Drug Utilization Review (DUR) Board Meeting
Wednesday, September 3, 2008
1:00 P.M. to 4:00 P.M.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members Present:	Philip Bedrossian, MD Lon Blaser, DO, CPE Patrick Cory, PharmD Daniel Erickson, MD Robert Factor, MD Michael Ochowski, RPh Dennis Olig, RPh Nancy Ranum, MS, RN, CS-ANP, APNP Eva Vivian, PharmD
DHCAA:	Rita Hallett, MA, RN Jason Helgerson James Vavra
APS Healthcare, Inc.:	Allan Mailloux, PharmD Debbie Matitz (squire) Michael Mergener, RPh, PhD Tom Olson, PharmD
Guests:	John Bullard – Amgen Kay Cram – University of Wisconsin Frank Cutaro – Astra Zeneca Dean Groth – Pfizer Greta Nemergut – UWHC Jagdish Shasfri – Eli Lilly

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

I. Introduction of New Members

Four new Board members attended today's meeting: Philip Bedrossian with MercyCare Health Plans, Lon Blaser with Group Health Cooperative of Eau Claire, Dennis Olig with Centene Corporation/Managed Health Services, and Eva Vivian with University of Wisconsin-Madison School of Pharmacy .

II. Approval of Minutes – June 4, 2008 Meeting

Minutes approved as published.

III. Approval of Agenda

Agenda approved as published.

IV. Presentation of Amended Bylaws

Resulting from discussion at the 6/4/08 DUR Board Meeting, Rita Hallett amended the existing DUR Bylaws by adding the phrase "cost effective prescribing" to section VI. Duties and Responsibilities. The amended bylaws were distributed at today's meeting.

V. Review of Secretary's Decisions from August 6, 2008 PA Committee Meeting

The Wisconsin Medicaid Pharmacy Prior Authorization Committee is responsible for reviewing and making recommendations about the Preferred Drug List (PDL). The Committee meets twice per year. Currently, about 80 drug categories are being reviewed annually with approximately half the categories reviewed in February and half in August. Provider Synergies is Wisconsin's contractor for negotiating supplemental rebates as well as providing clinical information for the PDL. The PDL Committee reviews drugs for inclusion on the preferred list for efficacy and safety as well as reviewing the supplemental rebates provided by manufacturers. Generally, Medicaid's policy for obtaining a non-preferred drug is that a preferred drug must be tried and failed before a non-preferred drug can be used.

The Mental Health Advisory Group is a separate committee that reviews the recommendations made by the PDL Committee on mental health drugs. This group meets after the PDL meeting and weighs in on their recommendations to the Secretary. Medicaid typically grandfathers mental health drugs.

Dr. Mergener then provided a summary of the drug categories that were reviewed at the 8/6/08 meeting. Mr. Vavra stated these drugs will be phased in with the first classes going into effect in October.

VI. Atypical Antipsychotic Intervention (Attachment 1)

Dr. Mergener presented a report on the Atypical Antipsychotic Interventions. An intervention was designed focusing on low dose monotherapy of atypical antipsychotics. For the first intervention, patients were aggregated by prescriber and the top 100 prescribers ranked by number of prescriptions were targeted for an intervention letter. For evaluation purposes, a cohort group of prescribers ranked in the next 100 was used. After the initial results showed a decrease in prescribing low dose atypical antipsychotics, the DUR Board asked for additional evaluation, e.g. what happened with patient's other psychotropic drug use. This analysis showed nothing significant except for a small increase in sedative hypnotics and stimulants. A "do no harm report" was also done focusing on the amount of mental health services before and after the intervention. This group of 100 had less crisis intervention and hospitalizations for mental health diagnosis after the intervention than before.

The Board requested a similar intervention be done with the next 100 prescribers. Eliminating any prescriber that was previously in the top 100 resulted in 86 prescribers with 5 or more patients being selected. These 86 prescribers had written prescriptions for atypical antipsychotics for 780 patients. At the time of this intervention, no managed care patients were receiving drugs in the FFS environment. Fifty-seven patients were dropped due to non-continuous eligibility post-intervention. The results showed 23%

were no longer on any atypical antipsychotic post-intervention; 9.5% decreased their dosage; 27% took the same dose; 40% increased their dosage. The "do no harm report" done on the cohort group from the previous intervention showed patients with more events, e.g., hospitalizations and mental health services. Costs increased 20% pre to post with the average number of prescriptions increasing by almost 1 per patient. Twenty-two patients received at least 2 drugs some time in the post-intervention evaluation. For both interventions, responses indicated that even though prescribers modified their behavior, they were not supportive of this issue.

Action Item: Based on suggestions from today's meeting, Dr. Mergener will do the following:

- Review atypicals and other drugs, specifically anticonvulsants (specific to bipolar)
- Review pediatric patients
- Review patterns amongst providers (those who dropped vs. increased vs. stopped dosage completely)
- Analyze data for the 1st group of 100 over the same period of time
- Review provider specialty
- Analyze medical claims and attaching diagnosis for the 1st and 2nd groups

VII. Break

VIII. Lock-in Program Review (Attachment 2)

Allan Mailloux provided an update on the Recipient Lock-in Program. Since the 2/1/08 implementation of pharmacy carve-out, the lock-in program has experienced a doubling of the number of members and claims that undergo surveillance for lock-in. Three types of lock-in recommendations may be made: 1) warning letters to members, 2) letters to prescribers, and 3) lock-in enrollment. Four graphs detailing these results were distributed.

- Graph 1 looks at the total number of reviews performed for June, July, and August of 2007 and compares it to the same months in 2008. The results show a 96% increase in reviews performed.
- Graph 2 looks at member warning letter recommendations. In July 2008, member warning letter recommendations increased by 900%.
    i. Previous analyses of 6 months of claims pre and post letter intervention has shown a $1,500 average savings per letter sent.
    ii. Another reason for the increase in member warning letters is the use of the National Provider ID (NPI) to identify the prescriber. Beginning May 19, 2008, pharmacies were required to submit the NPI rather than the DEA number on drug claims. Since we do not have the official exhaustive crosswalks to match the NPI to the prescriber name, we have no address for interventions involving the prescribers. This results in more warning letters to the members.
- Graph 3 looks at the Surveillance Utilization Review (SUR) recommendation letters. These are the alert letters sent to prescribers. Since the carve-out, there has been a 275% increase in the number of SUR letters sent.

- Graph 4 looks at the lock-in recommendations. This graph shows an 80% increase since the carve-out.

About 2/3 to ¾ of the warning letters, SUR letters, and lock-in recommendations are HMO-enrolled members. We copy the HMOs on all interventions.

An analysis of the effectiveness of the warning letters will be done as part of the annual comparison of utilization and expenditures for lock-in interventions. The analysis will include identifying shifts in care between physician, physician office visits and emergency room visits. In past analyses, emergency room visits have decreased 25% on average.

In Wisconsin, there are approximately 240 members enrolled in lock-in, placing us in the low to mid range compared to other states for numbers enrolled.

A decision tree analysis using a series of measures was developed to assist in looking at patterns in medication profiles (controlled substances only-90 to 95% are narcotics). "Shopping" scores are calculated by tallying numbers for 6 months of overlapping day supplies for each claim grouping reviewed. There are 2 types of patterns seen:

- Patients who go to a lot of physicians and pharmacies, get a lot of small quantities and go to the emergency room. The pharmacy gets the early refill and therapeutic duplication alerts, but may override them.
- Patients with only 2 or 3 prescribers, but also going to a pain management clinic, getting short- and long-acting 30 day supplies ordered from the pain management clinic in addition to 2 to 4 small quantity prescriptions from an emergency room. They may have only 2 or 3 prescribers/pharmacies, but are considered lock-in because they are violating their pain management contract.

Jason Helgerson inquired if managed care companies have a list of people under contract for pain management and to what extent do HMOs know about those people? Some HMOs have some information, but it is incomplete. The DUR program does receive lock-in referrals from some pain management clinics and have placed a member in lock-in on a voluntary basis. This is possible if the pain management contract is written in such a way that the person agrees to get their controlled substances from only 1 physician or team of prescribers. In many cases, doctors require patients to sign up for lock-in as a condition for treating them but because it is voluntary, a patient can opt out at any time and, according to our administrative rules, we have to release them. Mr. Helgerson commented this is one example of how we as a program can work with health plans and independent physicians to effectively manage pain by publicizing the option that individual physicians can contact us and enroll patients directly. Mr. Helgerson will talk with State staff regarding the lock-in program and the budget initiative.

IX. Approval of Modified Prospective DUR Criteria (Attachment 3)

As part of the expansion of cost savings initiatives, we are expanding some of the prospective DUR alerts to be more inclusive. Dr. Mergener is presenting two lists and seeking the Board's recommendation to move forward on implementing these in the prospective system.

- Early Refills (ER)
  The document entitled "Drugs to Add to the ER Prospective DUR Edit" (see attachment 3) is a list of drugs we would alert pharmacists on through the ER prospective DUR edit. Pharmacists receive ER "soft" alerts they have to act on, but do have the ability to override. On average, a pharmacist overrides approximately 30% of the alerts they receive, meaning 70% of the time they are not filling the drug early.

  First, we are proposing this list of drugs be incorporated into our soft edits and second, we are recommending changing the threshold from 75% to 85%. This means that 85% of the drug has to be expended – if greater than 85%, the pharmacy would get the alert. Drugs dispensed in anything less than a 10 day supply is exempt from an ER alert.

  An estimation of potential cost savings on a cumulative of 4 months of prescriptions has been done and for those prescriptions for which an ER is enforced, the savings would be about half a prescription volume over 4 months if it is stopped. The extent of drug overlapping is currently not known as that is a calculated field which uses the day supply to set the alert. With the exception of Dennis Olig, due to his concern with atypical antipsychotics, the motion was made and all members were in favor of moving the list of ER drugs to ER "soft' alerts in the prospective DUR system.

  There was considerable discussion about the change in the threshold and what effect the 100 day supply would have on threshold. There was no motion to change the threshold from 75% to 85%. The threshold issues are deferred and should be brought back for evaluation after implementation of the new InterChange system.

- 100 Day Supply
  Referring to "Drugs recommended for 100 day supply prospective DUR alert" in attachment 3, some of these are currently available in soft edits with the desire to make them hard edits. These are mostly maintenance drugs. The drugs would be implemented in phases. There are 2 drug categories in phase 1: 1) those under administrative code permissive to being dispensed in a 100 day supply, and 2) OTC drugs that have been added.

  A discussion about how the system will determine when a person has been stabilized on a maintenance drug ensued. The current processing system does not have the ability to look at whether the prescription is new, for purposes of setting the 100 day supply alert. If a prescription is written for 30 days, the pharmacist must call the physician to change the prescription to 100 days or get a prior authorization to override the policy.

  The Board did not want to proceed with hard edits to the 100 day supply list until the system could recognize that a person has been stabilized on a particular dose of drug. We first want to get the system up and running and once it is implemented, work on desired changes. Dr. Mergener suggested pairing down the list and doing soft edits initially, discuss outreach issues, and look at desired changes once the new system is implemented. Dr. Ochowski suggested sending patients a letter informing them that their benefit allows 100 day supply and along those lines, Mr. Helgerson suggested talking to the SSI advocates in Milwaukee.

Action Item:
Early Refill: Move the list of ER drugs to ER "soft' alerts in the prospective DUR system. Defer the threshold change to 85% and bring back for evaluation after implementation of the new InterChange system.
100 Day Supply: Pair down the list of drugs and do soft edits intitially; discuss outreach issues; look at the system going forward with changes.
Answers to outstanding issues will be brought back to the next meeting.

X. Future Directions of Drug Utilization Review

Jason Helgerson talked about the future directions of DUR. With the drug carve-out and SeniorCare, the DUR Board's work has increased in importance and he would like to use this Board as a problem solving group moving forward. The State is currently developing a comprehensive Medicaid quality improvement plan which is looking at the various ways we have within our power and/or in coordination with other groups to improve health outcomes. One area is drug management and the DUR Board would be extremely helpful in advising the State on strategies along the lines of not only ideas from today's discussion, but other ideas as well. Mr. Helgerson is interested in pursuing the use of the lock-in program as a way to reinforce efforts of physicians and managed care organizations to get people into pain management programs that work. Nancy Ranum inquired if the oversight for home medication administration comes under the DUR Board – there is the Home Care Advisory committee. Both Mr. Helgerson and Mr. Vavra agreed this could be reviewed by both groups. Another organization the State needs to work and coordinate with is the Wisconsin Pharmacy Quality Collaborative. Dr. Mergener mentioned the Mental Health Advisory Group discussed looking at ways to perform outcomes evaluation and management.

Today's discussion is demonstrative of what the DUR Board can advise the State on and Mr. Helgerson encourages all DUR Board members to think of ways to improve health outcomes. Today's feedback will revise a couple of existing ideas and definitely have an effect on what we do moving forward.

XI. Adjournment

The meeting adjourned at 4:05 p.m. The next meeting is scheduled for December 3, 2008.