

Prescription Drug Monitoring Program Center of Excellence at Brandeis

PDMPs and Third Party Payers Meeting **December 2012**

Report of Proceedings

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- Table of Contents -

Executive Summary ----- 3

Background: The Prescription Drug Abuse Epidemic and its Costs ----- 4

The Purpose and Functions of PDMPs ----- 5

Completing the Picture: The Value of PDMP Data for Third Party Payers ----- 5

Experience in Washington State ----- 6

The December 2012 PDMPs and Third Party Payer Meeting ----- 7

Workgroups on Providing PDMP Data to Third Party Payers ----- 9

Conclusion: Expert Opinion Supports Third Party Payer Use of PDMP Data ----- 10

Appendix A: Workgroup Findings ----- 11

 Workgroup 1: Sharing Prescription History Data with Third Party Payers ----- 11

 Workgroup 2: Protecting PDMP Data and Ensuring Appropriate Use ----- 13

 Workgroup 3: Identifying and Overcoming Barriers to Data Sharing ----- 16

 Workgroup 4: Evaluating Data Sharing Collaborations ----- 19

 Workgroup 5: Sharing Data with Health Care Systems ----- 21

 Workgroup 6: Identifying Questionable Activity by Providers ----- 23

 Workgroup 7: Third Party Payer Support for PDMPs ----- 26

 Workgroup 8: Enhancing Drug Abuse Referral and Treatment ----- 29

Appendix B: List of Attendees ----- 31

PDMPs and Third Party Payers Meeting

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Executive Summary

Prescription drug abuse continues at epidemic levels in the United States, with increasing numbers of deaths, emergency room visits, and treatment episodes attributable to non-medical use of controlled substances. Prescription drug monitoring programs (PDMPs) are valuable tools in mitigating the abuse and diversion of prescription controlled substances from legitimate medical use to illicit use (diversion) and improving medical practice, but they need wider utilization by all appropriate users, including third party payers. This report describes the proceedings of the PDMPs and Third Party Payers meeting held in December 2012 in Washington D.C., as well as background information on the role and functions of PDMPs and current examples of third party payer use of PDMP data.

The purpose of the meeting, convened by the PDMP Center of Excellence at the request of the Office of National Drug Control Policy, was to explore the potential benefits and mechanisms of third party payer use of PDMP data. Attendees included representatives of third party payer organizations,¹ including major health insurance companies, the Center for Medicare and Medicaid Services, and workers' compensation programs. Also attending were representatives from state and federal government agencies involved in addressing prescription drug abuse, PDMP administrators and staff, researchers, and other PDMP stakeholders. (See Appendix B for a list of meeting participants.) Presentations focused on the costs to health insurers and the public from the prescription drug abuse epidemic: deaths, injuries, addiction, lost productivity, and costs to insurers of unnecessary prescribing and claims associated with non-medical prescription drug use. The prescription abuse and fraud-related costs to a medium-sized insurer were estimated to be over \$42 million a year, and could exceed \$70 billion to all health insurers—private and public. Other presentations described current third party payer data sharing projects, how use of PDMP data can reduce insurers' costs and improve medical care, and what legislative, policy, and operational barriers to data sharing currently exist.²

Workgroups at the meeting focused on a series of issues to gain further insight into third party payer use of PDMP data, how use could be implemented and regulated, and how barriers to use could be overcome. Proceedings of the workgroups were recorded by note-takers and reviewed by workgroup co-chairs. Topics included the goals and proper use of PDMP data by insurers, how data can be protected from inappropriate use, how data sharing collaborations can be evaluated and improved, and how third party payers could help support PDMPs. (For details of workgroup findings, see Appendix A.)

¹ Third party payers are health insurance providers that pay medical bills under insurance or workers' compensation plans. They include private insurers (e.g., Blue Cross Blue Shield and Kaiser Permanente) and public health insurers such as Medicare, Medicaid, and state workers' compensation agencies.

² Presentations from the meeting can be viewed at <http://www.pdmpexcellence.org/content/third-party-payer-meeting-presentations>.

Meeting participants agreed that for health care insurers to improve care and reduce unnecessary costs, a complete picture of the prescribing and dispensing provided to their enrollees and carried out by their providers is essential. Because PDMP data are uniquely suited to complete this picture (insurers do not receive information on their enrollees' prescriptions paid in cash or by other third party payers, but PDMPs have this data), a consensus emerged that carefully regulated third party payer access to these data should be considered as a policy objective. Barriers to data sharing can be identified, addressed, and overcome as the value of PDMP information for third party payers becomes increasingly evident. In particular, since many states do not currently permit access to PDMP data by third party payers, enabling legislation and regulations would have to be adopted. Specific proposals discussed in the workgroups (see Appendix A) could serve as the basis for next steps in developing policies and procedures to expand PDMP data use by health insurers, whether public or private.

Background: The Prescription Drug Abuse Epidemic and Its Costs

The last 15 years in the United States have seen a rapid rise in the prescribing of opioid pain relievers, and with it a dramatic increase in their misuse, abuse, and diversion.³ The Centers for Disease Control and Prevention (CDC) has declared prescription drug abuse an epidemic. Deaths from unintentional drug overdoses continue to rise, surpassing motor vehicle fatalities as the leading cause of accidental death. Emergency department visits due to misuse of controlled substances now substantially outnumber those for illicit drugs such as heroin and cocaine. Treatment admissions for prescription opiates have more than doubled in the last decade.⁴

The costs stemming from the non-medical use of prescription opioids—in lost productivity, law enforcement, drug abuse treatment, and medical complications—have been estimated at over \$50 billion annually.⁵ A recent analysis conducted for the Coalition Against Insurance Fraud estimated that costs to health insurers resulting from prescription drug diversion total at least \$18 billion a year, but could exceed \$70 billion, with nearly \$25 billion borne by private insurers.⁶ A typical doctor shopper (someone obtaining medically unwarranted prescriptions from multiple doctors and/or pharmacies) was estimated to cost insurers up to \$15,000 annually.⁷ Such costs are often passed on to consumers and tax payers in the form of higher health care insurance premiums, increased Medicaid and Medicare payments, and higher governmental expenditures for programs such as public hospitals and clinics, the Department of Defense health care system, and the Veterans Administration (VA).

³ Factors contributing to more liberal opioid prescribing include more aggressive treatment of chronic non-cancer pain in response to patient advocacy groups, the development of new formulations of opiate analgesics to meet this demand, and increased marketing of opiates by pharmaceutical companies.

⁴ Jones, C. M., "Prescription drug abuse and overdose in the United States," presentation for the PDMPs and Third Party Payers meeting, Washington D.C., December, 2012, convened by the PDMP Center of Excellence, <http://www.pdmpexcellence.org/sites/all/pdfs/Jones.pdf>.

⁵ Hansen et al. (2011) Economic costs of nonmedical use of prescription opioids. *Clinical Journal of Pain*, 2:3

⁶ Mahon, W. (2007) Prescription for peril: How insurance fraud finances theft and abuse of addictive prescription drugs. Coalition Against Insurance Fraud, pp. 38-9, <http://www.insurancefraud.org/downloads/drugDiversion.pdf>.

⁷ Estimate from Coalition Against Insurance Fraud, cited in "Costs associated with prescription drug abuse," PDMP Training and Technical Assistance Center, <http://www.pdmpassist.org/content/costs-associated-prescription-drug-abuse>.

Given the community, family, social, and economic costs of the epidemic, bringing non-medical use of prescription drugs under control is a national public health priority. It will require a coordinated effort by all stakeholders, including medical providers, federal and state public health and safety agencies, community drug abuse prevention coalitions, treatment programs, and not least, public and private third party payers.

The Purpose and Functions of PDMPs

PDMPs are now gaining recognition as an important tool in efforts to assure and improve the quality of medical care and to contain the prescription drug abuse epidemic. A PDMP is a statewide electronic database that gathers information from pharmacies on dispensed prescriptions for controlled substances.⁸ Prescription data generally include information on the date written and dispensed, patient, prescriber, pharmacy, medicine, day's supply, dose, and source of payment. PDMP reports are made available on request from end users, typically prescribers and pharmacists, but also medical licensure boards, law enforcement and drug control agencies, medical examiners, drug courts, addiction treatment programs, and, in some states, third party payers. Because they capture all dispensing by non-hospital pharmacies in a state (and sometimes in other states depending upon data sharing arrangements), PDMP data are uniquely suited to identifying possible non-medical use and diversion of controlled substances by patients, as well as problematic prescribing and dispensing. PDMP data can also help track patterns of legitimate prescribing of controlled substances.

A growing body of evidence strongly suggests that PDMPs, now operational in most states, are effective tools in assisting health care professionals in providing improved clinical care and in mitigating the prescription drug abuse epidemic.⁹ However, their effectiveness depends to a large extent on whether prescription data are completely and accurately collected, analyzed appropriately, and made available in a proactive and timely manner to all appropriate end users.

Completing the Picture: The Value of PDMP Data for Third Party Payers

Among these end users are third party payers, for whom the increase in prescribing, abuse, and diversion of controlled substances has added substantially to the morbidity and mortality of their enrollees and to their costs. To help maintain good medical care and monitor costs related to prescriptions, health insurers and pharmacy benefit managers have procedures for reviewing prescription claims data on insured patients. Data showing multiple or overlapping prescriptions for drugs in medically unnecessary quantities may be indicative of prescription drug abuse or diversion. Such findings, if confirmed, can trigger appropriate interventions by insurers, such as placing patients in a Patient Review and Restriction Program (also known as a "lock-in program"), which restricts them to a single prescriber and dispenser for controlled substance

⁸ For further information on PDMPs, see the PDMP Training and Technical Assistance Center FAQ, <http://www.pdmpassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>.

⁹ Prescription Drug Monitoring Program (PDMP) Center of Excellence (2013) Briefing on PDMP effectiveness, http://www.pdmpexcellence.org/sites/all/pdfs/briefing_PDMP_effectiveness_april_2013.pdf.

prescriptions. However, insurance claims data will ordinarily not include prescriptions prescribed by out-of-network providers, nor will it include prescriptions paid for in cash or by another third party payer.

Since PDMPs collect information on filled prescriptions from all dispensers in a state, including those paid for in cash, PDMP data can provide insurers a more complete picture of what controlled substances an insured individual might be obtaining, using, or diverting from legitimate use, as well as which providers have prescribed and dispensed to these individuals. Without PDMP information on prescribing and dispensing, patterns suggestive of controlled substance abuse and diversion may well go undetected by insurers.

As of 2012, just 28 states were sharing PDMP data with Medicaid or Medicare, eight with workers' compensation programs, and only one state—Michigan—is known to have provided data to private health insurers.¹⁰ Given the potential of such sharing to improve monitoring by third party payers of their patients and providers, there is ample opportunity to expand their access to PDMP data.

Experience in Washington State

Washington State has recently implemented PDMP data sharing with its Medicaid and workers' compensation programs. Authorized users in these programs, all licensed health professionals, can query the PDMP database to view the prescription histories of individual enrollees. Data are also shared via bulk file transfer in which the PDMP sends prescription information to the programs on all their enrollees, to be analyzed by the program. Outcomes indicate the significant value PDMP data can have for third party payers.¹¹ An investigation by the Washington Medicaid program using bulk PDMP data found that from January to July 2012, over 2,000 clients had been dispensed Medicaid and cash-paid controlled substance prescriptions on the same day. During the same period, 478 clients were found to have overlapping prescriptions, having filled cash-paid and Medicaid prescriptions for the *same* controlled substance less than 10 days apart, 25% of them on the same day. (Prescriptions overlap when the days' supply of the earlier prescription exceeds the number of days between the prescriptions.) Only by accessing PDMP data did the Medicaid program become aware of these significant problems.

Similarly, Washington's workers' compensation program found, using individual PDMP queries, that some claimants were receiving opioid prescriptions from out-of-network providers, and that others had been prescribed high doses of opioids in the three months prior to an injury. Given the costs of unnecessary prescribing and the extra medical care often associated with opioid abusers, estimated at over \$17,000 annually,¹² identification of such individuals can lead to

¹⁰ Data are from the PDMP Training and Technical Assistance Center 2012 survey of state PDMPs.

¹¹ Prescription Drug Monitoring Program (PDMP) Center of Excellence, 2013, "Using PDMP Data to Improve Medical Care: Washington State's Data Sharing Initiative with Medicaid and Workers' Compensation," http://pdmpefficiency.org/sites/all/pdfs/washington_nff_final.pdf.

¹² Mahon, W. "Prescription for peril: the health insurance impact and risks of epidemic-level prescription drug diversion." Presentation for the PDMPs and Third Party Payers Meeting, Washington, D. C., December, 2012, convened by the PDMP Center of Excellence. <http://www.pdmpefficiency.org/sites/all/pdfs/Mahon.pdf>.

appropriate intervention, help ensure safer prescribing, and bring significant savings to third party payers. For example, placing Washington Medicaid clients identified by PDMP data in lock-in programs is estimated to save \$6,000 annually per client by reducing unnecessary medical care and prescriptions.¹³ WellPoint Anthem Blue Cross Blue Shield of Virginia estimated that it saved \$333,418 in drug and medical claims by restricting to one pharmacy 100 clients who had been receiving multiple narcotic prescriptions from five or more sources over a 90-day period.¹⁴

Questionable prescribing and dispensing on the part of some providers, identifiable in PDMP data, can also compromise medical care and contribute substantially to high costs for insurers. Using PDMP information, Washington State's Medicaid program found that, in violation of contractual agreements, 435 pharmacies in the state were accepting cash payments for controlled substance prescriptions that duplicated prescriptions dispensed to their patients covered by Medicaid.¹⁵ Prescribers who have high proportions of doctor shoppers among their patients, or who prescribe high daily doses of controlled substances compared to other prescribers with similar practices, can also be identified using PDMP data. Should an in-network prescriber fall into these categories, an insurer can conduct further review to determine whether or not the prescriber is conforming to good medical practice.¹⁶

The December 2012 PDMPs and Third Party Payer Meeting

These and other potential benefits of PDMP data use by insurers were explored at a meeting convened by the PDMP Center of Excellence: "PDMPs and Third Party Payers: Working Together to Assure Safe Prescribing and Interdict the Prescription Drug Abuse Epidemic." The meeting was convened at the request of the Office of National Drug Control Policy in its 2011 prescription drug abuse prevention strategy,¹⁷ and was held in Washington D.C. on December 3-4, 2012. Among the 77 participants were representatives of major insurance companies, the Center for Medicare and Medicaid Services, workers' compensation organizations, other state and federal government agencies, PDMP administrators and staff, researchers, and other PDMP stakeholders. (See Appendix B for a complete list of attendees.) The meeting was supported by a grant from the U.S. Department of Justice's Bureau of Justice Assistance.

Presentations at the meeting made clear just how much is at stake for insurers in gaining access to PDMP data, given that prescription drug abuse is a driver of excess costs.¹⁸ William Mahon, head of Mahon Consulting Group and insurance fraud expert, noted in his presentation (see footnote 11) the "three dimensional cost impact" of prescription fraud and diversion on insurers: 1) private insurance covers an increasing share of the cost of prescription drugs (47%

¹³ Best, S. "PMP use by Medicaid," 2012, presentation at the PDMP and Third Party Payers meeting, <http://www.pdmpexcellence.org/sites/all/pdfs/Best.pdf>

¹⁴ Mahon, W. op cit. (footnote 12).

¹⁵ Best, op cit. (footnote 13)

¹⁶ Note that PDMP data alone do not constitute proof of malpractice, fraud, or diversion, but they may serve as a preliminary indicator of *possible* questionable activity that could be the focus of further review and/or investigation.

¹⁷ See ONDCP, "Epidemic: Responding to America's Prescription Drug Abuse Crisis" at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf.

¹⁸ Presentations can be viewed at <http://www.pdmpexcellence.org/content/third-party-payer-meeting-presentations>.

in 2005); 2) costs to insurers include not only those of medically unnecessary prescriptions, but also the much greater costs of medical claims, both falsified and actual, associated with prescription drug abuse; and 3) insurers must take into account the large potential liability costs related to dangerous prescribers¹⁹ and the abuse-related deaths and injuries of insured parties as well as the deaths and injuries they might inflict on others. According to Mahon, a *conservative* estimate of the prescription abuse and fraud-related costs to a medium-sized insurer (500,000 lives insured) is over \$42 million a year.

The same story emerged in presentations from experts on workers' compensation. Recent studies indicate that extending opioid prescriptions for non-cancer chronic pain beyond the first 30 days is strongly associated with slower recovery from injuries and longer delays in returning to work.²⁰ This obviously increases costs and liabilities for workers' compensation programs. Bruce Wood, Associate General Counsel and Director of Workers' Compensation for the American Insurance Association, called opioid abuse "the most urgent issue facing workers' compensation." Citing a study of workers' compensation claims in Michigan, Wood noted that use of long-acting opioids to treat chronic pain increased the chance of a "catastrophic claim" (over \$100,000) by nearly four times, while use of short-acting opioids nearly doubled it.²¹

As suggested by the recent experience in Washington State mentioned above, PDMPs can help third party payers identify unnecessary and illegal prescribing and dispensing, poor medical practice, and fraudulent claims that now constitute such a threat to the health and safety of insured individuals and such a burden for the insurance industry. Presentations at the meeting by representatives of Washington State's Medicaid and workers' compensation agencies reinforced the point that data sharing is both feasible and beneficial in increasing insurers' capacity to monitor medical practice. Other presentations described the cost savings and improved medical care that the more complete prescription monitoring afforded by PDMP data would likely make possible for insurers.

Although third party payers have an evident interest in using PDMP data, such use is far from universal. Only one state—Michigan—now provides PDMP data to private insurers. As of July 2013, 31 states indicated that they allow access to PDMP data by their Medicare, Medicaid, state health insurance programs, and/or health care payment/benefit providers or insurers, but the extent and means of data use is unknown.²² In particular, it is unknown whether states besides Washington are providing insurers with bulk PDMP data files for analysis, which is potentially a very promising practice for monitoring use of controlled substances.

¹⁹ Mahon recounted that a prescriber in the Houston area engaged in prescription fraud, prescribing over 1.7 million doses of hydrocodone and 2,500 gallons of promethazine with codeine.

²⁰ Swedlow, A. "Prescribing Patterns of Schedule II Opioids in California Workers' Compensation" 2012, presentation at the PDMP and Third Party Payers meeting, http://www.pdmpexcellence.org/sites/all/pdfs/Swedlow%20CWCI_ResearchUpdate_S-II_0311.pdf.

²¹ Wood, B. "Prescription Drug Monitoring & 3rd Party Payers," 2012, presentation at the PDMP and Third Party Payer meeting, <http://www.pdmpexcellence.org/sites/all/pdfs/Wood.pdf>.

²² Data from the National Alliance of Model State Drug Laws, <http://www.namsdl.org/library/17C0A10D-1C23-D4F9-743C8DD064D89E71/> and <http://www.namsdl.org/library/17A074E7-1C23-D4F9-7495AECDB78BEC94/>.

Workgroups on Providing PDMP Data to Third Party Payers

Given the potential benefits of third party payer access to PDMP data, workgroups were convened at the meeting to explore in more detail the advantages and possible pitfalls of such access, the barriers to data sharing, how to overcome these barriers, and policies and procedures for data sharing collaborations. Workgroups focused on eight topic areas:

- Overview: Sharing Prescription Histories with Third Party Payers
- Protecting PDMP Data and Ensuring Appropriate Use
- Identifying and Overcoming Barriers to Data Sharing
- Evaluating Data Sharing Collaborations
- Sharing Data with Health Care Systems
- Identifying Questionable Activity by Providers
- Third Party Payer Support for PDMPs
- Enhancing Drug Abuse Referral and Treatment

The workgroups reached internal consensus on a number of conclusions. (Summaries and specifics of workgroup findings are presented in Appendix A.)

- PDMPs should be authorized to share prescription data with third party payers. Insurers have a central role to play in assuring quality health care and addressing the prescription drug abuse epidemic; their use of PDMP data is key to an effective response. Without it, insurers do not have a complete picture of the prescribing and dispensing carried out by network practitioners and provided to their enrollees.
- Safeguards are essential. Providing PDMP data to third party payers is feasible and worthwhile so long as appropriate safeguards are put in place to assure use is appropriate, data are kept secure, and patient confidentiality is maintained. Insurers must address concerns about denying coverage based on viewing PDMP data.
- Barriers to data sharing can be overcome. Facilitating insurers' access to PDMP data requires collaborative efforts on the part of all stakeholders to modify legislative and regulatory language to permit such access. It will also require developing policies and procedures on data security, standardization, and interoperability.
- Data sharing policies and procedures need evaluation to maximize effectiveness. Research is needed to identify process and outcome measures relevant to assessing the impact of third party payer use of PDMP data. Research could also focus on the wider public health impact of PDMP utilization by insurers, helping to make the case for data sharing initiatives.
- PDMPs should be authorized to provide data to health care systems. Sharing PDMP data with health care systems (e.g., the VA, Indian Health Service, Tricare, Kaiser Permanente) can help improve medical care and identify appropriate patterns of prescribing and use of controlled substances. Such sharing can also permit quality assurance programs to earlier identify and intervene in problematic prescribing.
- Insurers should use PDMP data to identify questionable prescribing and dispensing. PDMP data on medical providers can be used to help identify fraud, monitor provider performance, and detect pharmacy non-compliance with insurance regulations. Third

party payers and the wider public would benefit from use of PDMP data to monitor prescriber and dispenser behavior.

- Third party payers should support PDMPs. Since PDMP data can play an important role in insurers' efforts to improve medical care and reduce costs, they should consider assisting PDMPs by means such as educating policy makers, direct contributions, or collaborative efforts to secure stable sources of funding.
- Providers should be encouraged to refer patients to treatment. A primary goal of use of PDMP data, including by third party payers, should be the identification of individuals in need of substance abuse treatment or better pain management. Providers need education and training in the use of the PDMP and tools such as SBIRT (screening, brief intervention, referral to treatment). Insurers can help assure that these objectives are met.

Conclusion: Expert Opinion Supports Third Party Payer Use of PDMP Data

The overall message coming out of the workgroups and other presentations at the meeting was clear: there is a great deal to be gained from allowing insurers access to PDMP information, and much to lose if insurers are unable or fail to make use of it. Meeting participants judged that third party payers are an important partner in the effort to assure quality medical care and mitigate prescription drug abuse. Without use of PDMP data, their contribution will be limited.

This judgment represents the considered deliberations of a diverse group of concerned stakeholders, each with a particular public health expertise and perspective. The group recognized that there are barriers to third party payer access to PDMP data and that all stages of its implementation will require close cross-agency collaboration. However, the consensus in favor of sharing PDMP data with health insurers suggests that it merits consideration as a policy objective in the effort to contain the prescription drug abuse epidemic. Suggestions made in the workgroups (see Appendix A) can contribute to the development of data sharing policies and procedures, as well as regulatory frameworks for those states that do not currently allow third party payer access to PDMP data.

Appendix A

Workgroup Findings

METHODS

Those attending the PDMPs and Third Party Payer meeting were invited to participate in two workgroups of their choosing. Each workgroup had two co-leaders as well as a resource person familiar with the topic and a designated note-taker. On average, there were 10 participants in each group. The workgroup proceedings were recorded by the note-takers, then checked and amended as necessary by the workgroup co-leaders. The proceedings of each workgroup are summarized in the Findings section below.

FINDINGS

Workgroup 1: Sharing Prescription History Data with Third Party Payers

This group considered the overall landscape of issues on sharing PDMP data with third party payers. Issues included:

- Principles constraining third party payer use of PDMP data
- Benefits from third party payer use of PDMP information
- Risks and concerns
- Barriers to data sharing
- Incentivizing use of PDMP data
- Financial support of PDMPs

The group reached the consensus that, given the potential benefits, there is a strong case for third party payer access to PDMP data so they can review all prescriptions dispensed to their enrollees. Insurers have a central role to play in addressing prescription drug abuse, and access to PDMP data is key to an effective response. Without it, the insurers do not have a complete understanding of the scope or type of prescribing actually provided to their enrollees. However, data sharing arrangements must include guidelines on the legitimate uses of prescription history information as well as strict controls to ensure patient confidentiality and data security. Checks and balances must be in place to prevent misuse of the system. Third party payers could be recruited to provide financial support of PDMPs since they stand to benefit from use of PDMP data. The group recommended taking a proactive, comprehensive approach to encouraging data sharing partnerships, including fostering statewide cooperation, developing model legislation, and reaching out to both public and private insurers.

Principles constraining third party payer use of PDMP data

- The health and best interests of the patient must always remain the top priority.

PDMPs and Third Party Payers

- PDMP data must be kept secure and used only for legitimate purposes related to improving patient care, assuring good prescriber practice, and reducing costs related to misuse, abuse, fraud, and diversion.

Expected benefits

- Improved patient health care and safety in both the private and public sectors.
- Improved clinical decision-making and prescribing to promote better patient care.
- Mitigation of the financial impact on insurers and the social costs of the prescription drug abuse epidemic.
- Help to settle false claims. PDMP data can be used to assist in the development or refinement of third party payer analytics to improve quality of care.

Risks and concerns

- Assurances are needed to avoid cost reduction becoming the primary focus over other third party payer considerations in their use of PDMP data.
- Safeguards are needed to assure that PDMP data are only considered preliminary indicators, not definitive proof of questionable behavior.
- Third party payers need to consider all appropriate interventions, not just turn data over to special investigative units (SIUs) that might tend to criminalize misuse, possibly foreclosing other interventions.
- All participants with access to PDMP data must use the data prudently and with safeguards in order to avoid a chilling effect on legitimate prescribing.

Barriers to data sharing and utilization

- State legislation prohibits such use or is ambiguous.
- Concerns about misuse of data (see above).
- Some pharmacists and rural physicians may not have Internet access.

Incentivizing use of PDMP data

- Provide financial incentives and reimbursements for prescribers to check the PDMP, conduct screenings, and refer to treatment.
- Institute non-monetary incentives for prescribers—e.g., establish the peer group norm that use of PDMP constitutes excellence in practice.
- Increase funding for fraud units and investigations.

Financial support of PDMPs

- Demonstrate the cost effectiveness of PDMPs to third party payers—for instance, in reducing costs related to fraud, over-prescribing, and diversion.
- Consider allocating a percentage of third party payer false claim settlements to fund PDMPs.
- Explore other funding mechanisms, direct or indirect, from insurers to PDMPs, being cognizant of risks, perceptions of influence, etc.
- Fund PDMPs via licensure fees assessed on providers.

Other recommendations

- Take a proactive, comprehensive, and systematic approach in developing data sharing protocols and partnerships.
- Foster state-level cooperation.
- Develop model legislation.

- Have Medicaid providers establish data sharing contracts.
- Make the system user friendly for the technologically challenged.
- Institute data security protections and standard data access agreements.
- Establish a single depository, such as a health information exchange (HIE) for all patient data for a state, including PDMP data.
- Create provider directories.
- Institute direct user notifications (unsolicited reports and alerts).

Workgroup 2: Protecting PDMP Data and Ensuring Appropriate Use

This group took up the questions of appropriate uses of PDMP data by third party payers, how to ensure data are not misused, and how to protect data security. Discussion focused on:

- Appropriate purposes of PDMP data use by third party payers
- Appropriate PDMP end-user groups in third party payer organizations
- Policies and procedures to ensure appropriate use
- Enforcing data use agreements
- Ownership of PDMP data
- Monitoring third party payer use of PDMP data
- Two way data exchange
- Data security and storage
- Concerns about data sharing with third party payers
- Preventing denial of insurance coverage based on inappropriate use of PDMP data

The group agreed that improving patient care should be the first priority in allowing third party payer access to PDMP data, while noting that reducing costs might be a primary incentive for insurers. Data sharing agreements must be clearly specified in writing to ensure only appropriate user groups within an insurance organization have access, that data are not made available to unregulated subcontractors or vendors, and that enforcement mechanisms are in place to prevent misuse. Providing PDMP data to third party payers seems feasible and worthwhile so long as use is appropriate, data are kept secure, and patient confidentiality is maintained. Insurers must address concerns about denying coverage based on viewing PDMP data. The potential exists for third party payers to become allies and supporters of PDMPs once the value of prescription history information for insurers becomes evident.

Appropriate purposes of PDMP data use by third party payers

- Determining medical necessity and improving patient care
- Monitoring enrollees who are doctor shopping or obtaining very large daily quantities of controlled substances
- Identifying enrollees in need of substance abuse treatment and assuring they are appropriately referred
- Detecting criminal acts, fraud, etc.
- Reducing inappropriate drug treatment and concomitant costs

Appropriate PDMP end-user groups in third party payer organizations

- Patient review and care coordination
- Fraud investigation
- Claims review

Policies and procedures to ensure appropriate use should

- Ensure controlled data access, data security, and that data are utilized for the proper purposes—e.g., not open to the entire insurance company, but only to specific groups and individuals tasked with enhancing public health and reducing fraud and diversion.
- Specify in writing via legislation, regulations, and individual memorandums of understanding (MOU) the uses of PMP data by third party payers and the policies and procedures regulating such uses.
- Specify in MOUs the end users *within* a third party payer organization who are allowed access to the PDMP data.
- Enable close monitoring of access, especially at first, to make sure that data are being used as intended and that the right data are being provided.
- Assure that PDMP data are not transmitted to unregulated individuals or agencies—e.g., a claims processing or benefit managing subcontractor. Subcontractors have to be regulated, making third party payers responsible for any misuse on the part of a subcontractor. Subcontractors and vendors should be bound by the same restrictions as the insurance company in the uses of PDMP data.
- Perhaps give immunity to PDMPs in sharing data. The insurer bears responsibility for any data misuse—e.g., in peer review or by a subcontractor, independent medical examiners, etc.
- Assure data quality and accuracy: MOUs between PDMPs and third party payers should state that a carrier has to check and verify all PDMP information as a basis for action since sometimes data are incomplete or inaccurate.
- Consider other sorts of data sharing arrangements—e.g., electronic health records EHR and health departments—as models for data protection.
- Examine different states' experience—e.g., Washington and Michigan—for data sharing policies and regulations.

Enforcing data use agreements

- Must specify enforcement mechanisms and security standards in regulations and in MOUs.
- PMPs could withhold data or cancel user accounts as possible sanctions for data misuse.
- Penalties for misuse could be specified in legislation and regulations.

Ownership of PDMP data

- Need to establish clear policies on this.
- Examine possible policy: receiver of data has full rights to its use, full ownership, so long as 1) no violations of state or federal laws—e.g., of HIPAA—result from such use, and 2) use conforms to written data sharing agreements.

Monitoring third party payer use of PDMP data

- Should be able to monitor third party payer data use: need to know where the PDMP data went and how it was used by third party payers—a transparent system.
- Could do a selective audit of use of PDMP data by third party payers, but it is not feasible to audit all use. Could conduct a monthly audit that could include outcomes, but this involves a great deal of work for a PDMP.
- Possible model: Washington State sends an automated audit report to law enforcement for review and sign off; if no sign off, access to data is forfeited.

PDMPs and Third Party Payers

- Possible barrier: could be difficult for insurers to track use of PDMP data since other data can be mixed into files.

Two way data exchange

- It is important for evaluation purposes to have data on the utility and outcomes of insurers' use of PDMP data, especially in cases of fraud and diversion. PDMPs want to show their programs are worthwhile and improve their performance, so feedback on outcomes of insurers' use of data is important.
- Insurers might give data back on the results of a query only in cases where they find suspected abuse, but not on every query because that could represent too much work.
- Third party payers usually have mechanisms and obligations to report fraud, so could include PDMPs in such reporting.
- Insurers and PDMPs could write two way data exchange into an MOU.
- Possible barrier: Insurance industry may not be ready for two way data flow.

Data security and storage

- Security practices vary between companies, so MOUs between insurers and PDMPs should include uniform, well-defined security standards.
- Data storage: states have different rules and restrictions, so storage protocols must be decided and established between insurance companies and each state.
- A process could be established for a regularly conducted independent data security audit of third party payers, including IT policies and procedures, physical security, data access policies, etc.
- Predictive modeling technology could be used to detect data phishing attempts as a security enhancement.

Addressing concerns about data sharing with third party payers

- There is much concern about privacy of health information—e.g., lawsuit in Oregon to quash a blanket subpoena for PDMP data. It is important to have good responses to these concerns.
- Need to articulate clear regulations, standards, and rationales for use.
- Have to reassure legislators that insurers will not use data to deny care (see below) or compromise patient privacy.
- Language focused on health care as the primary rationale for data sharing will make sharing more acceptable, especially in states with high sensitivity to privacy issues and concerns about possible overreach in law enforcement scrutiny.

Preventing denial of insurance coverage based on PDMP data

- First obligation must be to give patients good medical care.
- Insurance companies should be prohibited from denying coverage based on PDMP data unless fraud, diversion, or legitimate health concern is identified on a claim being investigated.
- Should prohibit use of PDMP data for actuarial tables or other tables that might restrict access to care.
- There are already some protections in place against misuse—e.g., via insurance regulatory boards.
- HIPAA has a carve-out for using health data in suspected fraud investigations. Data cannot be used for underwriting purposes; to deny claims would violate federal law.
- Thus far there is little reported misuse of PDMP data by third party payers. Insurers know that they should not misuse data; they have a good track record on this.

PDMPs and Third Party Payers

- Could write prevention of denial of benefits using PDMP data into regulatory rules or legislation and/or in MOUs.
- PDMP could provide an audit trail to help enforce such a provision—e.g., presenting what data were accessed by third party payer, and when.
- Must reassure legislators and the public that third party payers will not use PDMP data to deny legitimate medical care.

Other observations

- Data sharing with third party payers could potentially create new resources, funding, and allies for PDMPs in working to prevent prescription drug abuse once payers see value in PDMP data.
- Michigan allows private insurers to request PDMP data; it is a possible model for data sharing protocols.
- The Affordable Care Act needs to be researched vis a vis its impact on data sharing.

Workgroup 3: Identifying and Overcoming Barriers to Data Sharing

This group identified some significant barriers to data sharing with third party payers and suggested possible solutions. After surveying the current status of data sharing, topic areas discussed included:

- Modification of PDMP legislation
- Adoption of uniform data standards
- Considerations for a federal role
- Barriers to PDMP interoperability
- Concerns about data sharing
- Outreach to promote data sharing

Major barriers to third party payer use of PDMP data include the lack of legislative and regulatory authorization for such use, lack of uniform data standards among PDMPs, lack of PDMP interoperability, and concerns about misuse of data. Overcoming these barriers will require collaborative efforts by PDMPs and stakeholders, including insurers, to allay concerns, reform legislation, and encourage data standardization and interoperability. Federal involvement may assist in these efforts. There are strong public health and business cases to be made in support of data sharing with third party payers that will likely prove persuasive to legislators, employers, and the public.

Overview of barriers to data sharing

- Barriers to data sharing with third party payers are legislative, regulatory, educational, and attitudinal.
- Data standardization and interoperability among PDMPs are needed to facilitate sharing.
- To overcome barriers, need
 - Legislative/regulatory reform.
 - Data standardization and interoperability.
 - Education and outreach to health care practitioners, patient advocacy groups, legislators, insurers, the public, and the media.

Current status of data sharing with third party payers

- According to the PDMP Training and Technical Assistance Center at Brandeis University, as of July 2012, 29 states allow their Medicaid, Medicare, or state health programs to have access to information collected by the state PDMP.
- Of these states, 23 allow the state Medicaid program to have general access to PDMP data for administration of the Medicaid program to monitor their patients' controlled substance usage, while five states limit the access to investigations involving fraud and abuse, and two allow Medicare to have access.
- Until December 31, 2016, the Michigan PDMP is authorized to provide information to the health care payment or benefit provider for the purpose of ensuring patient safety and investigating fraud and abuse. A health care payment or benefit provider is defined as a person that provides health benefits, coverage, or insurance in the state of Michigan, including a health insurance company, a nonprofit health care corporation, a health maintenance organization, a multiple employer welfare arrangement, a Medicaid contract health plan, or any other person providing a plan of health benefits, coverage, or insurance subject to state insurance regulation.

Modifying PDMP legislation

- Many states have statutes that do not provide for access to PDMP data for certain user groups, including insurers.
- Some statutes are less restrictive than people realize, so each state and third party payer must research the exact language.
- A legal challenge or broader interpretation of some of these statutes might allow wider access to PDMP data by third party payers.
- The Alliance of States with Prescription Monitoring Program's model law provides for access to PDMP data, including Medicaid and workers' compensation agencies as potential users.
- Insurance companies could advocate for modifying state laws for greater access to PDMP data. There is a strong business case *and* public health case to be made for this. States' legislation, except in Michigan, does not provide them access to the data, which prevents cost-effective and optimum health care delivery.

Adopting uniform data standards

- There is wide variability in data fields and reporting standards among states.
- Storing PDMP data in the same standard format and incorporating them into EHRs would facilitate data sharing.
- The American Society for Automation in Pharmacy and the National Council for Prescription Drug Programs have competing standards; this will need resolution to have a single data standard.
- The lack of standardization of data collection among 50 states and needing separate MOUs to access each state's PDMP data are barriers to uniform data access.
- Pharmacies operate in real time, so they would benefit from standard data fields and reliable data available for quick, easy, real-time access.
- Perhaps federal legislation could be considered for data standardization; federal money could be used as an incentive to standardize. (See "Considering a federal role" below for more possibilities.)

Considering a federal role

- From the VA's perspective, the variation in state laws is a significant barrier to their submitting data to PDMPs. Could there be a federal solution? Note: The Indian Health

PDMPs and Third Party Payers

Service (IHS) is developing a system that varies to meet the data submission requirements for each PDMP to which it is submitting data.

- A federal–state partnership is a possibility, perhaps linked to a state model act. An option might be finding a state that would take the lead in trying to forge a partnership and then carrying the idea to other states.
- The health care system is primarily a local and state system, so a federal solution might be hard to impose.
- There is a possible federal role in promoting data standardization (see above).

Barriers to PDMP interoperability

- States have difficulty in sharing PDMP data; for example, as of December 2012, the Prescription Monitoring Information Exchange (PMIX) and PMP InterConnect (PMPi) systems were unable to communicate, though a solution is being worked on.
- The lack of a standard prescriber identification number is a barrier, though PDMPs generally collect DEA numbers to identify prescribers. In the future, perhaps prescribers' NPI number might be used. A state driver's license number is unique to an individual provider and could be used as a unique identifier.
- Federal funds (e.g., from BJA and Substance Abuse and Mental Health Services Administration (SAMHSA)) can be used as incentives to achieve interoperability between PDMPs and integration of PDMPs with EHRs and HIEs. BJA's Harold Rogers PDMP grants have supported interstate interoperability for almost a decade, and SAMHSA is funding pilot PDMP-to-EHR/HIE interoperability projects in FY2013 and FY2014 from which much can be learned concerning the issues listed here.
- There is great variability in the type of state agency providing oversight to different PDMPs and the quality of that oversight; some think that might pose problems in achieving interoperability.

Concerns about data sharing

- Procedures have to assure that third party payer access is not abused; for example, drug manufacturers gaining access to PDMP data.
- Downstream disclosure of private data would be unacceptable from a public policy perspective.
- Thus far, there does not seem to be any evidence of further disclosure of information.

Outreach to promote data sharing

- Three key factors for PDMPs were identified: funding, data standards, and interoperability. Moving ahead in these three areas will improve the effectiveness of PDMPs and thus public health and safety.
- The value of registering with and participating in PDMPs needs to be demonstrated to the medical community and other end users. Patient safety and health care quality improvement will result from greater use of the PDMP data.
- There is a business case to be made to third party payers as to why PDMPs are valuable; this should be developed.
- Legislators may be impressed with the benefits employers gain by third party payer use of PDMP data; for example, there might be reduced health care costs and reduced time off work because of faster recovery from injuries.
- Presentations to legislators to approve access for third party payers should be considered.

Workgroup 4: Evaluating Data Sharing Collaborations

This group explored the potential research agenda in evaluating the impact of third party payer use of PDMP data, as well as barriers to research and possible funding sources. Topics included:

- Concerns about data sharing and use of PDMP data
- Process and outcome measures for evaluating third party payer use of data
- Patient-level research questions and concerns
- System-level research opportunities
- Data linking
- Potential funding sources for research and evaluation

The group identified process and outcome measures relevant to assessing the impact of third party payer use of PDMP data, as well as basic research questions at the patient and system level. Research could also focus on the wider public health impact of PDMP utilization—e.g., a possible shift to heroin use as prescription opioid misuse is reduced, the role of community prevention, and best practices in prescriber education and utilization of PDMPs. Adequate data linking and access via EHRs were identified as facilitating factors in encouraging PDMP utilization and evaluating its impact.

Concerns about data sharing and use of PDMP data

- Third party payers contract out to claims processors and benefit managers, thereby increasing the risk of security issues and potential misuse of PDMP systems' data.
- Some concerns were expressed about sending alerts or data reports to providers indicating doctor shopping activity—e.g., are some of those patients dropped or “fired” from the practice, which does not solve the patient’s underlying problem(s)? Are there possible unintended consequences of these providers’ actions (e.g., patients switching to heroin as a result)?
- Are third party payers providing insufficient reimbursement for using PDMP systems and subsequent patient care? Third party payers could provide a payment code for referrals to treatment or contacting other providers; the SBIRT code in Medicaid is insufficient for prescriber’s time.

Process and outcome measures for evaluating third party payers’ use of data

- Process measures could include
 - Time prescribers spend on “problematic” patients (with PDMP data vs. without)
 - Extent of PDMP utilization by third party payers and providers
 - Indicators of better care coordination
 - Number of prescribers investigated
 - Types of actions taken with prescribers, pharmacies, and patients
- Outcome measures could include
 - Number of individuals with substance abuse issues
 - Number of poisonings and unintentional injuries
 - Mortality rates
 - Medical services utilization and associated costs relative to groups without access to PDMP information

Patient-level research questions and concerns

- Who is truly at risk? For example, is it the patients consuming over a 120 mg morphine equivalent dose per day?
- What are valid data indicators to trigger reports and interventions? What are the “correct” thresholds, taking into account factors such as practice type (e.g., oncologist vs. general practitioner)?
- What types of interventions produce what responses (e.g., unsolicited reports to prescribers, prescriber education initiatives on using PDMP data)?
- Does the fact that many PDMP programs are within law enforcement agencies or funded by the Department of Justice lead to trust issues between practitioners and patients?
- What is the wider scope of public health issues (e.g., whether adequate treatment beds are available)?
- What are the roles of community-based task forces on health outcomes related to prescription drug abuse?

System-level research opportunities and suggestions

- Linking medical conditions to utilization of opioids and other controlled substances. If private insurers can merge PDMP data with claims/administrative data, this could lead to developing improved algorithms for identifying aberrant patient care and ensuring appropriate care for legitimate patients.
- Conducting an environmental study of what is currently being done. What is the current state of the art in third party payer approaches to identifying aberrant patient care? What actions are taken with respect to patients/providers when aberrant behavior is detected? Because of legal restrictions, randomized controlled trials are in general not feasible, but we could design studies to observe states with Medicaid access and randomize PDMP access on 50% of patients; or compare states with Medicaid access with those that do not have Medicaid access. Outcome measures would include those listed above, derived from Medicaid claims data, and PDMP-based measures of patient risk and problematic provider behavior.
- Simulating what would happen if private insurers could access PDMP data—e.g., by studying Michigan’s pilot program with PDMP data in EHRs: DrFirst, which includes data from about 10 other states, with perhaps 50,000 prescriptions per month in the system. Suggestive changes in outcomes over time as the simulation proceeds might help to justify an actual field study.
- Evaluating what happens when providers have PDMP information. What kinds of decision-making support tools are needed? How to train providers to deal with patients needing an intervention?
- Ideally, using payer claims data as part of the evaluation.

Data linking

- Connecting PDMP data with other data such as medical services and other prescription drugs (legend drugs) would enable better studies.
- Overcoming the most common error of matching the prescriber DEA number.
- Evaluating Michigan’s current work on a pilot program to connect its PDMP with HIEs.

Potential funding sources for research and evaluation

- Cost-saving studies could use NIH mechanism(s) (e.g., R03) that are considered time-sensitive research or are secondary data analyses.
- May be able to use the R34 mechanism to conduct an implementation study working with health plans linking with PDMP data.

- The National Institutes of Health’s National Institute of Neurological Disorders and Stroke may be interested in a study of how use of PDMP data can improve care and increase appropriate access to controlled prescription drugs.

Workgroup 5: Sharing Data with Health Care Systems

This group explored the potential for PDMPs to share data with health care systems and facilities that provide direct care to patients. These systems function in some ways like third party payers. For example, some systems, such as TriCare (Department of Defense) and the VA, provide care by paying external health care providers. When using internal providers—as Kaiser Permanente does, for example—these systems collect premiums/funds from employers or other organizations or individuals and use the funds to pay providers serving enrollees. Like third party payers, they have responsibility for assuring health care services. Topics of this workgroup included:

- Types of health care systems and facilities appropriate for PDMP data sharing
- Background on the need for sharing PDMP data with health care systems and facilities
- Benefits of sharing PDMP data with health care systems and facilities
- Creating a path to sharing data
- Other considerations on data sharing

The group identified important benefits that may be derived from PDMPs sharing data with health care systems. Such sharing can identify appropriate patterns of prescribing and use of controlled substances in clinical practice, for example by comparing use of controlled substances between systems and within the different types of services provided by each system. PDMP data sharing can also permit existing quality assurance programs (already well-established within health care systems and facilities) to earlier identify and intervene in problematic prescribing, before licensing or law enforcement agency action becomes necessary. This innovation could provide protection to patients’ health and safety not otherwise possible under existing PDMP data uses. Implementing this type of data sharing will require legislative and regulatory changes in most states, as well as testing approaches to data use by health care systems in those states that permit sharing.

Types of health care systems and facilities appropriate for PDMP data sharing

- Department of Defense
- Indian Health Service
- Veterans Administration
- Large, multi-state health care systems—e.g., Kaiser Permanente
- Smaller health care systems within one state—e.g., Berkshire Health Systems in Western Massachusetts, which includes three hospitals, outpatient ambulatory care clinics, physician practice offices, home health care, and long-term care facilities
- Hospitals

Background on the need for sharing PDMP data with health care systems and facilities

- Current systems for monitoring prescriber practices and intervening if a prescriber inappropriately or fraudulently prescribes controlled substances are health professional licensing boards, which have investigative and disciplinary authority, and law enforcement agencies, which have investigative and prosecutorial authority.

PDMPs and Third Party Payers

- Prescribers involved in inappropriate and/or fraudulent prescribing may have developed such practices over multiple years of questionable or increasingly inappropriate behavior.
- Such early prescribing problems may begin and slowly increase over a period of years before coming to the attention of health professional licensing boards or law enforcement.
- During such periods, injury to patients may occur but not be identified, prevented, or remediated.
- Health care systems and hospitals are responsible for the care provided by their prescribers and other health care professionals. States, federal agencies, and organizations that accredit health care facilities hold health care systems and hospitals accountable for these responsibilities.
- For example, in standards adopted by the Joint Commission, hospitals are responsible for operating Focused Professional Practice Evaluation (FPPE), previously referred to as peer review, to evaluate the quality of care provided by their health care professionals and to take appropriate corrective action or other steps when there are opportunities for improvement.
- Medical staff leadership in hospitals and health systems across the country use FPPE and other quality initiatives to encourage best practices in most areas of care, including drug therapies. However, except in the states of North and South Dakota, health care systems' and hospitals' clinical supervisors and FPPE committees are not authorized to review PDMP data regarding the prescriptions issued by prescribers, even if review of such data is critical to determining the quality of treatment provided by prescribers.
- IHS has developed systems for clinical oversight of its patients, prescribers, and pharmacies, but currently it is only able to monitor prescriptions issued by its prescribers to the extent the prescriptions are dispensed in IHS pharmacies. When prescriptions are dispensed to its patients by pharmacies outside IHS facilities, IHS is unable to monitor those prescriptions or to compare them to those dispensed in IHS pharmacies. IHS has requested that its clinical supervision and oversight staff be able to obtain data from PDMPs for prescriptions issued by prescribers who work in IHS facilities, regardless of the pharmacy in which the prescription is dispensed.
- The Berkshire Health System in Western Massachusetts has identified an opportunity to improve the management of acute and chronic pain and thoughtful prescribing of pain medication by use of PDMP data as a quality management tool. Berkshire Health Systems clinical leaders believe that there is a significant lack of understanding among area prescribers about their own prescribing practices over time and how their practices compare with others in the same specialty. In addition, Berkshire Health Systems clinical leaders believe that PDMP data, aggregated and available on a regional and local basis, would allow individual prescribers and community clinical leaders to understand how individual prescribing patterns compare to those of peers to adjust prescribing practices where appropriate and to begin developing more refined best practices for use of prescription controlled substances. Similarly, Berkshire Health Systems clinical leaders hope that, through quality management use of PDMP data, prescription of controlled substances as a treatment modality will join every other treatment regimen in being subject to peer challenge for appropriateness and effectiveness and become an integral part of FPPE (peer review) committees' review of practitioner quality.
- Preliminary discussions with major health care systems have identified a similar need.

Benefits of sharing PDMP data with health care systems and facilities

- Health care systems and facilities are responsible for and committed to quality improvement and the safety of their patients.
- Sharing of PDMP data with the quality improvement and patient safety programs in health care systems and facilities can provide important data they need to 1) improve the quality of acute and chronic pain management, 2) protect the safety of patients, 3) assure their prescribers are providing appropriate and safe medical care with optimal coordination across providers, and 4) intervene when they find inappropriate prescribing.
- Injury to patients can be prevented by developing “best practice” approaches to controlled substance prescribing and allowing for early identification of areas where prescribing practices can be improved and interventions can be applied before patients are injured.
- Data sharing can create a Prescriber Clinical Support System: optimal prescribing practices can be developed and inappropriate prescribing practices can be identified and remediated as a quality improvement intervention, not merely responding to prescribing issues when they warrant investigation and action by health professional licensing boards or law enforcement.
- Providers can be given tools to improve their prescribing through the routine process already established across the nation for addressing clinical problems.

Creating a path to sharing data

- Model legislation for PDMPs to share data with health care systems and facilities should be developed.
- The PDMP Center of Excellence should work with a few states to develop and run pilot tests.
- States that may be interested in such a pilot test include Indiana, Massachusetts, and Washington.

Other considerations for data sharing

- Medical practice guidelines should be modified to call for requests of PDMP prescription profiles of each patient at appropriate times as part of the continuum of care. This would need to start at the beginning of care.
- All service providers and other caregivers should be involved in care planning.
- PDMP data, like all data sources, should feed into the metrics—all leading to one virtual medical record for each client/patient.

Workgroup 6: Identifying Questionable Activity by Providers

This group took up the question of how third party payers might use PDMP data to monitor the prescribing and dispensing by medical providers in a third party payer network, the barriers to such use, and how to overcome them. Issues addressed included:

- Value and uses of PDMP data on providers’ prescribing by third party payers
- Incentivizing and managing third party payer use of data on providers
- Responding to concerns on data sharing
- Examples of current third party payer and others’ use of PDMP data on providers
- One insurer’s suggestions on using PDMP data to detect over-prescribing, fraud, and diversion

PDMPs and Third Party Payers

The group identified current examples of how provider data are used to identify fraud, monitor provider performance, and detect pharmacy non-compliance with Medicaid regulations. One insurer speaking from his own experience made the case for the importance of systematic PDMP data use in detecting over-prescribing, fraud, and diversion. The group agreed that third party payers and the wider public would benefit from use of PDMP data to monitor prescriber and dispenser behavior. Efforts to modify legislation to permit data sharing with third party payers, and allay concerns about it, are therefore very worthwhile.

Background considerations

- Some PDMPs are proactive in identifying questionable prescribing—e.g., Kentucky.
- Medical boards are often understaffed and sometimes do not have authority to go beyond patient care issues in investigations; this suggests a role for third party payers in conducting investigations.
- Third party payers are motivated to uncover and reduce questionable activity by providers.
- There is need to understand how third party payers currently use prescription data on providers.

Value and uses of PDMP data on providers for third party payers

- Insurers currently do not have complete prescription data—e.g., prescriptions paid by cash or other sources or drugs prescribed by out-of-network providers.
- Pill mills often are primarily cash operations, hence the importance of PDMP data to identify them.
- PDMP data on providers can help
 - Identify outliers in comparison to peers, using summary statistics.
 - Qualify providers when setting up a network: insurers may want to look at prescription history of a provider before signing a contract with them to determine, for example, whether they are part of a pill mill.
 - Monitor ongoing prescriber behavior: regular provider report cards on prescribing patterns.
 - Identify pill mills and systematic fraud via utilization reviews.
 - Back up or inform a pharmacist's decision to dispense or deny a prescription.
 - Help pharmacy benefit managers (PBMs) to review providers; data would be useful for PBMs that have contracts with preferred providers to determine if they want to continue that contract or initiate a new contract.
- Third party payers would want the ability to query a PDMP database if there is suspicion of fraud or if they want to set up a contract with providers. Are they outliers? Are there any red flags?
- Payers could see if high volume prescribers identified with PDMP data were following good practice guidelines—e.g., conducting random drug screens.

Incentivizing and managing third party payer use of data on providers

- States could leverage insurers' need for data on providers—e.g., investigating fraud, vetting providers, setting up formularies and narcotic agreements—so that they come to PDMPs and ask for data, rather than states pushing data out and hoping it will get used.
- If there is no exposure with respect to a suspect provider, an insurer will not take action since this does not affect the company. But if an insurer sees exposure to someone on a list of outliers, they will take a look at provider's claims; to do that the insurer will need PDMP data to see the full story.

PDMPs and Third Party Payers

- Third party payers could query PDMP if they have a question on providers, rather than have access to the data set itself.
- If PDMPs could provide summary statistics and provider report cards to third party payers, could that become a fee-based service of PDMPs?
- States would need to establish accounts for insurers to have controlled access to PDMP data, or perhaps states could provide monthly reports on providers.

Responding to concerns on data sharing

- Third party payers: They are perceived as wanting all available data, but state policy makers may be reluctant to let them have it due to concerns about privacy.
- Medical organizations: Some medical groups will not want insurers to have access to PDMP data on providers, hence a barrier to sharing.
- Data sharing: Allowing PDMPs to share prescriber data with third party payers will require statutory changes, so all parties need to think through how to respond to questions.
- Public health and diversion: There might be a lower privacy standard with sharing data on providers as opposed to patients, but it is still going to raise questions. The goal must be clear—i.e., it will help protect patients and society against abuse, overdoses, addiction, and diversion more effectively than if data are not shared.
- Quality of care: When insurers contract with a provider, PDMP data would assist in making a determination on the quality of care of the practice. This should allay privacy and legitimacy concerns: insurers want high quality providers—e.g., they could request a report card on a provider.
- Data security: There needs to be definition of who has access in an insurance organization—not just anyone. Data use has to be tied very closely to goals and designated users so that legislators and advocates know the purpose of data use and what the access and control protocols are.

Examples of current third party payer and other use of PDMP data on providers

- Workers' compensation: The SIU conducts pattern-of-practice reviews—e.g., compares one prescriber to 20 others in the same area, and if the prescriber is out of the norm for many claims, then they are referred to the Drug Enforcement Administration and/or licensure boards as appropriate (they may also be referred for corporate review to determine internal actions). SIUs also look at type of practice—e.g., pain management that has expanded as a specialty.
- Improve prescriber performance: Washington Medicaid (WA Medicaid) uses PDMP data to improve prescriber performance. WA Medicaid gives information on mis-prescribing to the assurance commission, but the commission is very slow to act, so WA Medicaid needs to implement its own procedures—e.g., stop contracting with those providers, and start sharing information with managed care plans. It would be helpful to give all entities information on providers so that they can make informed decisions on quality of care.
- Using PDMP data: WA Medicaid found that some pharmacies were dispensing cash-paid prescriptions in addition to dispensing Medicaid-paid prescriptions, even though the pharmacy knew the person was in the Patient Review and Restriction Program (lock-in)—i.e., eligible to only receive prescriptions from one prescriber and one pharmacy, and only those prescriptions paid by Medicaid.
- Self-lookup for providers: Prescribers should be able to see data on their insured patients and also an overall view of all prescriptions prescribed by network prescribers. Prescribers in Kentucky can query their own prescribing history using their DEA number;

they also have expressed interest in summary statistics so they can see how they compare with peers.

- Large group data sharing: the Center for Medicaid and Medicare Services and Tricare have collaborated with private health plans to share data on providers.
- Alerts regarding providers: the [Aggregated Medical Database](#) sends out alerts regarding providers to their member organizations.

One insurer's suggestions on using PDMP data to detect over-prescribing, fraud, and diversion

- Example of a type of case where PDMP data would help insurers: When a client pays a \$1,000 per month co-pay for multiple Actiq prescriptions, the insurer would like to see if there are any other cash payments for this drug with this or other prescriber or pharmacy; there needs to be PDMP data for this.
- Legal investigations: Investigations are very slow (e.g., 7 years). What an insurer tries to do is act on the basis of medical necessity. If an insurer suspects illegal activity, then it can refer to Medic (which handles illegal Medicare part B) and to the client's SIU. Also, plans say that insurers are not liable to pay for claims that are not medically necessary, so they can consult with a pain management consultant who will evaluate care; if care is found unnecessary, then insurers can contact the doctor indicating they have a medical opinion that care is not necessary. This is more expeditious than the legal route, and PDMP data plays a critical role in this.
- Diversion: Many of the bigger diversion schemes are not at the individual patient level—e.g., a) the same provider is diverting for all members of the family, or b) all physicians in one clinic or nursing home are diverting. To identify those higher-level connections, it is very helpful to have the PDMP data and the pharmacies involved.
- Pharmacy use of PDMP: If pharmacists are registered with and use PDMP, they could document their suspicions and choose either to not fill a prescription or to call the doctor. PDMP data gives objective information to back up professional judgment.
- PBMs: If insurers could view PDMP information, they could alert pharmacies and a flag would come up when a prescription comes in from a pill mill.
- Utilization review: Insurers may want to do some retrospective utilization review to see if there is a pattern of suspicious behavior by a provider. That is the key question PDMP data could help answer: Can insurers access PDMP data to do utilization reviews, not just to determine whether a particular prescription is for a legitimate medical purpose, but for larger purposes (e.g., using PDMP data to pursue illegal activity if a pattern is suspected)?
- Use PDMP data on an organizational basis: Can insurers have individual pharmacist consultants and individual program medical directors register with PDMPs and request data? States should address the question of whether to grant that sort of access to third party payers and not just to individual prescribers.

Workgroup 7: Third Party Payer Support for PDMPs

This group considered the possibility of PDMPs finding support from third party payers, given the potential utility of PDMP data in reducing costs and improving quality of care by network providers. Topics covered were:

- Funding requirements
- Funding sources
- Funding recipients
- Securing funding

PDMPs and Third Party Payers

- Benefits of improved PDMP systems for third party payers and others
- Evidence in support of funding
- What third party payers can do for PDMPs beyond funding
- Possible risks of third party payer involvement
- Next steps

The group agreed that third party payers should fund and support PDMPs, and that this would help to ensure reliable funding of PDMPs and help them to adopt best practices to increase effectiveness. There is a strong business case for supporting PDMPs that can be made to third party payers, given their potential savings from using PDMP data and other benefits of such use. Obtaining funding requires addressing concerns about misuse of data and data security, amending legislation, and developing specific funding mechanisms acceptable to payers and the public. The group suggested a number of next steps, including the formation of a working group to develop model legislation, interstate compacts, and data sharing contracts with PDMPs.

Funding requirements

- PDMPs should identify the amount of funding they need with consideration for future needs such as cross-state border sharing. PDMPs should incorporate the information from the PDMP and Third Party Payer meeting to identify the benefits of data sharing related to improving outcomes for patients.
- There was some discussion of funding amounts—e.g., the Florida PDMP runs for \$500,000 annually; California is looking for a budget of \$2.5 million to build a PDMP and \$2 million a year to sustain it.

Funding sources

- Private third party payers in the insurance industry, in addition to workers' compensation and other insurers such as health and disability, should be considered.
- Public third party payers from state and federal public health and safety entities should be considered such as Medicare, Medicaid, VA, and Departments of Defense and State insurance. There was concern and some discussion about the difficulty of getting funding from federal government entities in the current fiscal climate, as well as the length of time it might take to secure such funding due to the legislative process (e.g., getting congressional approval).
- Some states require professional licensing fees and/or controlled substances registration fees from providers (e.g., physicians and other prescribers), pharmacies, drug wholesalers, and/or drug manufacturers as current funding sources for some PDMPs. This should not be changed.
- In workers' compensation in some states, there is an assessment on employers paid to the Division of Workers' Compensation; similarly, the users and beneficiaries of PDMP data could fund them.

Funding considerations

- Funding can be targeted to robust, user-friendly systems that can integrate data across state borders.
- Funds are needed for maintenance to keep individual PDMPs functioning.
- Functional/per query payments could be made to distribute some of the funding based on usage.

Securing funding

- State laws will need to be amended; enabling legislation should be developed for the states that is broad enough to allow the states to move forward with sharing the data across state lines and with third party payers. States should also have the opportunity to negotiate business arrangements with third party payers.
- A model state law and/or regulations should be developed.
- Federal legislation can be considered that would mandate certain state action (as was done for state uniformity related to insurance agents and brokers), or a federal program could be put into place.
- Assessments by regulators on insurance carriers could be used, as is currently done by states for other functions (these typically pass through to employers in the rates or as a straight-through assessment).
- Licensing fees for providers could be increased.
- Federal funding that may be available for enhancing information technology could result in cost savings for PDMPs.

Benefits of improved PDMP systems for third party payers and others

- Development of improved standards of care for the patients or injured workers.
- Avoiding over-prescribing of prescription medication (particularly opioids) has far-reaching effects, including saving lives, families, communities, and money.
- Integration with federal, group, and workers' compensation health care data improves the standard of care; it also reduces costs of the health care system.
- Enhanced anti-fraud efforts, though PDMPs are only a red flag—this needs to be looked into further.

Evidence in support of funding

- A PDMP improves patient outcomes, addresses the prescription drug abuse epidemic, and ultimately generates cost savings across the economy. Papers presented at the PDMP and Third Party Payers meeting should be used to support this case. Benefits include mitigation of health care costs—reduced office visits, testing, additional treatments, injuries, etc.
- An analysis from the California Workers' Compensation Institute suggests that insurers will see over a 15/1 return on investment from regular use of PDMP data to enhance opioid management controls.²³

What third party payers can do for PDMPs beyond funding

- Provide information on denied prescription claims as an indicator of patient or provider issues.
- Build predictive analytics to identify red flags for different treatments and earlier detection of fraud or criminal activity.
- Analyze data from a different perspective.
- Reduce medical malpractice premiums when there is evidence of provider use of PDMPs.
- Identify and control for possible risks of third party payer involvement.

²³ California Workers' Compensation Institute, "Estimated Savings from Enhanced Opioid Management Controls through 3rd Party Payer Access to Controlled Substances Utilization Review and Evaluation System (CURES)," January 11, 2013, <http://www.cwci.org/research.html> (scroll down to 1/11/2013, Research Report: "Estimated Savings from Enhanced Opioid Management Controls through 3rd Party Payer Access to Controlled Substances Utilization Review and Evaluation System (CURES)").

PDMPs and Third Party Payers

- Address concerns about data security, confidentiality, and integrity because of inconsistent and complex state IT systems, statutes, and regulations.
- Help states correct delayed timing of information collected by PDMPs; it must be at the point of service.
- Help create standardization across PDMPs to improve capability to share information.
- Develop systems to protect against insurer misuse of the data; there are both irrational fears about this but also potential for abuse. An example would be an insurance carrier denying future coverage due to information gleaned from PDMP data.
- Guard against insurers wanting too much from PDMPs and making them unnecessarily complicated.
- Avoid thinking that access to PDMP data is the end point for law enforcement when it is the starting point.

Next steps

- Recommend that a small group work on model legislation, model interstate compacts, and model contracts.
- Need to continue the discussion with all stakeholders engaged, including providers/prescribers, pain doctors, pharmacists, private and public insurers/payers, public health agencies, public safety/law enforcement, and regulators.
- Recognize that state legislators will be more willing to accept the idea if other states are also authorizing third party payer access to PDMP data.
- Make this a coordinated national effort, not just one state or a few.
- Seek political leaders at the state and federal levels who can support the cause of third party payers helping to fund PDMPs.

Workgroup 8: Enhancing Drug Abuse Referrals and Treatment

This group considered how PDMPs and third party payers can improve clinical practice with respect to individuals found to be abusing or addicted to controlled substances. Questions addressed included:

- How can PDMPs and third party payers educate providers on the value and uses of PDMP data?
- How can they and other stakeholders train prescribers to identify, intervene, and refer persons who need substance abuse treatment?
- How can stakeholders work to expand use of SBIRT?

The group agreed that a primary goal of use of PDMP data, including third party payers' use, should be the identification of individuals in need of substance abuse treatment and that providers need education and training in the use of the PDMP data and SBIRT. The group identified resources for researching and promulgating best practices in these areas and made recommendations on policies and action steps to improve the chances that patients can access appropriate treatment.

Medical objective of provider interventions

- Aim to refer patients to substance abuse treatment rather than law enforcement.

Practitioner considerations

- Practitioners need lists of substance abuse referrals that are easy to access.

PDMPs and Third Party Payers

- Managed care may be a good starting point for communicating information to patients and providers.
- Providers need education and guidance on SBIRT and use of PDMPs.

Evidence base

- SBIRT does not have enough clinical trials on outcomes for opioid misuse/abuse, although evidence indicates positive outcomes.
- There is a need for studies to inform best practices on prescriber education, use of PDMPs, and clinical response if addiction/misuse is discovered.

Developing resources for providers based on specialty and geographical regions by key stakeholders

- Federal government: create fact sheets and provide grants—e.g., SAMHSA created 1-2 Fact Sheets for each state on substance abuse prevention and treatment resources. Consider developing more informational notices/briefs for states.
- PDMPs: develop and disseminate resources, alerts, and unsolicited reports to providers.
- Third party payers: provide information on potentially “problematic” patients, monitor providers, and incentivize providers appropriately.
- Providers: train them on how to administer SBIRT and coordinate care using PDMP, how to broach the subject of prescription misuse/abuse, and how to do follow-ups with patients by teaching “series of tasks” vs. teaching processes.
- Community-level coalitions: help them to coordinate efforts among prevention and treatment providers and encourage best practices and strategies.

Recommendations for policies and action steps

- State PDMPs could add SAMHSA’s treatment locator on their web site. However, states and providers need to be mindful that there are pockets of geographic areas that have no treatment facility. The National Institute on Drug Abuse (NIDA) had a project in which emergency department physicians could get a real-time treatment locator—perhaps this approach could be commercialized to primary care providers.
- One possible alternative for those regions without a treatment facility is to encourage access and use of take-home naloxone as a prevention/intervention tool.
- States could tap into community coalitions (especially SPF-SIG grantees) to link treatment and prevention services/providers.
- PDMPs could provide community-level profiles to coalitions using rates of prescription drugs per person by county level and have practitioners go visit, educate, and advocate for strategies within that area.
- ONDCP/NIDA may be able to develop grants (small business grants) for decision-making support systems that are appropriate for regions and specialists.
- Specialty providers should be encouraged to refer patients back to their primary care providers for better care coordination.
- States should be encouraged to link their PDMP with HIEs.
- PDMPs and third party payers should reach out to opioid treatment programs (OTP), suggesting they present webinars on using PDMP data in treatment settings; could collaborate with substance abuse experts, e.g., Ron Jackson (WA Dept. of Social and Health Services) to encourage OTP providers to use the PDMP system.²⁴

²⁴ See PDMP Center for Excellence, 2011, “Keeping Patients Safe: Using PMP Data in Outpatient Addictions Treatment,” http://www.pdmpexcellence.org/sites/all/pdfs/methadone_treatment_nff_%203_2_11.pdf.

Appendix B

PDMPs and Third Party Payer Meeting Attendees

Marty Allain Program Director, Indiana PDMP	Teresa Anderson Program Information Coordinator, Idaho PDMP
Chris Baumgartner Director, Prescription Monitoring Program Washington State Dept. of Health	Scott Best Clinical Nurse Advisor, Patient Review and Coordination Washington State Health Care Authority
Danica Binkley Policy Advisor for Substance Abuse & Mental Health, Bureau of Justice Assistance, Department of Justice	Madeleine Biondolillo Director, Health Care Quality and Safety Massachusetts Department of Public Health
Robert Bonner Chairman, VP Medical Practices and Medical Director, The Hartford	Michael Botticelli Deputy Director ONDCP
Amy Bricker Executive Director for Controlled Substance Policy and Provider Strategy, Express Scripts	Melinda Campopiano Medical Officer, Division of Pharmacologic Therapies, SAMHSA, Center for Substance Abuse Treatment
Thomas Clark Senior Research Associate, PDMP Center of Excellence, Brandeis University	Richard Creager Medical Director, CVS/Caremark
William Davies, Director DOD Pharmacy Utilization Management TRICARE, Department of Defense	Sarah Duffy Associate Director for Economics Research National Institute on Drug Abuse
John Eadie Director, PDMP Center of Excellence Brandeis University	Richard Fiore Executive Director Alabama Health Insurance Exchange
Gary Franklin Medical Director, Washington State Department of Labor and Industries	Cathy Gallagher Chief, Liaison and Policy Section Office of Diversion Control Drug Enforcement Administration
Jim Giglio Director, PDMP Training and Technical Assistance Center Brandeis University	William Greene Special Investigations Unit, CNA Financial
Rachelle Grey Mercury, Clark & Weinstock	Cindy Gunderson Chief Pharmacist, Indian Health Service
David Hamby Deputy Director, National Methamphetamine and Pharmaceuticals Initiative	Rene Hanna Senior Policy Advisor, ONDCP

PDMPs and Third Party Payers

Douglas Hillblom Vice President, Professional Practice and Pharmacy Policy, OptumRx	Dave Hopkins Project Manager, Kentucky PDMP, Kentucky Cabinet for Health & Family Services
Dennis Jay Executive Director, Coalition Against Insurance Fraud	Greg Johnson Assistant Vice President, Federal and Regulatory Affairs, Pharmaceutical Care Management Association
Chris Jones Health Scientist, Center for Disease Control and Prevention	Kenneth W. Jones Vice President, Travelers Insurance
Karen Kelly Executive Director, Operation UNITE	Meelee Kim Research Associate PDMP Center of Excellence, Brandeis University
Pat Knue Consultant, PDMP TTAC & COE, Brandeis University	Bonnie Konopka Program Analyst, Drug Enforcement Administration
Peter Kreiner Principal Investigator, PDMP Center of Excellence, Brandeis University	Alanna Lavelle Director, Special Investigations Unit, Wellpoint
Amy Lee Special Deputy Commissioner for Policy and Research, Texas Dept. of Insurance, Division of Workers' Compensation	Jinhee Lee Public Health Advisor, Certification and Waiver Team, Division of Pharmacologic Therapies, SAMHSA
Tony Loya Director, National Methamphetamine and Pharmaceuticals Initiative	Bob Lubran Director, Division of Pharmacologic Therapies HHS-SAMHSA
Cynthia Lucas Senior Director, Anti-Fraud Initiatives National Health Care Anti-Fraud Association	Kristen Mahoney Deputy Director for Policy Bureau of Justice Assistance, U.S. Department of Justice
William Mahon President, Mahon Consulting	Jaymie Mai Pharmacy Manager, Washington State Department of Labor and Industries
Marie Manteuffel Senior Assistant Pharmacist, Centers for Medicare and Medicaid Services	Jeffrey McLeod Senior Policy Analyst, National Governors Association
Ted Miller Principal Research Scientist, Pacific Institute for Research and Evaluation (PIRE)	Carol Newman General Counsel, State Compensation Insurance Fund
Mark Niedergang Project Manager, PDMP Center of Excellence, Brandeis University	John O'Brien Director of Field Operations, Center for Medicare and Medicaid Innovation Centers for Medicare and Medicaid Services
Joe Paduda Principal, Health Strategy Associates	Carol Pamer General Health Scientist, CDER Safe Use Initiative, Food and Drug Administration

PDMPs and Third Party Payers

Susan Payne Professor & Senior Research Associate University of Southern Maine	Jennifer Phillips Manager, Innovation Programs, Alliance of Community Health Plans
Sue Pechilio Polis External Relations and Outreach, Trust for America's Health	Phylicia Porter OASH Public Health Fellow, Office of the Assistant Secretary for Health, HHS
Rebecca Poston Program Manager, Florida PDMP	Carol Prost Research Associate, PDMP Training and Technical Assistance Center Brandeis University
Sharon Reif Senior Scientist, Institute for Behavioral Health, Brandeis University	Nick Reuter Senior Public Health Advisor, Division of Pharmacologic Therapy, Substance Abuse and Mental Health Services Administration
Ian Reynolds Senior Associate, Pew Prescription Project Pew Charitable Trusts	Anne Rogers Data & Research Manager, Maine PDMP
Becky Salay Trust for America's Health	Dr. Dale Slavin Associate Director for Programs, Acting Director for Safe Use Initiative, Center for Drug Evaluation and Research, Food and Drug Administration
Mike Small Director, California PDMP	Glen Smyth Pharmacy Director, Travelers Companies, Inc.
Cecilia Spitznas Senior Science Policy Advisor, White House Office of National Drug Control Policy	Jack Stein Director, Office of Science Policy and Communications, National Institute on Drug Abuse
Chris Stewart Manager, Pharmacy Professional Affairs, Humana	Samuel Stolpe Associate Director, Quality Initiatives, Pharmacy Quality Alliance, Inc.
Gregg Strott Network Services, Managed Care, Commercial Markets, Liberty Mutual Group	Alex Swedlow Executive Vice President for Research California Workers' Compensation Institute
Greg Terman Professor, Department of Anesthesiology University of Washington	Cindy Thomas Associate Research Professor, PDMP Center of Excellence, Brandeis University
Douglas Throckmorton Deputy Director for Regulatory Programs, CDER, FDA	Vennela Thumula Policy Analyst, Workers Compensation Research Institute
Virginia Torrise Deputy Chief Consultant, Pharmacy Benefits Management, Department of Veterans Affairs	Jeane Tuttle Pharmacist Program Manager, Department of Veterans Affairs
Don Vogt PDMP Administrator, Oklahoma PDMP	Dongchun Wang Economist, Workers Compensation Research Institute

PDMPs and Third Party Payers

Chris Watson Captain, U.S. Department of Health and Human Services, Indian Health Service	Sarah Wattenberg Senior Advisor on Substance Abuse Policy Office of the Assistant Secretary of Health, Department of Health and Human Services
Gary Wirth Pharmacist and Contracting Officer Representative, Medicare Drug Benefit Group, Medicare Part D, Centers for Medicare and Medicaid Services	Mike Wissel Pharmacy Specialist, Michigan PDMP
Bruce Wood Assoc General Counsel & Director of Workers Compensation, American Insurance Association	