Drug Utilization Review (DUR) Board Meeting
Wednesday, March 4, 2009
1:00 P.M. to 4:30 P.M.
1 W. Wilson Street, Room 630
Madison, WI 53701

DUR Board Members Present:	Robert Breslow, RPh Ward Brown, MD Patrick Cory, PharmD Daniel Erickson, MD Robert Factor, MD, PhD Franklin La Dien, RPh Michael Ochowski, RPh Dennis Olig, RPh Nancy Ranum, MS, RN, CS-ANP, APNP Eva Vivian, PharmD
DHCAA:	Carrie Gray Rita Hallett, MA, RN Jonathan Moody Lynn Radmer, RPh James Vavra
APS Healthcare, Inc.:	Debbie Matitz (squire) Michael Mergener, RPh, PhD Tom Olson, PharmD
Guests:	Kathy Bovid - BMS John Bullard – Amgen Joe Busby – Eli Lilly Kay Cram – University of Wisconsin Chris Duerfer – ABM Brian Groeschel – EDS Dean Groth – Pfizer Jeff May – Astra Zeneca Laura Scheurer – Astra Zeneca Russ Sobotta – Sanofi/Aventis Jagdish Shastri – Eli Lilly

James Vavra called the meeting to order at 1:05 p.m. Introductions were made.

I. Approval of Agenda
Agenda approved as published.

II. Approval of Minutes – December 3, 2008 Meeting
Minutes approved as published.

III. ForwardHealth Demographics (Attachment 1)

Rita Hallett presented on Demographics of the ForwardHealth Medicaid-Related Programs. Included under ForwardHealth are BadgerCare+ (Standard and Benchmark plans), Medicaid (primarily the Elderly and Disabled), all waiver programs, and SeniorCare. Costs in State fiscal year 2008 (7/1/07 – 6/30/08) totaled $4.93 billion with 60% paid for by federal funding. As of January 30, 2009, approximately 950,000 members were enrolled in BadgerCare+ with the biggest expenditures in the Elderly and Disabled program. 50% of the members are BadgerCare+ children (12% of costs) with the Elderly and Disabled membership at 5% (40% of costs). Drugs (after rebates) are a small piece of the $4.93 billion when looking at Medicaid vs. the whole program. CHIP federal dollars cover the children's portion and are included in the $4.93 billion. Of the 950,000 members, the 3 major programs are Badgercare+ at 591,000, Elderly and Disabled (includes SeniorCare), and Other Coverage. All of the Other Coverage categories are authorized with legislation and the majority gets federal matching funds with some exceptions (e.g., chronic disease program, SeniorCare). The Transitional Childless Adult population includes those previously enrolled in the GAMP Program which switched over in January 2009. BadgerCare+ enrollment indicates children as the biggest demographic group in the program. The Standard and Benchmark plans percentage-wise look similar, but the numbers are very different (Standard 350,000 vs. Benchmark 10,000 children) and Benchmark has higher income levels. In summary, about 1 in 6 (20%) of Wisconsin residents are covered under one or more of these plans and that is expected to grow. Pertaining to the Costs to Enrollment slide, Mr. Breslow commented it would be helpful to know within each of the cost categories what the drug benefit carve-out piece is of total cost. Mr. Vavra stated Jason Helgerson is interested in seeing an expanded dashboard of Medicaid drugs at a glance.

Action Item:
For the June 2009 meeting, Dr. Mergener will break down by cost category (SeniorCare, Standard, Benchmark) what percentage they are of total spend, as well as prepare an expanded dashboard of Medicaid drugs.

IV. Drug Spend Discussion

Dr. Mergener presented on the drug spend – pre and post managed care carve-out. The first handout "Utilization Comparison by Therapeutic Class" is sorted by 1st Databank therapeutic class and how that is defined for the periods August - October 2007 vs. August - October 2008. The 2007 period prior to the carve-out was traditional fee-for-service (FFS) utilization; the 2008 period is with the managed care drug benefit carved into the drug benefit. A user is defined as anyone with 1 or more prescriptions within the quarter as the denominator. Per user per quarter cost is cost divided by number of users. Medicaid amount paid average is what we're paying out exclusive of rebates. Our rebate program includes the federally required rebates received plus any supplemental rebates (average rebate received is approximately 40%). If the manufacturers' price increases exceed the consumer price index (CPI) for a particular year, Medicaid gets refunded the difference as additional Federal rebates. Those rebates are not reflected in these figures and drugs with very low utilization were excluded as well. In 2007, approximately $50 million was spent on atypical antipsychotics – spend increase is due to several more members than we previously had. Approximately 50% of Medicaid expenditures are in 10 drug classes.

Rebates for pump inhibitors are quite high and if rebates were included, this therapeutic class would not be at the top of the list. The actual number of users of the drug benefit has increased by 32%. The majority of highly prescribed drugs are generic maintenance drugs and for 2008, the #1 drug is Hydrocodone. Mr. Breslow inquired if there is a way to potentially look at the outliers in general. Dr. Mergener responded there are a couple of ways to manipulate the data – one is to look at everything all at once and drill down for targets (e.g. Oxycodone may be worthwhile). This currently does not take a refined look at pre and post managed care which could be done to see the effect the carve-out has had. The increase/decrease in RX looks at the percent change between 2007 and 2008, indicating an increase in utilization for new drugs. The majority of the large decreases is the result of a PDL change or shift in status from non-preferred to PDL, indicating the PDL is having a desired effect. The last handout shows the cumulative paid amounts and for both years, the #1 drug for expenditures is Nexium. When Nexium was non-preferred, it was 7.5% in the PPI list and currently in the PDL, 43% of PPIs are Nexium. Changes may occur in this category based on recommendations given to the Secretary. After further review of the materials, the Board should e-mail Dr. Mergener with any questions.

Action Items:

- For outliers in general, look at everything all at once and drill down for targets (e.g. Oxycodone). Take a refined look at pre and post managed care to see the effect the carve-out has had.
- The Board should review the handouts in more detail and e-mail Dr. Mergener with questions.

V. Break

VI. Miscellaneous Items

- **Atypical Antipsychotic Do No Harm Report (Attachment 2)**
  Dr. Mergener presented the Atypical Antipsychotic Do No Harm Report which was a follow-up item from the 12/08 Board meeting. There were approximately 600 patients in this intervention. This is a 6 months pre/post analysis for the period 8/1/07 through 1/31/08. The report looks at emergency room visits, inpatient admissions and outpatient office visits with psychiatric diagnosis pre and post intervention. Pre and post numbers are fairly similar in services per month. There were more ER visits in post vs. pre for all people in the intervention. Inpatient admissions and outpatient office visits dropped, indicating globally the intervention had no adverse effect.

- **Retrospective DUR Criteria (Attachment 3)**
  Dr. Mergener presented on the retrospective DUR criteria which was developed based on feedback from the 12/08 meeting. This covers 3 months (August-October 2008). The pharmacy staff reviewed 2,800 profiles in that time period. The selected reviews are those the staff chose to send intervention letters out to doctors. The report indicates more letters than cases, reason being letters are sent to multiple doctors (e.g. multiple prescribing of narcotics). Please note: the column "MD Yield" should be labeled "Prescriber Yield" and indicates the percent of responses received. The data shows we are still getting a 50% response rate, meaning we're sending letters out on issues that are important enough for the prescriber to take the time to respond back to us. Periodically, the criteria list will be reviewed. Dr. Mergener encouraged the

Board members to provide feedback on those criteria they feel we should/should not still be doing. Mr. Olig commented even though geriatrics may not line up with the demographics of the population we are serving, it should be a specific focus. The use of benzodiazepines for people with a history of drug abuse is another criterion that has recently been added. Is data available on the percent of time therapy is changed/adjusted? A report can be run looking at decreased utilization within the categories.

Action Items:

- The Board members are encouraged to provide feedback on those criteria they feel we should/should not still be doing.
- Dr. Mergener will check if the criteria for ACE inhibitors are available for turning on.

- **HEDIS Measures**

  Rita Hallett presented on HEDIS measures. Potential measures were looked at from a drug perspective that would be appropriate to the Medicaid population and we are proposing three: 1) betablocker treatment after a heart attack measuring the percentage of members who are discharged from the hospital with a diagnosis of acute myocardial infarction and received persistent betablocker treatment for 6 months after discharge; 2) antidepressant medication management measuring the percentage of members 18 years and older diagnosed with a new episode of major depression treated with antidepressant medication and remained on an antidepressant medication treatment; and 3) annual monitoring of patients on persistent medications measuring the percentage of members who had appropriate blood tests done if they were on any of the following types of drugs: ACEs, ARBs, progostine, diuretics or anticonvulsants. Tom Olson has started working on #3 looking specifically at ACEs and ARBs and whether people have had the appropriate lab monitoring after their initial prescription with 1 of 2 drugs. He reported the results are rather troubling which may be due to InterChange and the data warehouse. A report will be provided to the Board once all the data is compiled. Implementing this would require looking at both HMO managed care encounter data and FFS, and potentially sending intervention letters to the prescriber and/or patient. Dr. Mergener commented ACEs and ARBs are a bit confusing in that they are somewhat combined. A patient has to be 120 days on ACEs or ARBs for 6 months to be considered on maintenance therapy. However, a situation could arise when a patient is on both ACEs and ARBs simultaneously for the total number of days that would add up to be sufficient, but they wouldn't be on enough therapy to be considered on maintenance for the full time. One really has to look at the number of days on ACEs, the number of days on ARBs, and ensure that if it is cumulative, they still have to be on the therapy for the window of time. If looking at this as benchmarking towards other plans under Medicaid programs, it should be standardized in the way the HEDIS measure is written but if using for interventions, the aforementioned way is more appropriate. Mr. Vavra stated this issue exists especially with the managed care plans and we do make them uniform with the actual standard for that reason – not only to compare with other Medicaid programs, but also to look at the commercial population. The Board's feedback related to the issues Dr. Mergener raised would be very helpful.

Action Item:

- Tom Olson will continue compiling data for the proposed measure "annual monitoring of patients on persistent medications" and report back to the Board.
- The Board to provide feedback related to the issues raised by Dr. Mergener.

VII. Future Targeted Interventions (Attachment 4)

Attachment 4 presents the recommendations for future targeted interventions. The HEDIS measures discussion was driven from the idea of not only DUR targeted interventions, but also an attempt to establish quality measures. Mr. Vavra reported the Division is compiling a plan for a quality of care Medicaid context paper and Rita Hallett is working on the pharmacy piece which ultimately will reflect what we do, including prospective and retrospective DUR, prior authorizations, and targeted interventions. Rita explained there are 2 pieces - the benchmarking is how we compare to other Medicaid programs, and the targeted intervention is more in-depth and determines where we send letters. Mr. Cory commented benchmarking doesn't necessarily mean there has to be a targeted intervention – rather you have a dashboard of interventions and see where you perform well or poorly, and then focus on the poor. Dr. Mergener will prepare materials of what has been done in this area in the past either through DUR or as directed by the PDL and give an assessment of its effectiveness. Mr. Breslow commented this raises a question about adherence to medical recommendations in that we may be sending letters to the wrong person. Mr. Vavra agreed to take the approach of what we've done in the past and adherence to medical recommendations. As a way to broadly educate prescribers, Carrie Gray mentioned the State would like to resurrect the newsletters they've done in the past. Dr. Erickson suggested before sending this list out, it would be helpful to get an idea of the selection criteria, focusing on what will add value and easily retrievable data. Another suggestion is moving the dial – Mr. Cory suggested we identify issues for targeted interventions with potential for success.

Hydrocodone – Mr. Vavra stated that Jason Helgerson is very interested in the Board's ideas for controlling this product. Mr. Cory commented the problem with high use drug abusers is they go for long acting drugs which makes moving the dial difficult. There's a fine balance between someone who truly needs their medications and those who don't need it and sell it; those who have a semi-need for it and sell some; and those who use it that truly need to. Mr. LaDien suggested bringing in the DEA. Dr. Mergener suggested doing a couple of different takes on this: 1) looking at patients with excessive amounts of drugs (would need to work on definition of "excessive" – find out how the DEA defines this?) exclusive of a diagnosis that would support excessive amounts, and 2) profiling prescribers. Mr. Cory commented if we make this a target, we should research RX count per eligible adult per service and check for utilization increases, attaching costs to those. Mr. LaDien commented on the 100 days supply issue, he wants to be more proactive by educating the physician.

Additional Interventions: 1) Identify women of child bearing age who are being prescribed ACEs, ARBs or statins and determine their use of oral contraceptives. If not being used, send an intervention letter to the patient or prescriber, including pharmacists as they should be questioning patients about this (potential newsletter topic?). 2) Allow a once per year coordination of prescription fill dates for whatever your day's fill is (e.g. patient comes in 1 day to get all their prescriptions regardless of whatever day fill it is so they always fall on schedule).

To get Board consensus, Mr. Vavra suggested to eliminate the duplicates, send a revised list to the Board for ranking, and choose the top 5 or 6.

Action Items:

- Redo the list by eliminating duplicates, send the revised list to the Board for ranking and choose the top 5 or 6. Prior to sending out, get an idea of the selection criteria, focusing on what will add value and easily retrievable data.
- Dr. Mergener prepare document of past interventions done either through DUR or as directed by the PDL, including an assessment of effectiveness.
- Resurrect the newsletters for educating prescribers.
- Gather data on providers and their EMR vendors.
- Controlling Hydrocodone – look at patients with excessive amounts of drugs exclusive of a diagnosis that would support excessive amounts, and profile prescribers. Research the RX count per eligible adult per service, checking for increased utilization, and attaching costs to.

VII. Adjournment

The meeting adjourned at 3:50 p.m. The next DUR Board meeting is scheduled for Wednesday, June 3, 2009.

The CACHE Committee (clinical advisory on health and technology) is meeting on March 17, 2009 in room 751 and focusing on the core plan for childless adults. The meeting agenda will be posted prior to the meeting.