DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, November 28, 2007
1:00 P.M. to 4:00 P.M.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members Present:	Michael Boushon, RPh Robert Breslow, RPh Daniel Erickson, MD Robert Factor, MD Franklin La Dien, RPh Pamela Ploetz, RPh Nancy Ranum, MS, RN, CS-ANP, APNP
DHCF:	Kay Cram Carrie Gray Rita Hallett, RN Marilyn Howe, RN Jonathan Moody Lynn Radmer, RPh James Vavra
APS Healthcare, Inc.:	Allan Mailloux, PharmD Debbie Matitz (squire) Michael Mergener, RPh, PhD
Guests:	Greg Aronin – Johnson and Johnson Edward DePaz – Shire Ronald Diamond, MD-BMHSA Sarah Gerber – School of Pharmacy Dean Groth – Pfizer Melissa Vert – School of Pharmacy

Minutes

James Vavra called the meeting to order at 1:00 p.m.

I. Approval of the Agenda
Agenda approved as written.

II. Approval of Minutes – September 5, 2007 Meeting
Minutes approved as written.

III. Pharmacy Carve-out

Jason Helgerson, Medicaid Director, and Rich Albertoni, Pharmacy and Hospital Section Chief, attended the meeting to address the new pharmacy carve-out initiative, scheduled for implementation on February 1, 2008. The initiative is part of the budget resulting in the entire managed care organizations' Medicaid pharmacy being carved out to the FFS program. It

provides an opportunity to better meet the members' needs more cost-effectively by utilizing the buying power of the State in getting federal and supplemental rebates through negotiations with drug companies. There will now be a single Preferred Drug List (PDL). Having one statewide PDL should make doctors' and pharmacists' jobs easier. The DUR functions will be impacted as more members will be added to the DUR Board to assist with these issues.

The State anticipates adding 300,000 to 400,000 people to Medicaid FFS that are now under managed care and adding $200 million of drug spend in addition to our current $400 million. The State is committed to providing the plans with daily extracts of drug claims to accommodate their request for real-time data and is looking at also doing some HMO encounter data analysis.

The State is working with a variety of stakeholders, including the Pharmacy Society and Mental Health Drug Advisors. A steering committee has been formed with four subcommittees, as well as a technical advisory committee with representatives from each of the managed care organizations. Work is split into four major areas: continuity of care, recipient and provider communications and outreach, systems and data exchange issues, and fiscal and HMO rate setting.

Implementation will be as seamless as possible for members as they will continue to use their Medicaid card. Starting on February 1st, all prior authorization policies for this population will be suspended for 60 days with the hope that all necessary changes are made by April. Any physician-administered drugs that are billed using procedure codes will continue being paid for by the HMO, but self-administered drugs will be carved out and paid by Medicaid. Pharmacy-related supplies will be carved out as well. The same FFS policies currently in place around grandfathering for mental health drug classes will apply. All prospective/retrospective DUR and lock-in policies will also apply to this population.

The PDL is reviewed twice per year at the PA Committee meetings. The next meeting is scheduled for February 2008. The Committee gets a relative scale of drug prices, class by class, to see the relative price differences. The Committee makes a recommendation to the Secretary; a memorandum is compiled with the recommendations and is then discussed with Secretary Hayden. Pam Ploetz asked if there is a way to electronically send the Board the decisions made at various committee meetings. Meeting minutes and the PDL can be viewed on the DHFS website. Mr. Vavra also said we could e-mail the Board the member update that is going out to all people that will be affected by this initiative.

> **Action Item:** Dr. Mergener will provide a summary of the February 2008 PDL meeting at the March 2008 DUR Board meeting. The Board members will be e-mailed the member update that is going out to all people that will be affected by this initiative.

IV. Dr. Robert Factor Presentation

Dr. Factor made a presentation on prescription drug pricing and reimbursement. In September 2004, the US was spending $163 billion for prescription drug costs while the UK was spending $13 billion. By September 2007, the US increased to $204 billion. The biggest subcategories for the US are CNS drugs, GI drugs, and antibiotics. In comparison to the rest of the world, we are out of line due to use and pricing because most other countries implement some sort of

national price controls. In the US, we primarily rely on unregulated prices and negotiated rebates by individual payers.

Three steps are involved in drug pricing:

1) <u>Manufacturer to a wholesaler</u>: Price determined by research and development costs; manufacturing costs; taxes; profits; marketing issues; competition (specifically generic products); discounts for volume and prompt payment. In looking at market position relative to competing drugs and availability of generics, when drugs are launched, they are often priced to come in right below a competing drug. Another interesting consideration is who's likely to pay for a drug. An example of this is comparing novel antipsychotic agents and antidepressants to novel oral diabetic agents. Pharmacotherapy for both is a long-term commitment and are major cost centers for health care payers. New diabetic agents, new antipsychotics, and new antidepressants were all introduced in the mid-90s. From 1994 to 1997, the number of prescriptions written for each of the three drug classes increased: oral diabetic agents by 85%, antidepressants by 40% and antipsychotics by 20%. The new drugs were brands, not generics. The payment difference between the two is that oral diabetic and antidepressants were paid by a wide range of both public and private sector payers, whereas antipsychotics were largely paid by public sector payers. The cost per prescription for antidiabetic and antidepressant drugs increased by a factor of 2, while the cost for antipsychotic drugs increased by a factor of 8!

2) <u>Wholesaler to retail pharmacy</u>: The price paid by a retail pharmacy (known as the acquisition cost) includes a wholesaler's markup, typically 2 to 4%. Third party reimbursement to the pharmacy providers has been based on Average Wholesale Price (AWP). In Wisconsin, Medicaid pays pharmacies AWP minus 13% plus a dispensing fee of $4.88 per prescription; SeniorCare pays AWP minus 8% plus the dispensing fee. On average, HMOs pay AWP minus 15% (roughly) and dispensing fees that are less.

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3) <u>Retail pharmacy to consumer</u>: What the consumer pays is dependent on the payment method. If cash, it is the acquisition cost plus markup (varies by drug). A typical retail cost may be approximately 5% above AWP, but some consumers have discount plans that may apply. Pharmacy Benefit Managers (PBMs) negotiate with manufacturers for rebates. Generic manufacturers also set their own prices, but they may set a price that's high, but less than a brand name. The spread between what reimbursement is based on (AWP) and what the pharmacy actually pays for the drug may be wide, influencing the pharmacy to purchase that particular generic drug.

Rebates: Rebates are payments from the manufacturer to PBMs and Medicaid. HMO prescribers may be given incentives to prescribe drugs that are rebated due to the formularies created by HMOs. In the private sector, rebate amounts are determined by the number of prescriptions written for a drug or moving the drug's market share during a particular period of time.

The VA Hospital: The VA gets very good prices on its drugs because it is a large purchaser and good negotiator. Manufacturers also have an interest in their drugs because many VAs are major centers for training health care professionals. An example of 2007 VA price for a month's supply of:

- Clozaril (Novartis) – AWP is $682; community pharmacy acquisition cost is $569; VA is $299

- Clozapine (Mylan generic VA uses) - AWP is $409; community pharmacy is $102; VA is $51.96
- Halperidol – AWP is $23.40; community pharmacy is $3.50; VA is $0.32
- Fluoxetine – AWP is $79.96; community pharmacy is $2.30; VA is $0.71

What can we do as a society?

- Educate providers on how the system works,
- Think critically about why the system is so complex,
- What is our role as prescribers, and
- How we can make good prescribing decisions.
- Long term – advocate for systemic changes and a stronger FDA, along with a national system for regulating drug prices as is done in most other developed countries.

Action Item: Presenters are needed for the March 5, 2008 DUR Board Meeting. Please contact Dr. Mergener with presentation topics.

V. Break

VI. Atypical Antipsychotic Intervention Follow-up (Attachment 1)

Dr. Mergener presented follow-up to the last analysis conducted of the atypical antipsychotic intervention which looked at pre and post costs in the intervention group and resulted in cost savings across the board. The same methodology was used with the cohort group (cohort being the second 100 by rank) and included all psychotropic drug categories. This resulted in a 4.2% decrease in all drug costs in the intervention group vs. a 13.1% increase in the cohort group over that same period of time. People were dropped out of the cohort group if they had just gotten the low dose drug in the month reviewed or if newly eligible. With respect to criterion selection, both groups are identical. Analysis was not done on demographics.

The "do no harm" report looked at services associated with psychiatric diagnoses in four service categories: emergency room visits, inpatient admissions, outpatient office visits, and crisis services. This report was done in two ways: looking at percentages and at recipient eligibility months to make the denominators equal. Most results are not statistically significant except for inpatient admissions. Same analysis done for the intervention group and in all cases, services dropped pre to post with some statistically significant drops in utilization of services. The cohort group is utilizing more services than the intervention group. It appears those patients in the intervention group are having better outcomes post intervention. Robert Breslow suggested doing a future analysis of these same groups over a longer period of time (12 or 18 months) to see if changes made now are due to the short timeframe that was analyzed or if improvements would indeed continue over a longer period of time. Dr. Mergener responded we could keep running this forward. The next step is to develop the same intervention for the next 100 in the cohort group.

Action Item: Next step is for Dr. Mergener to look at next 100 in cohort group.

VII. Retrospective DUR (Attachment 2)

Dr. Mergener presented an analysis of retrospective DUR alerts for October and November 2007 showing the monthly average of how many alerts hit for selected mental health criteria. The first criteria are looking at benzodiazepines with a history of drug abuse which resulted in a

fair number of alerts. The combination of cyclic antidepressants and amphetamines also had a considerable number of alerts. The remaining categories are looking at effective doses for benzodiazepines as a separate category. Dr. Mergener recommends turning these criteria on, running them, and doing reviews on a select number of cases. Does the criterion look at prescriber patterns? These retrospective criteria look at individual patient profiles and identifies cases for review. A look at prescribing patterns could be done as a targeted intervention. If diagnosis data is available for the patient, it is extracted. The low, medium, and high columns on the report represent risk score. These are essentially "cutoffs" and are factors of whether or not the offending drugs are being prescribed by the same prescriber, whether they are filled at the same pharmacy, or whether it is more likely to see problems due to age (e.g. the elderly get extra points). Dr. Mergener typically looks at the high risk scores. The Board concurred to go with Dr. Mergener's recommendation to turn these criteria on and run them.

Action Item: Dr. Mergener will turn on the criteria and run for a selected number of cases and review those.

Non-Agenda Item: Anticholinergic Burden (Attachment 3)

The response rate for the anticholinergic burden intervention is 41.5% out of 123 that received the intervention. Prescribers judged usefulness as above neutral. Of the total responders, 41% are going to review the patient's drug regimen, 20% have already explored other options, 8% have modified regimens, 12% made no change, 15% responded the benefits outweigh the risks, 6% report patient refuses to get off medication, and 26% say they are going to monitor the therapy. This is just a preliminary report as there is not yet enough data to run pre and post. One finding is there is just one doctor prescribing all of the anticholinergic drugs. The next report will include the pre/post evaluation.

VIII. Re-Evaluation of Migraine Prophylaxis (Attachment 4)

The migraine prophylaxis criteria established by HID was run, but produced no hits. Dr. Mergener contacted HID regarding this and the criterion is basically set up for a 30-day supply any time back 180 days. It is possible the look-back period is too long. Attachment 4 contains HID's suggestions for tweaking the criteria in order to run it again.

Action Item: Dr. Mergener will discuss tweaking the criteria with HID and turn it on again to see if we get alerts.

Non-Agenda Item: DHCF Organizational Changes

Mr. Vavra addressed the organizational changes occurring at DHCF. The Division of Health Care Financing is being renamed to the Division of Health Care Access and Accountability and the configuration of bureaus is changing. The Disability Determination and Enrollment bureaus remain the same with Program Integrity expanding. Mr. Vavra's bureau changes to Benefit Management. He will still have primary responsibility for pharmacy, but people throughout the Division who contribute to Pharmacy will be consolidated into one section. There will no longer be a Managed Care Bureau, but Mr. Vavra will have a section devoted to Managed Care Compliance and Contract Oversight. Financial Management will now be a separate bureau. Ultimately, after the new interchange system is up, the existing Operations

Bureau that currently oversees EDS and the contract will be broken out to the relative service areas.

Robert Breslow questioned if it is possible for the information (e.g. meeting minutes) from other committees be shared with the DUR Board. Dr. Mergener suggested sending the members the web page links to where meeting minutes are posted. Mr. Vavra also suggested sending reminders for when meetings are scheduled and meeting agendas/minutes are posted. Carrie Gray mentioned that the Mental Health Drug Advisors web page is currently being worked on and will soon be available. Mr. La Dien asked if Dr. Mergener's work is shared with other organizations. There is no direct mechanism for dissemination, but it is shared from time to time at meetings of like individuals throughout the country. Nancy Ranum questioned what the mechanism is for identifying new DUR Board members and how many will be added. It is not known at this time what the plan is for soliciting members. Mr. Helgerson will most likely solicit nominations from the plans, but recommendations are welcome. Dr. Mergener indicated we do solicit from the State Medical Society, School of Pharmacy, and the Nurses Society for potential nominees.

IX. Adjournment

The meeting adjourned at 3:45 p.m.