MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, March 4, 2015
1:00 p.m. to 4:00 p.m.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members
Present:
Ward Brown, MD
Robert Breslow, RPH
Paul Cesarz, RPh
Daniel Erickson, MD
Hannah Delong, MSN, PMHNP-BC
Michael Ochowski, RPh
Jake Olson, PharmD
Lora Wiggins, MD
Absent:
Michael Brown, PharmD
Robert Factor, MD

HP Staff
Present:
Chally Clegg
Jenny Nelson, CPhT
Tom Olson, PharmD
Dawn Wild
Monica Yeazel, RPh

DHS Staff
Present:
Pamela Appleby, RN
Kelsey Gmeinder
Rachel Currans-Henry
Kevin Moore
Lynn Radmer, RPh
Lisa Reese
Tiffany Reilly
Kimberly Smithers
Dave Varana

Welcome and Introductions:
Rachel Currans-Henry called the meeting to order at 1:05 p.m., with thanks to the Board. Kevin Moore, the new Medicaid Director, gave a brief statement about his history with the Department and ended with thanks to the Pharmacy team. Hannah Delong is a new Board member and a psychiatric nurse practitioner with University Health Services. Each person present introduced themselves by name and position. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of December 3, 2014 Meeting Minutes:
Rachel Currans-Henry walked through the agenda as printed. Monica Yeazel reviewed the intention and contents of the new DUR Board binders. Prior to this meeting, Board members received the minutes, Lock-In Report, and RDUR Quarterly Report via e-mail and had the opportunity to review each document. Rachel briefly reviewed highlights of the minutes from the last meeting.
Paul Cesarz **motioned** to approve the minutes as printed. Michael Ochowski seconded the motion. The motion passed unanimously.

Prospective DUR Activity Update and Reports:
Lynn Radmer reviewed Prospective DUR alert activity by sharing the "Annual De-duplicated Claims" and "Percentage of Claims per Total De-duplicated Claims for 2012 through 2014" graphs. She also shared the "Quarterly De-duplicated Claims" and "Percentage of Claims per Total De-duplicated Claims" graphs for the previous five quarters. Finally, she examined the "Total Paid Claims with DUR Alerts by Categories" pie chart for fourth quarter 2014, as well as the "Percent of Alert Type Claims per Total Nursing Home Claims" chart. She included a glossary to define the terminology used. This review provided a high-level snapshot of claim and Prospective DUR activity. A few key observations:

- In both the annual and quarterly de-duplicated claims graphs, the largest absolute number and percentage was for claims paid with no DUR alerts.
- There was no dramatic change in the numbers or percentages of any claim type over the time periods analyzed. The data, at this point, is fairly consistent over time.
- The largest volume of alerts is still from the insufficient quantity (NS) alert, which will be changing to function independently of the other prospective DUR alerts. A response to that alert will not eliminate the need for the pharmacy to respond to the clinical alerts.

- Claims paid with a DUR alert were mostly overrides (59%), then informational (33%), and finally nursing home (3%). All nursing home claim alerts are also informational, meaning they require no response from the pharmacy.
- The Board discussed whether the nursing home claims should require a response. Concerns centered on the clinical alerts (for example, drug-drug interaction) rather than the early or late refill or NS alerts.
- The Department feels it may be prudent to require the dispensing pharmacy to respond to alerts on claims for nursing home residents.
- The Board determined that more data is needed regarding the nursing home claims before any decision can be made on changing the alert from informational status. Dave Varana reported that approximately 60–65% of skilled nursing facility beds are occupied by Medicaid patients.
- In summary, the Board would like input from a long-term care pharmacist regarding how their claims process works and how any potential change to alert status for nursing home claims would affect them. They would also like to see the NS alert function independently from the other active prospective DUR alerts and perhaps turned off entirely for the nursing home claims. They would like to consider requiring a response for clinical alerts on nursing home claims.

Hemophilia Update:

Pam Appleby provided background information on the hemophilia program. In 2014, the Department reviewed specialty drugs, as they are a significant driver of cost.

- Medicaid pays for clotting factor concentrates in two-thirds of patients; the Chronic Disease Program, which is funded solely by State dollars, pays for the remaining third.
- These drugs represent a $20 million annual spend, and treat 100 patients through 80 prescribers and 15 pharmacies.
- The Department determined the policies of the program by convening a stakeholder group. They drafted the program requirements based on metrics used by other state Medicaid programs and recommendations of the Hemophilia Foundation.
- The program published the requirements in *ForwardHealth Update 2014-68*. The requirements became effective January 1, 2015, with auditing to begin no earlier than this summer. Compliance is handled by audit.
- The majority of hemophiliacs in the program are being seen at a hemophilia treatment center. It is not a restricted network system, but the requirements tend to funnel patients toward these centers.
- The Board appreciated the information presented and would value more information about specialty drugs in the future.

Update on Stimulants Targeted Intervention Results:

Lynn Radmer updated the Board on the current status of the targeted intervention regarding maximum stimulant daily dosage limits in children 14 years old and younger.

- The project started in 2013 and analyzed data from May 1 through October 31, 2013.
- Initial letters went to 155 prescribers, and follow-up letters went to 77 prescribers who did not respond to the initial mailing. The Department's child psychiatrist consultants reached many prescribers by telephone.
- Total responses received numbered 140, which is approximately 90%. This response rate is much higher than regular response rates to monthly RDUR letters, because this intervention made the response mandatory.
- The Board was very impressed with the impact and amount of change that resulted from this intervention.
- All prescribers were mailed a post-intervention follow-up letter in February 2015. The Board reviewed a copy of that letter. The Board expressed that a follow-up letter was very helpful in "closing the loop" and should be considered standard practice for future targeted interventions. The post-intervention follow-up letter provides a way for the prescriber to see how they compare to their peers.
- A lively discussion of stimulant use and latest trends in research into best practices ensued. As stimulants represent the number one class in drug spend, the Department will likely do more with this in the future as resources allow. For now, the Department has planned a provider newsletter including information and resources about best practices, dose escalation, and dose maximization. The Board recommends including graphs and charts of data for the newsletter.

- Future possibilities include evaluating the feasibility of requiring blood levels as a part of prior authorization policy, putting a policy in place for rate of titration, and repeating the same type of intervention in the adult ADHD population. The adult ADHD population is significantly larger, which may make intervention more difficult. Board members suggested different ways of reporting the data going forward.

Review of Hydrocodone Claims after CII Status Change:
Lynn Radmer reminded the Board that hydrocodone products switched from schedule III to schedule II effective October 6, 2014. The Department wanted to know if this change resulted in any change in claim volume or quantities dispensed.

- The Department compared overall claim counts and claim counts per 1000 members for each of the hydrocodone oral tablet products for quarter 3 and quarter 4 of 2014.
- In general, no significant change occurred in either the number of claims or the number of tablets per claim. The most popular tablet strengths decreased slightly.
- An examination of other opioid analgesics did not reveal an increase in those claims, with the exception of a small uptick in acetaminophen/codeine #3. At this point, there does not appear to be a major shift to other agents as a result of the rescheduling of hydrocodone.
- The Department will continue to monitor this data.

Pharmacy Services Lock-In Annual Activity Report:
Monica Yeazel presented highlights of the report that the Board received for review.

- As in previous years, monthly profile reviews exceeded 400 each month. The majority of prescriber letters were alert letters, which are educational and take no adverse action against the member.
- Lock-In referrals from HMOs numbered five this year and all were from the same HMO.
- While the data was not included in the report, Monica noted that in a large number of reviews the member was using the same prescriber, which would be the requirement if the member were locked in.
- In reviewing the responses received from prescribers who were sent intervention letters, it appears that many of those members do not have stable ongoing provider relationships. This finding is similar to past years.
- The Board read some of the narrative comments prescribers made on the response forms.
- Board members made suggestions on potential improvements to the Program, such as pairing drug claims with claims for urine drug screens, combining the Lock-In Program data with PDMP data, and making a link on the PDMP site that would lead straight to Lock-In referral.
- The Department plans to make changes and enhancements to the Lock-In Program as changes in laws and administrative codes evolve, and as stakeholder involvement and resources allow.

NAMD Rx Abuse Recommendations:
Kimberly Smithers reminded the Board that in December we reviewed a report prepared by Mercer Government Human Services Consulting for the National Association of Medicaid Directors (NAMD) related to interventions for preventing prescription drug abuse and overdose. That report summarized current practices and emerging opportunities. The approaches fell into six areas:

- Improving Medicaid data and analytic infrastructure, with specific suggestions such as investing in technology enhancements for MMIS and claims processing systems that show “hot-spots” and expanding integrated substance use disorder (SUD) treatment options.
- Adopting preventative measures such as considering daily dosing maximums or other limits and increasing the use of non-pharmacological pain management interventions, including pain centers that limit prescription use.
- Providing active monitoring and surveillance at both the member and provider level, with specific suggestions including data mining, maximizing usability and adoption of the PDMP, and enhancing lock-in programs.
- Ensuring effective treatment of addiction, including supporting access to naloxone to reduce overdose deaths, and improving use of evidence-based treatment for chronic pain.
- Strengthening cross-agency collaboration, specifically advocating for enhanced PDMP functionality and requiring mandatory e-prescribing of controlled substances.

Tiffany Reilly reported on the results of a review of the work we have been doing within the Medicaid program and the work that the DUR Board has contributed on this important issue.

- Medicaid is actively engaged in proactive prevention measures through policies and provider education via prospective and retrospective DUR activities, newsletters, and specialized interventions.
- Script limits and quantity limits reduce the amount of opioids a member can receive each month.
- New RDUR criteria addressed concerns found as a result of direct member profile reviews, for example, concurrent use of temazepam and zolpidem.
- Communication directly with providers with an educational DUR newsletter on appropriate opioid utilization, a targeted intervention on stimulants, and focused RDUR reviews for appropriate utilization of triazolam.
- Active monitoring and surveillance is supported with 1000 individual member profile retrospective reviews each month for appropriate utilization of all drugs, including drugs of abuse.
- An additional 400 member profiles are retrospectively reviewed each month specifically to identify misuse of restricted medications and potential for lock in.
- Ideas for the future include integrating the PDMP with the Lock-In Program and developing more educational prescriber letters for use of stimulants in children and for best practices in treating chronic non-cancer pain.

NGA Policy Academy Reducing Rx Drug Abuse:
Lora Wiggins gave a brief update on the National Governors Association's (NGA) efforts to produce recommendations to the governor on prescription drug abuse reduction. Dr. Wiggins is part of the Prescribers Optimization workgroup. Their efforts are focused on:

- Requiring PDMP registration for all prescribers, while not opting to compel mandatory use of the PDMP at this time.
- Requiring continuing medical education (CME) for all prescribers on pain management and opioid prescribing. The CME programs would be created and maintained by the Medical Examining Board (MEB). Legislative authority for this already exists. The group would need to check with other boards (nursing, dental) for other prescriber types.
- Developing, with the support of a broad stakeholder consensus, best-practice prescribing guidelines (not mandates). These guidelines would be very helpful to Medicaid auditors in cases of outlier prescribers. Developing these guidelines would require a statutory change.
- Ongoing work with EPIC to integrate access to the PDMP into their software to facilitate prescriber utilization of existing data.
- Improving PDMP reporting functions to be used for data mining to find outlier prescribers and patients, with the option of applying filters to a search.
- Expanding access to treatment centers for addiction with special focus on underserved areas of Wisconsin.

Mike Ochowski added the following:

- Physician assistants and nurse practitioners are asking for the ability to prescribe Suboxone. This change could require a change to federal law, or it may be accomplished through collaborative practice agreements.
- Addiction treatment proponents favor Suboxone and Vivitrol over methadone.
- With the passage of Act 290 in 2014, pharmacies will be required to identify who picked up a prescription, including checking photo ID. This change will have a huge impact on pharmacies and may need to be delayed past 2016 due to feasibility reasons.

Lynn Radmer added one forgotten item: The diagnosis requirement for prenatal vitamins will be dropped due to requirements of the Affordable Care Act (ACA). Prenatal vitamins must be available to all women of childbearing age, not restricted to pregnant or lactating women.

Adjournment: Paul Cesarz **motioned** to adjourn. Dan Erickson seconded the motion. The meeting adjourned at 4:09 p.m. Upcoming meetings are on the following Wednesdays: June 3, September 2, and December 2, 2015.

Guests: Patrick Moty (Supernus), Lisa Dunn (Amgen), David Heisch (Abbott), Kevin Gallagher (Astra Zeneca), Dee George and Patty Peterson (Novartis), Bob Heinsch (Purdue), Amy Brauns (Otsuka), Dean Groth (Pfizer), Carly Jones and Ardalan Abtehi (SOP/Skywalk Pharmacy).