AMERICAN COLLEGE OF RHEUMATOLOGY

POSITION STATEMENT

SUBJECT:	Beers Criteria
PRESENTED BY:	Committee on Rheumatologic Care
FOR DISTRIBUTION TO:	Members of the ACR Medicare officials Pharmacy Benefit Management Companies/Managed Care Entities Members of Congress

POSITIONS

1. ACR supports the American Geriatrics Society position discouraging the use of Beers criteria for pharmaceutical formulary decisions which do not account for individual diagnoses, signs, symptoms or disease severity
2. ACR strongly discourages use of Beers criteria for punitive measures or quality ratings for individual providers
3. ACR supports creation and updates for practice guidelines which inform treatment decisions in patients with musculoskeletal disease including people age 65 and over
4. ACR supports further research on safety and efficacy of therapeutics in the elderly
5. ACR supports enhanced technology and program support allowing pharmacists and providers to communicate efficiently to improve prescription safety

BACKGROUND

Origin and Evolution of "The Beers Criteria"
The original "Beers criteria" published in 1991 reported a list of 30 criteria for inappropriate use of medications for nursing home residents. (1) It was created using a Delphi method survey of 13 North American experts in geriatrics, pharmacology, epidemiology and long term care. The authors noted that the criteria could be used generally to improve quality of care and medical education. For example, the instrument could be used for "judging one aspect of the clinical performance of providers and the quality of medication use in an institution. As such, the application of these criteria in clinical settings may also serve as a means of improving quality of care." (1)

The Beers criteria were updated and modified in 1997, 2003, 2012, and 2015. These updates broadened the criteria to include therapy for all adults 65 and older, and divided potentially inappropriate medications between elderly patients in general, and those with specific disease-drug interactions. Notable changes in the 2015 update include a list of drugs for which dose adjustment is required based on kidney function and drug-drug interactions. As in 2012, the goal for the American Geriatrics Society (AGS) Beers Criteria in the 2015 update is for "improving the care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs)" (2) In a guide published by the AGS in 2015 on the proper use of the 2015 Beers criteria, the authors state that the "criteria are designed to support, rather than supplant, good clinical judgment. (3)

For example, the 2015 update recommends avoiding chronic use of non-cyclooxygenase-selective NSAIDs unless other alternatives are not effective, and a patient can take a gastroprotective agent. The qualification "unless other alternatives are not effective" supports the need for good clinical judgement in the essential treatment of arthritis pain.

The Beers Criteria and Medicare Policy

When Medicare coverage expanded in 2006 to include prescription drug benefits ("Part D"), the Beers criteria were utilized by researchers and government entities to monitor safety and improve quality. In one study of Medicare beneficiaries without prescription insurance who obtained coverage under Part D, there were "small increases in the use of high risk medications but no change in drug- disease interactions." (4) The legal statute which enacted Part D coverage also included a framework for payers to monitor and improve quality through medication therapy management programs. Eventually, with modifications from the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) implemented a 5 Star Rating program for Medicare Advantage prescription drug plans. The rating system formula gave a high proportional weight to use of high-risk medications. The system penalized plans with low ratings through negative publicity and rewards highly-rated plans with monetary bonuses and the ability to market to beneficiaries outside of the usual enrollment period. Partly as a result from review of the 2015 Beers Criteria and the fact that clinicians' freedom to individualize patient treatment plans was hindered by the 5 Star Rating System, CMS removed the high-risk medications from the 5 Star Rating system. (5)

Prescription Drug Plan Policies

During the time CMS developed its 5 Star Rating system policies, and possibly as a consequence of them, prescription drug plans have taken steps which ultimately limit access to Beers criteria medications and have adverse consequences on practicing providers. ACR has been informed that drug plans are currently:

1. Contacting providers (usually by facsimile) about individual prescriptions on the Beers list of medications for beneficiaries over age 65
2. Restricting formulary coverage of Beers criteria medications for all beneficiaries over 65 and often for those who are not 65 but who receive part D Medicare benefits (ie., SSI disability)
3. Imposing prior authorization constraints for these medications
4. Assigning low quality ratings to providers who prescribe Beers criteria medications

By taking these steps, drug plans are penalizing clinicians for developing individualized treatment plans. The AGS believes that a one size fits all approach is incorrect. For example, drugs on the PIM list are not intended to be completely avoided, but instead, use of such medications should trigger a "warning light" to fully consider the medication in the individual clinical situation. As noted in the companion article to the 2015 Beers Criteria update, "A key theme underlying these recommendations is to use common sense and clinical judgement in applying the 2015 AGS Beers Criteria, and to remain mindful of nuances in the criteria." It further notes that "... onerous restrictions on the many medications in the criteria that have appropriate use can hinder good clinical care and create the perception that the Beers Criteria are a punitive tool, undercutting their educational function."

Summary

In summary, the ACR supports the AGS goals for the 2015 Beers criteria update. Specifically, the ACR opposes use of Beers criteria for pharmaceutical formulary decisions which do not account for individual diagnoses, signs, symptoms or disease severity; discourages use of Beers criteria for punitive measures or quality ratings for individual providers; and supports further research on safety and efficacy of therapeutics in the elderly.

REFERENCES

1. Beers MH, Ouslander JG, et al. Explicit criteria for determining inappropriate medication use in nursing home residents. Arch Intern Med 1991;151:1825–1832.

2. The American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Journal of the American Geriatrics Society. 63(11):2227-46, 2015 Nov.
3. Steinman M, Beizer J et al. How to Use the AGS 2015 Beers Criteria – A Guide for Patients, Clinicians, Health Systems, and Payors. Journal of the American Geriatrics Society. 63(12)e1-e7, 2015 Dec.
4. Donohue J, Marcum Z, et al. Medicare Part D and potentially inappropriate medication use in the elderly. American Journal of Managed Care. 18(9):e315-22, 2012 Sep
5. Announcement of Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter and Request for Information. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf Accessed May 6, 2018.

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