N.C., 1999-2009*

In 1999, the number of unintentional poisoning deaths was 279; in 2009, the number of deaths had increased to 1,036.

*Provisional data.

Substances Reported by Medical Examiners for Unintentional Fatal Poisonings by ICD10 T-Code Poisoning Categories: NC, 2007

Chronic Pain Initiative:
The need is now in NC.
Chronic Pain Initiative
Wilkes County Project

- Organic, community-driven initiative.
- Goal is right patients, receiving right care for the right conditions.

Key Components:
- Care Management (CCNC)
- Screening
- Pain Contracts
- Storage and disposal training
- And much, much more....
- Prescriber Toolkits (PCP and ED)
- Medicaid Narcotic Lock-in
- Controlled Substances Reporting System (CSRS)
- Naloxone rescue kits and caregiver training (Project Lazarus)

Lock-in Criteria

- NC Medicaid recipients
- Criteria apply to controlled substances categorized as opiates or benzodiazepines and certain anxiolytics for a period of one year in the following situations:
  1. Recipients who have at least ONE of the following
     a. Benzodiazepines and certain anxiolytics: > 6 claims in 2 consecutive months
     b. Opiates: > 6 claims in 2 consecutive months
  2. Receiving prescriptions for opiates and/or benzodiazepines and certain anxiolytics from > 3 prescribers in 2 consecutive months

http://www.ncdhhs.gov/dma/pharmacy/index.htm
Chronic Pain Initiative

- Background/Rationale
- Implementation: multi-pronged approach
- Provider tool-kit
- Lessons learned
  - Benefits of educating of providers
  - Pain contract agreement utility
  - Provider/patient satisfaction
  - Decrease in opioid overdose deaths in-county
  - Deaths that have occurred are rarely due to narcotics prescribed in-county

Wilkes County NC 2008-11
Overdose Script History

% Of unintentional overdose deaths with a prescriptions from Wilkes Co. Provider

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>80</td>
<td>30</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

Unintentional and undetermined intent overdose mortality rate (Per 100k)

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>45</td>
<td>35</td>
<td>25</td>
<td>15</td>
</tr>
</tbody>
</table>
Chronic Pain Initiative: Outcomes Statistics

- ED Visits for overdose/accidental poisoning 2008-2010:
  - Wilkes County (w/CPI): 15.3% decrease
  - North Carolina (w/o CPI): 6.9% increase
- Coming soon to a county near you…. (contact your local CCNC Network for more information)
- State wide roll out in 2012

Florida Pill Mills

- “The Oxycontin Express”
  - Some 126 million Oxycodone pills were prescribed by 98 practitioners in Florida.
    - More than the other 49 states combined.
    - www.sun sentinel.com Accessed 11/15/11
- To quote Jay Campbell of the NCBOP:
  - Don’t fill the prescriptions.
    - http://www.ncbop.org/NewsItems/FloridaRx.htm
- DEA Drug Diversion Website

The Next Steps for North Carolina Medicaid and CCNC
Next Steps

- Build out Informatics Center, Provider Portal, decision support and advanced analytics as a shared resource for all communities
  - Implementation Advanced Planning Document (IAPD) initiative
- Expand physician enrollment to specialty providers
  - Pregnancy Medical Home
  - [www.mombaby.org](http://www.mombaby.org)
- Implement additional multi-payer projects

Next Steps

- Strengthen partnerships
  - Collaborate with NC Hospital Association on best practices for reducing readmissions
  - Work with NC Medical Society on best practices, decision support systems
  - Support NC Academy of Family Physicians in promoting patient-centered medical home (PCMH) recognition.

Next Steps

**Build new partnership opportunities with provider and service organizations**
- Home care and hospice agencies
- Nursing homes
- Adult care homes
- ED physicians
- Radiologists
- Psychiatrists and mental health providers/LMEs
- Other provider groups and community organizations
North Carolina: First in Flight

Helpful Websites

- Outpatient Pharmacy Services
  http://www.ncdhhs.gov/dma/pharmacy/index.htm
- Proposed Clinical Coverage Policies
  http://www.ncdhhs.gov/dma/mp/9proposed/index.htm
- Outpatient Pharmacy Policy
  http://www.ncdhhs.gov/dma/mp/9pharmacy.pdf
- North Carolina Medicaid Enhanced Pharmacy Program
  http://www.ncmedicaidpdm.com/
- North Carolina Controlled Substance Reporting System
  http://www.ncdhhs.gov/MHDDSAS/controlledsubstance/
Contact information

Questions?