

MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING

Wednesday, March 4, 2026

1:00 p.m. to 4:00 p.m.

Virtual meeting via Zoom

DUR Board Members Present:

Paul Cesarz, RPh
Jeff Huebner, MD
Robert Factor, MD
Travis Copeland, MD
Michael Ochowski, RPh
Brook Passolt, MD

Gainwell Staff Present:

Tom Olson, PharmD
Chally Clegg
Willie Wilberg, PharmD
Katie Counts, PharmD
LaToya Lang
Josh Wampler, PharmD

DHS Staff Present:

Kim Wohler
Tiffany Reilly
Darla Stachowiak
Pamela Appleby
Susan Seibert
Russ Dunkel, DDS

Absent:

Ward Brown, MD

Welcome and Introductions

Kim Wohler called the meeting to order at 1:04 p.m. and began with a welcome and thank you to the Board members for their attendance at the meeting. As the meeting was held virtually, Kim provided technical instruction on how the meeting would proceed. A quorum of members attended the meeting. Kim also noted that since the September 2025 meeting Lynn Radmer has retired and Jake Olson has resigned his position on the Board.

Review of the Agenda and Board Materials and Approval of September 2025 Meeting Minutes

The members were reminded of the meeting materials sent via email for reference and review. Prior to this meeting, Board members received the agenda, minutes, and RDUR Quarterly Report via email and had the opportunity to review each document. The September minutes were briefly reviewed and approved with an initial motion from **Paul Cesarz** and a second from **Mike Ochowski**. The motion passed unanimously.

Quarterly DUR Reports

Tom began by reviewing member enrollment. The enrolled member count continues to decrease due to the end of the public health emergency. The highest enrollment point was Q1 2023, and enrollment has returned to pre-public health emergency levels and has been stable for the last six months. He continued by pointing out that claim volume continues to trend downward mirroring enrollment. Tom then reviewed the quarterly reports with the Board beginning with the multiple drug classes report. He reminded the Board that this report identifies members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed by a pharmacist for possible inclusion in the Lock-In program or sending physician alert letters. There were six members identified in the last quarter. One of those members received an alert letter, and five had no action taken. Katie shared that upon review of those five members, most had already discontinued multiple medications and were only receiving one or two medications in the five drug classes.

Tom then presented graphs for the percentage of adults and children on stimulant medications. The first slide is a comparison graph of children and adults within the total Medicaid population that shows that the greatest increase of members receiving stimulants has been within the adult population. However, there has been a continued decrease beginning in 2023 of the adult population which is likely due to changes in enrollment status. The next slide is the percentage of children on stimulant medications remains cyclical due to the school year in this age group, but that trend has become less obvious in the data over time. The percentage of children has been down since COVID-19 public health emergency but now seems to be increasing and is close to the pre-public health emergency percentage. The percentage of children taking stimulants in the total Medicaid population is above the percent of adults now. There has been a sustained increase in use since 2020 in adults. Tom noted that there would be further discussion of stimulant utilization at a future meeting. Additional DUR alert trend graphs were presented. Tom noted that most of the alerts are stable or decreasing, although the early refill alert has been trending upwards.

Next, an overview of claim volume was presented to the Board and the percentage of claims with a DUR alert per quarter

has continued to remain stable overall and approximately 45% of paid claims are paid with no DUR alerts. He also noted that less than 2% of paid claims have multiple DUR alerts. Slides were presented to review claim count changes. Claim volume continues to decrease. The claim volume from Q4 2024 to Q4 2025 has decreased by about 370,000 claims. Tom noted that the changing member population and policy changes could be a component of the decreasing claims volume. Trend graphs for average morphine milligram equivalents (MMEs) per member per day and members utilizing buprenorphine from 2023 - 2025 were also included. The average MME has hovered around 41 MME for about a year and continues to remain stable. Upon presenting the members on buprenorphine graph it was noted that historically, as the overall average MME has decreased, the overall use of buprenorphine has increased. However, there has been a slight decrease in the number of members on buprenorphine over the last four quarters. While this may be a result of enrollment changes, the trend was further investigated to reveal that when looking at the percentage of members on buprenorphine, there is still an increase in use over time.

Naloxone Use Updates

Two graphs were presented to the Board looking at naloxone member trends from 2023-2025. Naloxone usage has continued to be steady. Further analysis of the trend graph was done based on opioid use and MME levels. This analysis continues to reveal that most members with a claim for naloxone either had no opioid claims or claims for low MME values (less than or equal to 50 MME per day). A third graph with data on the use of naloxone in non-opioid use members revealed that the percentage of members on buprenorphine continues to change and is now at 37%. Tom presented a slide which was introduced at the December 2022 meeting, tracking naloxone fills for members at 90 MME or greater. From Q1 2023 to Q4 2025, we saw a reduction in members with 90 MME as well as a reduction in naloxone dispensed. The average percentage of members with 90 MME or greater and receiving a naloxone fill in Q4 2025 was 8%, with the average fill rate over time being 12%. Additionally, a second slide was presented tracking naloxone fills for members receiving buprenorphine for opioid use disorder (OUD). For about a year we have seen a decrease in members with OUD as well as in naloxone dispensed. The average percentage of members with OUD and receiving a naloxone fill in Q2 2025 was 7%, with the average fill rate being 8%. It was noted that the slight drop in members and naloxone fills may be a result of the enrollment changes. A graph with the count of members getting naloxone since 2018 was shared. The graph indicated an increased dispensing until about Q3 2023, but a recent upward trend continues. Board member discussion on naloxone included a suggestion to review claims data for an appropriate fill date spanning multiple years or reviewing claims for multiple fill dates indicating use of the prescribed naloxone.

Opioid Script Limit

Tom began by presenting the average MME by override graph. There was a decrease in the average MME by override over the last few quarters that brought the average back down to where it had been for the last year. There is a process in place to review high MME outlier claims. The top five claims are reviewed each quarter for possible intervention. There were no members referred to Acentra for possible lock-in for this quarter. The percentage of override trend was also presented, and overrides are consistently issued for less than 0.5% of the total opioid claims. While the opioid script limit policy impacts a very small number of claims, trends indicated it is an effective policy.

Multiple CNS Depressants

Tom began by reminding the Board that this is a quarterly intervention. He also indicated an update to this intervention has been made that breaks the members into two age groups. The adult group is ages 18 to 64 years and the older adult group are those 65 years and older. The new older adult age group intervention was implemented for the February 2026 cycle. The older adult alert message was shared with the Board. The current methodology for inclusion has been in place since Q1 2022 and will continue to be utilized but will be modified to include older adults who are receiving three of the four drug classes while the adult group will continue to require use of all four drug groups. The methodology identifies members who are concurrently receiving medications from the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants, and are receiving 45 or more actual days' supply of the medications during the quarter. The members must have a claim for the drug class in the last month of the quarter. The selected members are reviewed, and a letter is sent to prescribers regarding the risks of the noted polypharmacy. Letters are sent quarterly to providers of newly identified members and annually to prescribers of previously identified members. A full send of letters for all identified older adults was done for the first cycle of the intervention. Going forward, a full refresh of all identified members will be done in the second quarter each year. For Q4 2025, there were 58 adult members on all four medications and 18 new members selected for intervention. There were 59 older adult members on at least three medications, and all 59 members were selected for intervention.

Clinical update

Tom announced that updates to the ForwardHealth portal were made as a result of the recent intervention identifying members with concurrent therapy with DPP-4 inhibitors and GLP-1 receptor agonists. Board suggestions at the September 2025 meeting included creating prescriber education that would be available to all prescribers and not just those identified by the intervention. A clinical update on this topic was written by the DUR workgroup to meet this request. The ForwardHealth portal was enhanced with a new “DUR Clinical Updates” section to house this, and any future, clinical updates. He shared screenshots of the portal depicting how to navigate to the new section via the “Drug Utilization Review Board” quick link.

Quantity Limits of Short-Acting Opioids Discussion

Tom began the discussion by reminding the Board that short-acting opioid quantity limits were last discussed at the September 2024 meeting. At that time, the cumulative quantity limit was 360 units in a rolling 30-day period. Based on reviews of quantity limit thresholds utilized in other states, the cumulative quantity limit for short-acting opioids was to be decreased to 240 units in March of 2025. During data analysis for a Board update, it was noted that the quantity limit change did not go into effect on March 1, 2025. As a result, it was noted in the December 2025 ForwardHealth Update that the new quantity limit of 240 units would be effective March 1, 2026. He went on to remind the Board that the quantity limit can be overridden in certain situations by the DAPO call center and that one-time quantity limit overrides will be issued until the end of March to assist prescribers during the transition period.

Lock-In Annual Report

Katie began the annual Lock-In Report with an overview of the program’s functionality and objectives, which are to identify and reduce drug-seeking behavior and to identify inappropriate prescribing patterns. The program currently reviews three criteria that look for excessive use of controlled medications (#3147), combinations of buprenorphine with opioid agonists (#5304), and the use of controlled substances with a history of drug poisoning (#9995). The Board was reminded of member rights, negating criteria used during reviews, and the types of letters sent to providers. A list of drugs that are included and excluded from the program was provided. The Board was reminded of the minor change made to criteria #3147 in 2024 for the days’ supply required to hit this criteria. In January 2024, the total days’ supply required for a member to hit criteria was decreased from 230 days to 220 days’ supply. Additionally, it was noted that updates were made to the alert messages in the letters.

A review of case counts for 2025 revealed a slight decrease in the number of cases identified for alert. The trend in the number of cases identified for warnings and lock-ins has also decreased, which may be a result of the continued decrease in member enrollment in the program. Katie noted that due to the time between review for an alert and review for a warning or lock-in, changes in case counts do often take time to see. It was noted that letters are sent on average every six months to allow the reviewer to better see changes to utilization patterns. Other trends noted for 2025 include a sustained downturn in prescriber responses. Over the last few years rates have dropped from close to 20% to 9%. It was noted that the decrease may be related to the inclusion of lower risk members in the review pool and less provider concern for these members. This same rationale may be contributing to the increasing rate of prescribers indicating they are not making changes as a result of the intervention. Despite the lower percentage of overall responses, the percentage of responses with comments remained relatively stable and continues the long-term trend of being over 50%. The overall response rate was 9% with a comment rate of 51%. Most comments were positive and indicated positive actions are being taken, however as expected, there were comments that indicate the program can be a source of frustration for providers. Katie noted that prescriber frustrations may be related to a lack of prescriber understanding of the review process, however it is also understood that many of these patients have very complex history and all background information for each member is not always easy to interpret during these reviews. Board discussion included “letter fatigue” as additional rationale for lower response rates. It was also noted that prescribers may be making changes despite not sending a response form.

To complete the discussion, Katie reviewed the previously mentioned letter updates. She noted that a comprehensive review of all letters and documents for the Lock-In program were reviewed and updated for clarity and consistency. These updates were a result of comments received from providers, members, and administrative law judges involved in the appeals process. Additionally, a new letter was created to address continued utilization issues while the member is currently enrolled in the Lock-In program. This letter will be sent to providers if undesirable utilization patterns continue after the completion of the first year in the program. The new and updated letters were implemented for the October

2025 cycle.

Buprenorphine & Benzodiazepine Intervention

Dr. Copeland began the discussion by reminding the Board that this is an ongoing intervention started as a result of FDA warnings regarding the use of concurrent buprenorphine and benzodiazepine use sent in 2016 and 2017. He discussed some of the reasons that these products may be used in combination, including poor treatment retention rates in patients with anxiety disorders. He also reminded the Board that in December 2023, the DUR workgroup felt that a review of the buprenorphine/benzodiazepine intervention and current literature was warranted given expanded access to buprenorphine and that an updated letter was created and signed by Dr. Huebner and himself in June of 2024. These updated letters were mailed in September 2024 to all prescribers, and in March 2025 to prescribers with new members.

Dr. Copeland continued the discussion with a recap of analysis of the intervention data presented at the June 2025 meeting. He reminded the Board that there was a desire to see if the intervention letters were making an impact (i.e., if members were still meeting criteria). A review of 15 months of claims data resulted in 45 members no longer meeting criteria by either no longer meeting the threshold for buprenorphine use (33) or by no longer meeting the benzodiazepine criteria (12). Multiple reasons were noted for why a member may no longer meet criteria including: gaps in claims data, treatment changes in prescribed MAT treatments, member plan coverage changes, and benzodiazepine tapers. Dr. Copland went on to discuss that, as a result of this analysis, changes were made to the inclusion parameters for the intervention. Gaps in claims data were a major concern, and the goal of the parameter changes was to decrease the impact of care transitions so that members who should be identified for a letter were not missed due to claims issues. He shared the following modifications with the Board: utilizing a longer data set of 12 months (vs. six months), adjustment to the day's threshold utilized for inclusion to 70% in 360 days (vs. 80% in 180 days), and the addition that a member must have a claim in the last month of the data period to ensure they are currently active in treatment. Members must still meet the previously determined benzodiazepine dose threshold. The new parameters are expected to generate 300-400 letters annually. He shared that the first set of letters utilizing these parameters will be mailed in March 2026 and will include 317 letters. Next steps for this intervention include analysis of the March 2026 intervention in early 2027 which will include a review for slow benzodiazepine tapers. Additional intervention cycles will occur annually with letters being sent to all prescribers. The next mailing will be in March of 2027.

Multiple Antipsychotic Use Letter Update

Dr. Copland began the discussion by reminding the Board that this topic was discussed at the September 2025 meeting and went on to provide an overview of the antipsychotic monitoring that is already in place for children. He indicated that monitoring for children has been in place since 2012 and currently multiple programs are in place including prior authorization for children under the age of nine, clinical reviews for children ages 9 – 18 for multiple antipsychotic use which can include peer to peer outreach, and letters and possible outreach for polypharmacy of sedating medications in children 18 and under. He further reminded the Board that the legislation mandates state Medicaid programs to monitor antipsychotic use in members over the age of 18. The legislation requires monitoring of members in home and community settings, as well as those in institutional settings. Dr. Copland went on to discuss parameters that should be considered while creating this new intervention and challenges associated with these parameters. He indicated that appropriate prescribing patterns, including polypharmacy and dosing, could be included. Also, diagnostically appropriate prescribing may be considered, but there can be issues with incomplete data due to medical coding issues. The last consideration is identifying members in the appropriate care settings. Data limitations do exist that can preclude accurate identification of the care setting, making it difficult to restrict an intervention based on this parameter. Given the data limitations, the decision was made to focus on polypharmacy of antipsychotics, specifically the use of multiple antipsychotics, and broadly apply this intervention to members of all ages and all care settings.

Dr. Copland continued the discussion by reviewing data for Wisconsin Medicaid members receiving antipsychotics. The data was stratified by age and the number of antipsychotics. He indicated that most members were on one or two medications. He stated that about 14% of adult members in Wisconsin Medicaid are on two medications. Additional data was shared that provided the volume of use for all antipsychotic medications based on age, and he went on to share that based on data from the first six months of 2025, children are infrequently chronically prescribed two or more antipsychotics, and adults are infrequently prescribed three or more antipsychotics. Based on this data, these thresholds were used in the development of intervention letters. He also noted there is documented risk for decompensation in the adult population when tapering from two to one medication, thus reviewing the members on three or more medications was the most clinically appropriate. Letters were developed based on patient age and identify children (0-18) that are

taking two or more antipsychotics and adults (19 years of age and older) taking three or more antipsychotics for 80% of the time in an 180-day period. Letters will be sent every six months with one year between letters regarding an individual member and the first round of the intervention was implemented in February of 2026. Dr. Copeland shared that for the initial cycle of letters, 103 children and 188 adults were identified and selected for intervention.

Dental Intervention Update

Dr. Russ Dunkel began by reminding the Board current criteria identifies prescribers who have three or more members under the age of 16, who received more than 10 pills or who have members 16 years of age and older who received more than 12 pills. He indicated that children and adults are tracked separately and there are two phases for this intervention. A phase II letter was developed for prescribers who still meet the criteria, and the number of members remained high, these prescribers were considered to be in the top 5%. The current data on the intervention was shared with the Board. The most recent mailing took place in February of 2026. For Q3 and Q4 2025, the phase I analysis included 50 prescribers with 18 new prescribers identified to receive a letter. Dr. Dunkel indicated that phase I data has a downward/positive trend with respect to member volume, and we hope it is attributed to the intervention. Phase II data analysis identified 11 prescribers for a phase II letter, which is also noted as a downward trend. Top prescribers have been tracked during the entirety of this intervention, and a subset of those prescribers are referred to Dr. Dunkel for review. He noted that the top six prescribers are relatively consistent over time. The discussion ended with a review of recent changes to prescriber letter frequency. Phase I letters will be sent in August/September to all dental prescribers that meet criteria for the January – June timeframe and letters in the July – December timeframe will be mailed in February/March to newly identified prescribers. Phase II letters will be sent yearly beginning in February/March to the top dental prescribers utilizing July – December data. Dr. Dunkel indicated that a review of the references and statistics included in the dental letters was conducted and updates were made to the phase I and phase II letters.

High MME Call Analysis

Tom began the discussion with a review of the High MME intervention history. He indicated that the SUPPORT Act of 2018 required states to monitor high MME members and prescribers. As a result, starting in December 2019, high MME members were identified in a focused intervention that is run monthly by Acentra. The initial high MME threshold was set at greater than 250 MME per day. Over time, the threshold has been reduced to 120 MME per day. High MME profiles are reviewed monthly with letters being sent to prescribers yearly, with letters being sent more frequently for prescriber changes or MME parameter changes. Tom went on to remind the Board that a secondary intervention including prescriber outreach performed by Gainwell consultants was started in 2020. A small set of “test” phone calls were made in September 2020 and in March 2021 quarterly phone calls were started. Prescribers identified for outreach are those that have not reduced a member’s MME at six months post-receipt of the high MME letter. Prescribers are asked a set of canned questions regarding member diagnosis, the opioid treatment plan, and naloxone prescription status. Answers are documented by the consultants. Tom shared that prescribers consistently indicated that members are prescribed naloxone with 73% of prescribers affirming they have issued a naloxone prescription. He also added that 69% of prescribers indicated there is no plan in place to decrease the member’s MME. However, based on additional analysis of claims data six months post-outreach, it was noted that some of those members did have a reduction in their MME. These positive changes indicate the calls are effective and Tom indicated that the calls will continue on a quarterly basis. Call flow will be modified to include informing the prescriber if naloxone has not been dispensed to the member based on claims data. Board discussion included the number of call attempts made before connecting with a provider office and if the consultant spoke to the prescriber or their office staff, as well as different ways to capture diagnosis information.

Adjournment

Mike Ochowski motioned to adjourn the meeting. The meeting adjourned at 3:49 p.m. Upcoming meetings are on the following Wednesdays: June 3, 2026, September 2, 2026, and December 2, 2026.

Guests: Ian Sutker, Otsuka; David Large, Chiesi Global Rare Disease; Bill Eicholzer, PTC Therapeutics; Todd Kailas, Alkermes; Sherry Betthausser, Jazz Pharmaceuticals; Caroline Faber and Dan Calloway, Johnson & Johnson; Ryan Miller, Teva; Andy Berg, Concis Labs; Joe Sullivan, Vertex; Jenna Doerr, Petauri Health; Mariam, Alboustani, Dyne Therapeutics