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 and 2012. 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. (2) The American Geriatrics Society (AGS) goals for the 2012 update were “to improve care of older adults by reducing their exposure to Potentially Inappropriate Medications (PIMs)” (2). An accompanying statement published with the update stated that the Beers criteria should not be used as the sole basis of formulary decisions nor for punitive measures against providers. (3)

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 gives a high proportional weight to use of high-risk medications. The system penalizes 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. In 2013, CMS indicated that the rating system will be updated to include the AGS 2012 Beers Criteria update and that the pertinent quality measure will be based on 2 or more fills of the same high risk medication. (5)

**Prescription Drug Plan Policies**

During the same time frame as the above CMS 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 (i.e., 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 “supersede clinical judgment or an individual patient’s values and needs,” in contradiction to the stated goals of the AGS 2012 Beers Criteria update (2). They prevent individualized treatment and shared decision-making that the AGS values. Specifically, this prevents senior citizens from having access to arthritis treatments that are clinically indicated for relieving pain on an individual basis. It also punishes providers trying to provide appropriate care. In 2013, the American Medical Association and other provider groups wrote to CMS discouraging the proposed Medicare Star Rating policy which promotes these actions. (6)

**REFERENCES**