Greater Tompkins County Municipal Health Insurance Consortium

125 East Court Street • Ithaca, New York 14850 • (607)274-5590
www.healthconsortium.net • consortium@tompkins-co.org

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

AGENDA
Joint Committee on Plan Structure and Design
February 1, 2018 - 1:30 P.M.

Rice Conference Room, Tompkins County Health Department

1. Welcome (1:30)
2. Changes to the Agenda (1:32)
3. Approval of October 5, 2017 and January 4, 2018 Minutes (1:35)
4. Election of Chair and Vice Chair (1:40)
5. Chair's Report (1:45)
6. Executive Director Report (1:50)
   a. Report from other Committees
   b. Update on Blue4You Program
   c. Update on CanaRx Program
   d. Wellness Consultant RFP
7. Can Our Benefit Plans Respond More Proactively to Opioid Crisis? (2:00)
8. Election of 3rd Labor Representative on Board of Directors & Alternate Director (2:30)
9. Next Meeting Agenda (2:35)
10. Adjournment (2:40)

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Next Meeting: February 1, 2018

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MINUTES – DRAFT
Greater Tompkins County Municipal Health Insurance Consortium
Joint Committee on Plan Structure and Design
January 4, 2018 – 1:30 p.m.
Rice Conference Room, Health Department

Present:
Municipal Representatives: 13 members
Judy Drake, Town of Ithaca and Board of Directors Chair (excused at 2:15 p.m.); Betty Conger, Village of Groton (excused at 2:50 p.m.) Bud Shattuck, Village of Union Springs; Eric Snow, Town of Virgil; Michael Murphy, Village of Dryden (arrived at 1:37 p.m.); Mark Witmer, Town of Caroline (arrived at 1:38 p.m.); Schelley Michell-Nunn, City of Ithaca (excused at 2:30 p.m.); Jennifer Case, Town of Dryden (arrived at 1:42 p.m.); Charmagne Rumgay, Town of Lansing; Jeff Walker, Village of Cayuga Heights; Ann Rider, Town of Enfield; Laura Shawley, Town of Danby; Tammy Morse, Village of Trumansburg

Municipal Representative via Proxy: 3
Carissa Parlato, Town of Ulysses (Proxy – Judy Drake); Tom Brown, Town of Truxton (Proxy – Eric Snow); Sandy Doty, Town of Willet (Proxy – Judy Drake)

Union Representatives: 4 members
Olivia Hersey, TC3 Professional Admin. Assoc. Unit; Tim Farrell, City of Ithaca DPW Unit; President; Jeanne Grace, City of Ithaca Executive Unit (Doug Perine, Tompkins County White Collar arrived at 1:44 p.m.)

Union Representatives via Proxy: 3
Jim Bower, Bolton Point Water Unit (Proxy – Olivia Hersey); Theresa Viza, Tompkins County Library Staff Unit (Proxy – Olivia Hersey) Tim Arnold, Town of Dryden DPW Teamsters (Proxy – Jen Case)

Others in attendance:
Don Barber, Executive Director; Ted Schiele, Owning Your Own Health Committee Chair; Ken Lansing, Tompkns County Sheriff, Bev Chin, Human Services Coalition; Emily Mallar, Marty Stallone, Rob Lawlis, CAP; Marty Lustic, Steven Conrad, Beth Miller, Excellus; Margo Polikoff, Tompkins County Health Department; Anna Kelles, Tompkins County Legislature; Andrew Washburn, Corey Prashaw, ProAct; Dr. Andrew Morpurgo, Cayuga Medical Center Director of Pain Management

Call to Order

Ms. Hersey, Chair, called the meeting to order at 1:32 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of Minutes of October 5, 2017

Approval of the minutes of October 5, 2017 were deferred due to lack of quorum.

Election of Chair and Vice Chair

Election the Chair and Vice Chair were deferred due to lack of quorum.

Opioid Presentation

Mr. Barber said the purpose of having a discussion on opioids is to provide an update on how the Consortium's Third Party Administrator's (TPA's) and providers are involved in the opioid crisis, which is an issue at the national, state, and local levels. He noted this presentation is being videotaped and will be posted on the Consortium's website. Mr. Barber said he attended a conference a few months ago at which slides were presented by Dr. Stephen Wolff who consented to the use of the slides at this meeting to introduce and share the history of the issue that developed over a number of years.

Mr. Barber presented slides showing the following information:

Timeline:

- A Synthetic extended release pain reliever manufactured by Purdue, Contin, was approved for distribution in 1987. Contin is orders of magnitude more powerful at pain relief and addictive than morphine;
- Oxycontin, also extended release and manufactured by Purdue, was approved in 1996 by FDA, which that same year warned Purdue of concerns with misinformation about the drug, Contin;
- 1996 - the American Pain Society issued guidelines on pain management;
- 1998 Federation of State Medical Boards also issued pain guidelines;
- At that same time Purdue issues promotional videos that compliments the guidelines and held >7000 seminars on extended release pain medications saying they are NOT addictive;
- 2001 - Veterans Administration states "Pain" as 5th vital sign;
- 2003 - the Federal Drug Administration warns Purdue of marketing of oxycontin being non-addictive;
- 2007 - Purdue pays $600 million settlement for false statements about the non-addictive qualities of these two drugs;
- Fentanyl was approved for distribution in 2012;
- 2016 – the Centers for Disease Control issued new pain guidelines;
- 2017 - pending lawsuits with allegations of fraud against Insys (manufacturer of fentanyl)

Problems with pain management system from 4 resources:

1. With Pain as a vital sign Medicare patient providers are reimbursed with incentives on quality care not just quality of service (i.e. patient satisfaction).
2. This puts pressure on providers to prescribe more opioids to achieve higher scores and more incentives.
3. Patient pain rating is "subjective".
4. Confirming logic of removing pain rating system from Hospital Value Based system eliminates pressure on clinicians to over-prescribe pain meds.

Progression of Opioid Epidemic

- Data through 2013 shows the amount of prescribed opioids continued to rise unabated until 2016 CDC ruling.

2016 CDC Guidelines

- New guidelines published in March 2016
- Guidelines state:
  - Non-drug treatments or treatment with non-opioid drugs are preferred
  - Use lowest effective dose
    - Reassess risk if considering greater than 50 morphine milligram equivalents MME) per day
    - Avoid doses above 90 MME per day
  - Limit to 3 to 7 day supplies of opioids for acute pain
- Establish Morphine Milligram Equivalent (MME) for standardizing pain relievers
  - Numerical approximation used to compare the relative strengths of different opioids
  -
  - 1 milligram of one opioid is not necessarily equivalent to 1 milligram of another opioid

Lastly, Mr. Barber presented the following slide showing suggestions from Dr. Wolff of things the Plan and medical providers can do to address the opioid crisis:

Plan solutions

- Plan design strategies can be used outside of, or along with, other strategies.

Strategy	Disruption
Set Refill-too-soon edits to 90%. For example, a member could only fill a 30-day supply 3 days early.	Low
Enhance benefits for alternative therapies such as physical therapy and acupuncture.	Low
Limit all controlled substances to a 30 day supply.	Medium
Require members taking high doses of opioids to see pain management specialists for all opioid prescriptions.	High
Limit chronic (or specific) high dose opioid utilizers to filling opioids at one pharmacy.	High
Limit chronic (or specific) high dose opioid utilizers to receiving opioid prescriptions from one physician.	High

- Many plans have their refill-too-soon edit set to 75% or 80% from initial implementation of PBM
  - This generally contradicts current guidelines and/or state laws
- Coordination between medical, pharmacy, and behavioral health providers
- Ensure access to addiction treatment
  - Remove PA on opioid addiction medications, e.g. Suboxone
  - Approval rates generally >90%
    - They likely don't save money
    - They do delay access to treatment

Dr. Marty Stallone, CAP Medical Director, said he appreciates the opportunity to participate in this discussion. CAP (Cayuga Area Preferred) is the local provider network and a partnership of Cayuga Medical Center and Cayuga Area Physicians Alliance, approximately 215 physicians. CAP coordinates care across different payers and in some ways set the rules for how physicians practice and the standards they are held to.

Dr. Stallone provided three case examples to demonstrate that counter to some belief, there are good people that have legitimate pain problems who are suffering and how opioid use can lead to other problems. He said there are not a lot of easy answers and many decisions need to be made on a case-by-case basis and there may need to be more active management with more active supports for patients.

Dr. Stallone said CAP receives a lot of great information from Excellus about the prescribing patterns of providers which includes the prescribing rates of all CAP's primary care physicians with respect to each of the controlled substance. It is very challenging to get involved from a case level and make conclusions from it. Physicians who end up prescribing more pain medication are treating patients with their own subjective biases on their level of pain and this poses challenges. It is a challenge for this network. They are working to organize information and come to terms with how to use the information fairly in the physician and provider community and steer physicians and providers towards a more productive endpoint. He said all CAP providers are engaged in education that is required by the State and expects CAP to have a network-wide pain management metric for physician performance by the end of 2018.

Dr. Morpurgo said he has been the Director of Ithaca Pain Management for 15 years. He stated that everyone is behind the curve in responding to the opioid crisis but it is important to remember that the majority of patients who are receiving opioids are taking them appropriately and need them. As we respond the opioid crisis it shouldn't be done in a vacuum and should not be done in a way that is punitive for the patients who need the medications as they represent the majority.

Dr. Morpurgo spoke of the scope of the problem and said more Americans die every day from opioid overdose than from car accidents. Opioids are derived from opium and there are many different kinds.

The Scope of the Problem:
- 90 Americans die each day after overdose on opioids.
- These include prescription pain medications, heroin or illicitly made medications, such as fentanyl.
- In most fatal overdoses, more than one substance involved (e.g., opioids + benzos + alcohol).

How We Got Here:
- Starting in 1990s, prescriptions for opioid pain medications rose dramatically.
- APS (American Pain Society): Pain is Fifth Vital Sign (1991).
- Pharmaceutical Companies Pushed Long Acting opioids as safe
- Expectation that pain be treated. He said doctors were assessed on how they assessed and treated pain.
- As opioid prescriptions skyrocketed, widespread misuse and diversion also rose dramatically.
- Opioid overdose rates soon began to rise dramatically.
- In 2015, 33,000 people died from opioid overdoses, including prescription meds, heroin, illicitly manufactured medications.

What Happens to Prescriptions:
- Based on CDC guidelines: 25% of patients prescribed opioids misuse them.
- 8% of patients given opioids develop an opioid use disorder.
- 80% of heroin users first misused prescription opioids.
- 54% of prescription drug abusers get the drugs from a friend or relative (trade, steal, buy).

Federal Response:
- New CDC Guidelines for Opioid Use in Chronic Pain.
- FDA (Federal Drug Administration): Ordered drug companies to ratchet down opioid production by 25%.
- Encouraging abuse deterrent formulations.

- DEA (Drug Enforcement Agency): Monitors prescriptions; looks for outliers.

Other:
- AMA: Call to eliminate the "Fifth Vital Sign" (June, 2016).
- JCAHO: New Pain Guidelines effective 2018.
- Insurance Companies: Limits on Pain prescriptions, pill limits, formularies to pay for abuse deterrent pills.

Guidelines:
- Focus on Assessment. Dr. Morpurgo said education is being done with providers on assessments.
- Pain Assessment:
  - 4 'A' s
    - Analgesia
    - ADLs
    - Adverse Effects
    - Aberrant Behavior
      (running out of meds early, euphoria, ongoing need for higher doses, diversion)
- Risk Assessment
  - ORT: a tool to assess risk of developing misuse
  - CAGE questionnaire
  - Brief Pain Interview
  - Screener and Opioid Assessment for Patients with Pain, revised (SOAPP-R)

NYS PMP (Prescription Monitoring Program) Prior to Opioid Prescription. Dr. Morpurgo said every prescription that is written for a controlled substance in the State of New York is required to be entered by the pharmacist into a database and a physician is supposed to check it before writing a prescription. The pharmacist is also supposed to check the database before filling a prescription.

- Urine Drug Testing is essential to ensure a patient is taking medication as prescribed Essential for monitoring for abuse and diversion
  - Should be performed at least annually
  - Prescribers should understand how to Interpret results

AAPM (American Academy of Pain Management) Guidelines
- Proper patient selection, Risk vs. Harm
- Informed Consent and Opioid Agreement (Written)
- Clear treatment Goals, including discontinuation if goals not met
- Organized monitoring of pain Intensity and patient function
- Looking for Aberrancy, including UDT
- Non-pharmacologic Treatments (Therapies, modalities, etc.)
- One clinician, one pharmacy
- MED (Morphine Equivalency Dose) less than 90 (and careful justification if greater)

State Response
- NYS requires all physicians who prescribe opioids to take 3 hours CME on safe opioid prescribing
- Pill limits on new prescriptions
- Electronic Prescribing
- Prescription Monitoring Program (I-STOP)
- Harm Reduction: Suboxone waivers, Needle exchange. Dr. Morpurgo explained that the theory of harm reduction is that abstinence does not work. In trying to limit the number of deaths or illnesses as a result of people going back to illicit opioid use, other

substancessuch as suboxone is used or a needle exchange program exists similar to what is being considered by the City of Ithaca where an individual has a safe place to inject and if there is an overdose medication is available to treat the overdose. He noted he doesn't agree or disagree with this.

Local Response/CAP

- Hospital has established a Pain Committee to bring this cooperative in line with new JCAHO (Joint Commission: Accreditation, Healthcare, Certification) guidelines of which he Chairs and to establish new criteria for how the Emergency Room will deal with people coming in for new pain medications.
- CAP: Continuing to educate providers on new realities and guidelines
- Look for Outliers and Educate them

Dr. Morpurgo responded to a question concerning Tramadol/Ultram and said this is a medication that works along different pathways and has very weak opioid activity. It is a schedule 4 drug and, although it has less addictive behavior and potential, it still has some addictive potential. It is a good drug that has been around for a long time and does have a useful role in pain management with less problems of abuse and overdose than other opioid drugs.

Corey Prashaw, Customer Service Manager from ProAct, the Consortium's Pharmacy Benefit Manager, introduced Austin Washburn, Clinical Pharmacist, to discuss what ProAct is doing for the Consortium in its Plan to combat the opioid epidemic while seeing that patients receive the medications they need to treat their conditions.

Mr. Washburn provided statistics from the CDC (Center for Disease Control) and said combined efforts are needed to combat this problem and try to mitigate the ongoing epidemic:

- Every 18 minutes there is a death from opioid overdose;
- 4.5 million Americans are estimated to have a substance abuse disorder with prescription pain killers;
- $78.5 billion - estimated costs of United States prescription opioid epidemic; and
- 1,375% increase in opioid treatment spending over five years, however, pain level reduction has not decreased at the same rate.

ProAct Opiod Risk Management:

- Prevention and education.
- Minimizing early exposure. An insurance company is able to monitor the claims process for the entire membership; therefore, it has the data to see if someone is visiting different doctors or pharmacies to identify abuse or red flags.
- Reducing inappropriate supply. In addition to the mandate by New York State for no more than a seven-day supply, ProAct has added on a limitation of an additional seven day-supply within a 60-day period in an effort to keep bulk supplies out of homes and to limit risk. In addition, there is dosing for individuals with chronic pain.
- Treating at-risk and high-risk populations. The higher risk population is the new member population and going forward he thinks catching these individuals who are early in treatment and preventing them from becoming addicted is where the pharmacy industry can have the most impact.
- Supporting chronic populations and recovery,

Current Programs:

- Access to Opioid Dependence Treatment – ProAct has removed requirements from products used to treat opioid dependence in an effort to remove barriers and help

streamline a doctor's ability to get patients on medications needed to help them with their addiction and manage their disease for the long-term.

- Minimizing Early Exposure and Reducing Inappropriate Supply – added quantity limits to all short acting opioids (7/1/17) to align with CDC recommendations.
- Drug Utilization Review – Cumulative Morphine milligram equivalent dose limit across all opioids and Cumulative acetaminophen dose check
- Minimizing Early Exposure, Prevention/Education and Reducing Inappropriate Supply – Adding prior authorization requirements to all long-acting opioids (1/1/18).

Offerings Available for 1/1/18:

- Refill Window Enhancement – For all controlled substances – 90% at retail and 80% at mail vs. 75% and 70% respectively
- Enhanced DEA Prescriber Edit – Rejects controlled substance Rx's for prescribers without appropriate DEA prescribing authority

Mr. Washburn concluded his presentation by stating ProAct is trying to catch members before they become addicted and is providing treatment and resources to members who are addicted and it will be a group effort requiring everyone to become involved.

Excellus

Steve Conrad, Clinical Pharmacist for Excellus Blue Cross Blue Shield, spoke of how the Excellus Pharmacy program works with its medical team on the opioid problem that pharmacists recognized as a problem many years ago.

NYS Legislation to Combat the Heroin and Opioid Crisis

- Insurance Company Requirements
  - Day Supply Limits
    - Opioids prescribed for the initial treatment of acute pain are limited to a 7-day supply
  - Provide coverage for emergency 5-day supply of opioid antagonist without prior authorization
    - Commercial insurance and managed care providers
  - Mandatory coverage of opioid antagonists prescribed to immediate family members under the same policy as the patient being treated
  - Managed Medicaid patients - Four opioid Rx fill limit per month

Excellus Utilization Management Highlights

- Prior Authorization for long acting opioids
- No prior authorization on Suboxone for all LOB (preferred brand tiering)
- Cover abuse deterrent opioids first line if patient history of certain methods of abuse
- Open access to naloxone/Narcan nasal spray
- Safety edits
  - Fentanyl patches for opioid tolerant patients only
  - Quantity limits
  - No concurrent use of opioids with MAT therapy
  - Recertification requirements

Opioid Addiction Treatment ECHO *For Providers and Primary Care Team Members at Western New York Collaborative*

- Panel includes representation from Excellus, SAMSHA, URMC, Huther Doyle

Goals

- Increase number of providers with Suboxone Waiver
- Instruct clinicians on the proper prescribing of opioids
  - **Didactics cover a wide range of pain / abuse related topics**
- Provide case based learning - real patient cases submitted by our participants
- Form community wide effort to combat the opioid epidemic

Provider Support

- Onboarding process for new buprenorphine prescribers
- Pay higher rate for 3 induction visits
- Multiple articles in our provider newsletter on opioids
- Quality peer-to-peer program
  - MD to MD discussion for providers prescribing high dose buprenorphine

Payment Policies and Services

- No barriers to outpatient Treatment
- Use Locadtr3 tool for all Lines of business
- No Prior authorization for first 14 days of inpatient treatment
- Cover urine screens to monitor treatment
- Developed opioid death bereavement group
- Health Plan Case Managers available for telephonic support of members with SUD

Accountable Cost and Quality Arrangement (ACQA)

- ACQA Objectives
  - Triple Aim – Improve quality of health care, decrease cost, enhance patient experience
  - Align incentives between insurer and provider
  - Support provider in population health management
- ACQA Elements
  - Defined patient population
  - Financial model

How can ACQA's Impact the Opioid Epidemic?

- Analyze claims data to identify providers with high prescribing rates
- Identify trends in opioid prescribing
- Are opioids being prescribed for the appropriate indications?
- Are the CDC guidelines for opioid prescribing being followed?
- Engage in outreach to educate on best prescribing practices

Dr. Lustic said Excellus has done a lot on its payment side to support what is happening on the pharmacy side. It has an integrated approach to the epidemic to working with providers from the way they are paid, creating services, bringing together experts to provide programs for families who have experienced a loss of a family member due to overdose, has ACO agreements that provide groups like CAP the information they need. He said the community is fortunate to have CAP which is set up to look at things like the opioid epidemic and create a systematic approach to it.

Dr. Lustic said he was speaking on behalf of Dr. Anne Green who is the Chief Medical Officer in Behavioral Health and an Addictionologist, approached him two years ago and stated this was an epidemic. He emphasized that this is an epidemic illness and that substance abuse is an illness like other illnesses such as diabetes. In Portugal 20 years ago they had the highest death rates from opioids. In 2001 they decriminalized all controlled substances and by 2015 their death rates of overdoses had dropped below 3 per 1,000, the lowest in Europe and compared to the U.S.

which was over 20 per 1,000. He said this needs to be acknowledged as a medical health issue and time and resources spent on treating people with this medical and health issue. It is critical that everyone, regardless of whether they are an employer, family member, politician, insurance company, or provider, come together to save lives.

New Business

There was no new business.

Next Meeting Agenda

The following items will be included on the February 1st agenda:

Approval of October 5, 2017 Minutes
Election of Chair and Vice Chair
Selection of 3rd Labor Director
Blue4You update
CanaRx update

Adjournment

The meeting adjourned at 3:03 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk

To: OYOH Committee
From: Don Barber- Executive Director

Re: Summary of some key points offered at Opioid Forum (January 4, 2018)

Historical Information

1. Pain Med's were developed and approved in the 1980's with minimal understanding of pain management and addictive qualities of these new drugs. Under influence of less than scrupulous Rx manufacturing companies, pain became the 5th vital sign with no objective means to measure it. Pain management even became an economic driver for reimbursement as providers were rated on how well they managed pain as graded by patients. Once pain management became a vital sign, prescriptions of these pain relievers soared.
2. Not understanding the impacts of the extended relief drugs, their addictive qualities, and a measurement system of their relative strengths led to a significant portion of US populations consuming opioids. 80% of today's heroin users started on prescription pain relievers. 25% of those consuming opioids become addicted; which conversely means that 75% do not.
3. Currently, prescribing providers and dispensers are working to provide pain management while limiting opportunity for addiction. Providers are also now working within a broader population that has been prescribed opioid pain killers. Therefore unused prescriptions are of high value to those predisposed to misuse opioids.
4. To address point #3: State Government has stepped in with data bank information that pharmacies and providers must access about prescription dispensing of control substances. In addition, Federal and national organizations have set standards for metering out of controlled substances into the general population and established more objective measures of effectiveness of opioid drugs on a milligram of morphine equivalent (MME) measuring stick.
5. Pain management has a number of aspects to it. Getting objective information about a patients pain level is problematic and is increasingly so when the patient has become addicted. Physicians are exploring other protocols for treatment of pain. This is all complicated by the fact that for a large percentage of patients extended pain relievers works successfully without addiction.
6. The Consortium's PBM, ProAct, is actively tracking dispensing of opioids; has different protocol for opioids to new patient's vs patients with previous exposure; and has limits on dispensing including Prior Authorizations to ensure the prescriber has all of the dispensing info.

Presenter suggestions:

1. For pain relief
    a. reduce co-pays for alternative pain treatments,
    b. expand to include acupuncture and similar treatments,
    c. support AQCA goals (between Excellus and provider community) to greatly reduce the propensity to prescribe opioids
2. Dr. Stallone- need more support for patients
3. Dr. Morpurgo- opioid addiction should not be treated in a way that is punitive, abstinence does not work, and those prescribing and dispensing pain relievers must recognize that the majority of patients benefit from these medications.
4. Washburn: The higher risk population is the new member population being exposed to these addictive pain relievers for the first time. Going forward he thinks catching these individuals who are early in treatment and preventing them from becoming addicted is where the pharmacy industry can have the most impact.
5. Conrad from Excellus said: Plans should not provide barriers to outpatient overdose treatment

The opioid problem then has several separate areas that can be addressed.

1. Treat addiction as a medical issue
2. Reduce opportunity for pharmaceutical pain relievers to be used and abused by patients- Alternatives to addictive pain relievers-
3. Reduce amount of prescribed Rx pain relievers
4. Discover and treat mental health causes that lead a small subset of patients when prescribed addictive pain relievers become chemically dependent.
5. Supporting chronic populations and recovery

Role of benefit plan: for addiction cases-

1. create easy access to addiction dependence treatments
2. when addiction is identified as a condition, behavioral health professionals are included in treatment
3. Reduce or elimination co-pays on overdose antidotes
4. Education of subscribers and employers to signs of addiction and actions when overdose is found
5. Mental Health benefits to address potential causes for which relief sought in the opioid experience

Role of Benefit Plans: for new population

1. with PBM- limit exposure through reduced amount prescribed
2. cover alternatives to pain relievers at attractive co-pays
3. Mental Health benefits to address potential causes of that lead to susceptibility for addiction

Plan topics for discussion from Dr. Wolff:

Plan solutions

- Plan design strategies can be used outside of, or along with, other strategies.

Strategy	Disruption
Set Refill-too-soon edits to 90%. For example, a member could only fill a 30-day supply 3 days early.	Low
Enhance benefits for alternative therapies such as physical therapy and acupuncture.	Low
Limit all controlled substances to a 30 day supply.	Medium
Require members taking high doses of opioids to see pain management specialists for all opioid prescriptions.	High
Limit chronic (or specific) high dose opioid utilizers to filling opioids at one pharmacy.	High
Limit chronic (or specific) high dose opioid utilizers to receiving opioid prescriptions from one physician.	High

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  - This generally contradicts current guidelines and/or state laws
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  - Remove PA on opioid addiction medications, e.g. Suboxone
  - Approval rates generally >90%
    - They likely don't save money
    - They do delay access to treatment