DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, March 5, 2008
1:00 P.M. to 4:00 P.M.
1 W. Wilson Street, Room 630
Madison, WI 53701

DUR Board Members Present:	Robert Breslow, RPh Ward Brown, MD Daniel Erickson, MD Robert Factor, MD Franklin La Dien, RPh Nancy Ranum, MS, RN, CS-ANP, APNP
DHCAA:	Carrie Gray Rita Hallett, RN Lynn Radmer, RPh Kimberly Smithers James Vavra
APS Healthcare, Inc.:	Debbie Matitz (squire) Michael Mergener, RPh, PhD
Guests:	John Bullard – Amgen Kay Cram – University of Wisconsin Dean Groth – Pfizer Susan Schmitz – GSK Michelle Wollersheim --MedImmune Ryan Barfknecht-pharmacy student

Minutes

James Vavra called the meeting to order at 1:10 p.m.

I. Approval of the Agenda

Robert Breslow requested an additional item be added to the agenda – the roles of DHCAA and the DUR Board in the Wisconsin Pharmacy Quality Collaborative. This item will be added to the agenda.

II. Approval of Minutes – November 28, 2007 Meeting

Dr. Factor submitted changes to the minutes. The Board approved the motion to incorporate his changes and send the revised version to Dr. Factor for approval.

III. Atypical Antipsychotic Intervention (Attachment 1)

Dr. Mergener presented on the Atypical Antipsychotic Intervention. The Board requested that Dr. Mergener do a similar intervention with the next 100 prescribers. The only substantive changes were the addition of Invega and changing the dates for claims review. After a review, Dr Mergener decided to drop prescribers with 5 or less patients

meeting the guidelines, resulting in 86 prescribers affecting 780 patients. Letters were mailed out on 2/21/08.

> **Action Item:** At the June 4, 2008 Board meeting, Dr. Mergener will present a preliminary evaluation as to whether this intervention produced the same results as the original intervention.

IV. Review of 2/27/08 WI Medicaid PA Advisory Committee Meeting

Dr. Mergener reviewed the recommendations from the 2/27/08 WI Medicaid PA Advisory Committee Meeting. The purpose of the PA Committee is to look at the PDL for the Medicaid Program. The committee consists of physicians, pharmacists, specialists, and consumer advocates appointed by the Secretary, as defined in statute. The State pursued a PDL with the intent of leveraging additional supplemental rebates. The State partners with Provider Synergies and is a member of a purchasing pool with six states, called TOPS. The meeting lasts all day, occurring twice per year. Currently, 60 drug categories have been reviewed; each half is reviewed every six months.

There is a separate committee appointed by the Secretary to review the decisions for mental health drugs. Packets containing clinical materials and a summary sheet with cost implications are sent to participants prior to the meeting. Cost data is included in the final decision making process inclusive of rebates, but it is "blinded" to the committee. The meeting discussion centers on the efficacy and safety of the drugs; then cost is a consideration. The meeting begins with an open session for public testimony, followed by a closed session to discuss both clinical parameters and cost data. The final deliberation is in a public forum where decisions are made. The Committee is allowed to address the speakers after public testimony for each class is completed.

State staff is also available for appointments from manufacturers to discuss the clinical information about a product. The PA Committee's recommendations are sent to the Secretary, including any negative votes and the reasons for those, and the Secretary makes the final decision on recommendations.

Dr. Mergener then provided a summary of the drug categories that were reviewed at the 2/27/08 meeting. The next PDL Committee Meeting is scheduled for August 6, 2008.

V. Break

VI. Progress of Pharmacy Consolidation Project

James Vavra presented on the progress of the Pharmacy Consolidation Project which Jason Helgerson initially talked about at the 11/28/07 meeting. Since its implementation on February 1, 2008, the project has been extremely successful and approximately 200,000 claims have been processed on behalf of 350,000 members whose drugs were formerly paid through HMOs. To date, no complaints have surfaced regarding difficulties in getting drugs, but there has been some difficulty with co-pays not being paid. There were also some issues with billing for drug-related supplies which have been resolved. Grandfathering and PA exceptions have gone without incident. For February and March, non-preferred drugs and Brand Medically Necessary drugs are allowed but in these instances, the pharmacist is getting an Explanation of Benefits (EOB) code alerting them that as of April 2nd, PA will be required. The State is currently reviewing the

number of EOBs and their associated drugs so if necessary, targeted interventions with prescribers can be done. Dr. Mergener commented one of the problem categories is the preferred inhaler ProAir for Managed Care because ProAir is not preferred in Medicaid FFS. Between now and April 1st, a provider update will be sent to providers and pharmacists reminding them of this policy as well as the "turn off" date of April 2nd.

VII. Annual Lock-in Report (Attachment 2)

Dr. Mergener presented on the annual lock-in report. Referring to the document "Recipient Lock-in Program Update":

- Summary of referrals – number of reviews have remained relatively constant from 2006 to 2007. We are expecting a small bump up when we add 350,000 lives. The DSS tool provided about 23% of referrals despite having fewer recipients. There were a significant number of HMO referrals this year compared to previous years. Moving forward, we will be making lock-in decisions for the HMOs on the drug benefit.
- Hearings and appeals are relatively low at 9.1%. When a lock-in decision is made, the patient is informed and they have the right to appeal. We typically win the majority of those. The Division of Hearings and Appeals provides adjudication of these cases. Hearing officers travel to the appeals, the patient attends in person, and APS, representing the State, appears by phone. We present our reasons for lock-in, the patient has a chance to rebut, and we then have a chance to respond to the rebuttals.
- Pharmacy recommendations by year have been fairly consistent. 21% resulted in lock-in recommendations; 14% resulted in no further action recommendations. The no further action cases are typically from verbal complaints where there is not enough evidence to support any action.
- Review Source and Pharmacist Recommendations Crosstab – 35% of referrals resulted in actionable recommendations; the percent of warning letters increased a bit.

The "Lock-in Program Work Flow" document was prepared as a result of ensuring continuity of care and talking with the HMOs about how to handle the process. As of February 1, 2008, 34 new members have been enrolled into FFS that were enrolled by the HMOs. Previously, the HMOs handled their lock-in, but since we took over the drug benefit, we will now administer the lock-in. The HMOs provided us with the patient names and informed us which pharmacy to lock the patient into. We do notify the HMOs of any changes that occur. This has gone fairly well but when we decide to lock someone in, even though we can continue to lock them into a pharmacy, the provider is the MCO so the MCO needs to be the liaison to their prescriber group. One issue for the HMOs is for any narcotic prescription coming from one prescriber, we have vested the pharmacist with the responsibility of deeming it appropriate and filling it. Another issue is the HMOs' concern about not having access to medications being prescribed. This has since been resolved and we now provide them with daily extracts of drug claims.

The second page outlines the role of Bureau of Benefits Management, what we currently do, and what we've asked the HMOs to do. We've asked them to be diligent in their referrals and to send those to us so we review the patients. If we get a referral, we submit it to the decision support system so even if they don't filter up, we are still going to force a review. To assist the HMOs, we have included a text field in the lock-in electronic record to indicate the primary prescriber. We also help prepare letters to send to

members, but it is the HMO's responsibility to designate who the lock-in prescriber is and provide any changes made by members.

VIII. Results of Anticholinergic Intervention (Attachment 3)

Dr. Mergener presented the Anticholinergic Intervention. The first pages of Attachment 3 consist of the preliminary work. The evaluation of the intervention is on page three. The anticholinergic burden intervention pre and post was calculated for those in the intervention group. A cohort group consisted of patients meeting the same criteria but who were not included in the list of prescribers that served as a control group. We also looked at whether or not the burden increased, decreased or stayed the same post-intervention. The changes in both the intervention and the control groups were similar. Although the intervention group did have a higher average burden, the change in burden pre to post was the same for both groups. Most of the burden was created by a single provider. We did decrease the anticholinergic burden but the burden also decreased in the cohort group. In conclusion, it appears this intervention did not have much of an effect.

IX. Retrospective DUR Criteria Activated from CNS Criteria (Attachment 4)

At the November 2007 Board meeting, approval was given for moving new DUR criteria into production. Dr. Mergener presented a report of the categories that were activated and the average number of reviews done for January and February. For persons taking benzodiazepines that also had a history of drug abuse, an average of 35 reviews per month were done. A number of people with a diagnosis of opioid dependence with benzodiazepines are also on the profile. Because benzodiazepines are used to take the edge off of people being treated for narcotic abuse, it is less likely that an intervention letter is sent for those cases. The alert for tricyclic antidepressants in combination with amphetamines is also a serious interaction. The other criteria are for a single benzodiazepine – when patients are exceeding recommended daily doses. Letters are sent out when 1) there has been an excessive daily dose or 2) long-term use by a patient.

> **Action Item:** Dr. Mergener will continue to examine the benzodiazepine history of drug abuse. We may want to tweak the criteria to include more drugs in that particular arena or some other categories.

X. Additional item – Wisconsin Pharmacy Quality Collaborative

Robert Breslow raised the topic of the Wisconsin Pharmacy Quality Collaborative. This is a cooperative effort between pharmacies, the State of Wisconsin, the Pharmacy Society of Wisconsin, and a number of other payers who are willing to pay for medication therapy management (MTM) services. The goal is to get better patient care in specific areas, most importantly with those patients having complicated drug regimens and requiring additional assistance outside of the scope of specific diseases. Furthermore, it's stepping outside of the scope of what has traditionally been the cognitive reimbursement arena for the Medicaid Program. Given the State's database of claims, a partnership between the Medicaid program and WPQC would be very useful in not only supporting this initiative. Secretary Hayden has already expressed that DHCAA is committed to supporting this initiative, but it is unclear as to what extent the support is and perhaps the DUR Board could have an advisory role for this initiative. Mr. Breslow stated a challenge on the outpatient side is the lack of information used to monitor patients.

Because measures to do this are not easily retrievable on the community side, some collaboration may have to occur between physicians and pharmacies. Mr. La Dien added he has attended training sessions and they have trained their pharmacists for this with seven stores already in the pilot.

Dr. Mergener, at the ADURS meeting, heard that Montana has been involved with its own medication management program which has been quite successful. They attribute their success to getting the prescriber to listen, and they actually reimburse the physician at a rate slightly greater than an office visit.

Dr. Erickson added Marshfield Clinic is involved in a physician group practice demonstration project whereby the clinic has a panel of patients and a comparison group. If the clinic can show they saved money on their patients relative to the comparison group, the clinic gets to keep some of that savings.

Mr. Vavra expressed that Secretary Hayden does have an overall commitment to quality of care and outcomes. An agreement has been signed, currently being reviewed by legal counsel, which will raise the specter of procurement issues. Secretary Hayden further expressed because the State is in the process of converting to a new MMIS, their fiscal agent's involvement is limited but we will commit what we can. It is hoped this initiative will complement the Department's current efforts on quality outcomes. There is a meeting scheduled for early next week to look at cost savings projections.

XI. Adjournment

The meeting adjourned at 3:30 p.m. The next DUR Board meeting is scheduled for June 4, 2008.