MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, December 3, 2014
1:00 pm to 4:00 pm
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members
Present:
Michael Brown, PharmD
Robert Breslow, RPh
Paul Cesarz, RPh
Daniel Erickson, MD
Robert Factor, MD
Michael Ochowski, RPh
Lora Wiggins, MD
Absent:
Ward Brown, MD
Jake Olson, PharmD

HP Staff
Joseph Barus, RN
Chally Clegg
Teai Czajka
Tom Olson, PharmD
Monica Yeazel, RPh

DHS Staff
Rachel Currans-Henry
Lynn Radmer, RPh
Lisa Reese
Tiffany Reilly
Kimberly Smithers
Lisa Sardesai (SOP Intern)

Welcome and Introductions:
Rachel Currans-Henry called the meeting to order at 1:05 pm, with thanks to the Board. Introductions were made. Joe Barus is a newly hired nurse consultant who will initially assist with Hepatitis C drug management. Lisa Sardesai is an intern from the school of Pharmacy on rotation with the Department. A Quorum of members was present.

Review of the Agenda and Board Materials and Approval of Minutes-September 10, 2014 meeting:
Rachel Currans-Henry walked through the agenda as printed and the Board packets. Members had received minutes and RDUR Quarterly Report via email and had the opportunity to review prior to this meeting. Rachel noted no objections to changing the order of the agenda to have the PDL Report immediately follow the approval of the Minutes. Rachel briefly reviewed highlights of the Minutes from the last meeting.

Motion to approve minutes as printed made by Lora Wiggins and seconded by Paul Cesarz. Motion passed unanimously.

PDL Meeting Report:
Kimberly Smithers presented highlights of the meeting held November 5, 2014. The PA Committee made recommendations for preferred drugs in 38 previously reviewed classes and one new class (Glucocorticoids, Oral) submitted for consideration. Most of the recommendations were approved and are in various stages of implementation. Of particular interest was a discussion of the Cytokine and CAM Antagonists class, where public, industry and committee members weighed in. It was noted that Medicaid's Preferred Drug List is more open than many commercial insurance formularies and according to American College of Rheumatology guidelines, biologics are not a first line treatment in most cases. Also highlighted was a discussion of Otic Antibiotics, specifically that Ciprodex will be moved back to non-preferred status as of January 1, 2015. It was decided that, requiring a PA for specific diagnoses (e.g. tympanoplasty) would not be overly burdensome. The PDL approach of utilizing generics and maintaining a Brand Medically Necessary (BMN) list is still helping to control costs. High cost specialty drugs will likely present cost increases and require attentive management.

Prospective DUR: Update on Previously Reviewed Alerts:
Lynn Radmer reviewed Prospective DUR Alert activity by sharing graphs covering the 2011 through 2013 timeframe. A glossary was included to define the terminology used. This provided a high-level snapshot of claim and Prospective DUR activity. A few key observations:

- There was a decrease in the number and percent of claims denied with a DUR Alert, and an increase in the number and percent of claims paid with a DUR Alert.

- The decrease of total paid claims is likely due to the implementation of the three month supply policy during this same timeframe.
- Claims paid with a DUR Alert likely increased due to informational Alerts for High Dose being turned on during this timeframe. We expect this to even out in the future as the High Dose Alert has now been turned off.
- Claims that denied without a DUR Alert were denied for some reason other than Prospective DUR, i.e., eligibility. The DUR Board influences claims paid or denied with a DUR Alert.
- The decline in the number of claims denied with a DUR Alert is likely due to the reduction of Prospective DUR Alerts monitored. There are currently seven active Alerts compared to twelve in the past. This reduction also resulted in a reduction of "noise" and "alert fatigue" experienced by pharmacy providers.
- The question of whether Prospective DUR Alerts are "working" or effective in changing behavior does not have a clear answer. Various alerts are still in transition and some changes have not been implemented yet. e.g., in 2015 there will be changes implemented to the Early Refill (ER) and Three Month Supply (NS) alerts. Once all changes are implemented, we can obtain a better baseline, and do more analysis.
- A potential future goal may be to collect and analyze responses the pharmacy enters to process a Prospective DUR Alert for adjudication. We could analyze the appropriateness of responses and edit against responses not deemed appropriate to allow the claim to pay.

OBRA 90 and DUR Overview:

Lynn reviewed the basics requirements of the Omnibus Reconciliation Act of 1990 as they apply to the DUR Board. The pertinent Code of Federal Regulations (CFR) was included in the Board's packets. Highlights included:

- State DUR Boards are required by Federal law, and must perform three essential functions: Prospective DUR, Retrospective DUR, and educational activities and interventions.
- The Board must be composed of physicians, pharmacists and other prescribers who are actively practicing and licensed.
- Federal law requires every state to provide for a review of drug therapy before each prescription is filled or delivered to a member. States must also establish standards for member counseling as well as provide pharmacies with instructions on how to comply with Prospective DUR requirements.
- For Prospective DUR in Wisconsin Medicaid, alerts are transmitted electronically to pharmacy providers through the point-of-sale (POS) claims processing system, and most may be overridden by the pharmacist. All Alerts are approved by the DUR Board and are maintained using clinical drug tables provided by First DataBank (FDB). Using FDB ensures that Alerts are updated and maintained without manual or ad hoc intervention which could be operationally difficult and resource intensive. There are seven Prospective DUR Alerts actively functioning in Wisconsin. Prospective DUR Alerts send information to pharmacy providers before a drug is dispensed.
- Federal law requires states to provide an ongoing periodic examination of claims data after prescriptions have been dispensed to a member. These Retrospective DUR reviews must occur no less often than quarterly. The Retrospective DUR program must be provided as part of the Medicaid Management information system (MMIS).
- In Wisconsin, Health Information Designs (HID) is responsible for performing the Retrospective DUR reviews, under a sub-contract with Hewlett Packard (HP), the State's Fiscal Agent. HID receives data from HP monthly that contains up to and including the previous month's paid pharmacy claims and any available diagnosis data for each member. Every month, 1000 members are selected for review of their complete prescription profile. A series of algorithms are applied utilizing DUR Board-approved criteria to look for potential drug therapy issues. Additionally, another 400 members are selected for review using criteria specifically for detection of misuse and/or abuse of controlled substances. These members may become locked-in to one pharmacy provider and one prescriber if their prescription misuse and/or abuse pattern does not change over time. The Retrospective DUR program sends information to prescribers based on prescriptions that have been dispensed.
- Federal law requires states to provide for ongoing educational and outreach programs. These programs should aim to improve prescribing and dispensing practices by educating providers on common drug therapy problems.
- In Wisconsin, we have used newsletters, Focused RDUR Interventions and Targeted Interventions to fulfill this requirement.
- Most recent newsletters were May 2012: Antipsychotic Drug Use in Children and Adolescents and August 2010: Monitoring Opioid Utilization. Historically, newsletters have been infrequent as they are resource intensive. They can take up to 2 years to complete.

- Most recent Focused RDUR reviews (a subset of the 1000 regular reviews) were March 2014: Appropriate use of triazolam and June 2013: Appropriate Use of Stimulants. A focused RDUR review takes a specific subset of the already approved RDUR criteria and looks at all the members who have that drug therapy issue. It is quick, can be implemented in 1 to 2 months and can be replicated and measured after 3 to 6 months. Feedback from Focused RDUR reviews can be used to alter existing criteria or point to another area to examine.
- Most recent Targeted Interventions were November and December 2013: High Dose Stimulants for Children 14 Years Old and Younger, November 2012: High Dose Citalopram and Simvastatin, March 2011 Pediatric Anti-Psychotic Use, and July 2010: Lack of ACE and ARB use in Members with Type 2 Diabetes. Targeted Interventions are highly customizable and can address a variety of issues.

National Governors' Association Academy/ PDMP Update:

Rachel informed the Board about this Academy which involves multiple stakeholders who, working together, develop a plan for a State over a period of one year to help address the growing nationwide issue of prescription drug abuse. In Wisconsin, the Department of Safety and Professional Services (DSPS) is leading the effort. They are starting to form workgroups to address specific areas. Their mission statement is "To reduce prescription drug misuse, abuse and diversion through a patient/ family centered, data-driven collaborative multidisciplinary approach that ensures adequate access for those with medical needs." There has been recent legislative action to increase access to treatment, and tools to fight heroin use, with more legislation to come to address underlying issues related to Substance Use Disorders.

- Seven workgroups:
  1. Legislative action.
  2. Criminal enforcement.
  3. Data collection, what is collected and how is it accessed.
  4. Determining if WI has adequate access to substance abuse treatment programs.
  5. Informing WI healthcare providers about the seriousness of prescription drug abuse epidemic and the resources available to them.
  6. Educating prescribers how to use PDMP data effectively and draft best practices.
  7. Proposing to create a separate PDMP Governing Board.
- Kickoff meeting will occur in January and workgroups will work concurrently throughout the year to come up with a proposal.
- National Association of Medicaid Directors' Report was shared with the group prior to the meeting via email. They commissioned a report titled "State Medicaid Interventions for Preventing Prescription Drug Abuse and Overdose".
- This will be a state and national focus in 2015 regarding prescription drug abuse, and our goal is to have the DUR Board align their work with this larger effort.

Denise Webb, the state's Director of Health Information Technology, expanded on Rachel's introduction. Wisconsin is involved in the second round of states that has undertaken the NGA workgroups endeavor which is expected to develop a strategic plan for reducing Prescription Drug Abuse. See http:/www.nga.org/cms/Rx

- Each state will determine how to operationalize these strategic priorities. There is no nationalized consensus plan at this point.
- There is a drive to make a national landscape to link Health Information Exchanges and PDMP sites across state lines. This has been identified as a useful tool.
- E-prescribing of controlled substances will potentially be required by 2017. This will involve 3 systems being certified: the e-prescribing system that sends the prescription, the pharmacy software receiving the prescription, and the health information exchange that the provider accesses.

Denise went on to discuss the PDMP. While 49 states have legislation to allow the PDMP, only 41 states have operational systems. Ideally, the system works to prevent problems on the front end if prescribers and pharmacies would use the system, and if using it was easily incorporated within the existing workflow. However, the Office of the Inspector General (OIG) does have some access on the back end for fraud detection and the potential to influence the lock-in program.

- In 2015, Medicaid can reduce payments if offices do not have certified Electronic Health Records (EHRs) and are meaningful users of such systems. Right now 85% of prescribers have adopted and are using certified EHRs and have access to e-prescribing.
- The Wisconsin Statewide Health Information Network (WISHIN) operates a health information exchange which shares clinical data from EHRs through a virtual community health record. Now a pilot project has tried to link the PDMP into WISHIN. It can be done, and in fact, national inter-operability is possible. However, it needs legislative changes and financial resources in addition to technical configuration, and, importantly, provider buy-in.
- Medicaid is doing a pilot with WISHIN to send MA prescription data to WISHIN.
- For Medicaid, OIG is working to get access to the PDMP on a routine basis, electronically (not on a case-by-case basis). OIG will be having a meeting with DSPS attorneys and DHS attorneys to work out a way to access data.
- Health Information Designs is the vendor for Lock-In as well as the PDMP. DSPS would like to pursue a way to allow data flow directly from PDMP to Lock-In. Stakeholders would like to access and share data with border state PDMPs.
- Questions for 2015: How do we use the data we get access to? Do we need to change lock-in criteria? How do we inform prescribers and encourage PDMP use?

Potential Topics for Future DUR:

- Rachel led a discussion of where to go from here in 2015. The sedatives /hypnotics focused RDUR is set aside for now. The Board was invited to send ideas.
- Lynn spoke about a follow-up letter going out to the prescribers who participated in the Stimulants Targeted Intervention. That intervention got a lot of good feedback data. That data will be brought to the March 2015 Board meeting and may also lend itself to a newsletter.
- Board suggestions included
    1. Another opioid newsletter
    2. Promoting more use of Lock-In referrals
    3. Trying to find which members are driving total costs of care
    4. Working toward optimization of medications at discharge
    5. Buprenorphine guidelines
    6. Morphine equivalent dosing
    7. Methadone and Suboxone, including dosing limits on Suboxone.
- Look for some small thing we can do based on policy initiatives that come out of the Governor's Academy.
- Balance how to use limited resources to accomplish the best meaningful health outcomes.
- Manage high cost drugs by pursuing common purchasing with other state entities.

Adjournment: Meeting adjourned at 4:00pm. Upcoming meetings are: Wednesdays March 4, June 3, September 2, and December 2, 2015.

Guests: Mike Healy (Gilead), Robert Heinsu (Purdue), Nick Boyer (Otsuka)