MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, September 11, 2024
1:00 p.m. to 4:00 p.m.
Virtual meeting via Zoom

DUR Board Members Present:
Jake Olson, PharmD
Michael Ochowski, RPh
Jeff Huebner, MD
Brook Passolt, MD
Robert Factor, MD
Jordan Wulz, PharmD

Absent:
Paul Cesarz, RPh
Ward Brown, MD

Gainwell Staff Present:
Tom Olson, PharmD
Kara Varney
Ashley Beaderstadt
Chally Clegg
Willie Wilberg, PharmD
Katie Counts, PharmD
Travis Copeland, MD

DHS Staff Present:
Kim Wohler
Lynn Radmer, RPh
Tiffany Reilly
Darla Stachowiak
Russell Dunkel, DDS
Susan Seibert
Nicole Schneider

Welcome and Introductions
Kim Wohler called the meeting to order at 1:03 p.m. and began with a welcome and thanks 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.

Review of the Agenda and Board Materials and Approval of June 2024 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 March minutes were briefly reviewed and approved with an initial motion from **Mike Ochowski** and a second from **Jake Olson**. The motion passed unanimously.

Quarterly DUR Reports
Lynn began by reviewing member enrollment. The enrolled member count does continue to be higher than in the past but continues to decrease due to the end of the public health emergency. Overall decrease of about 310,000 members since Q1 2003, our highest enrollment point. Lynn pointed out that claim volume has started trending downward after leveling off for several quarters. Lynn then reviewed the quarterly reports with the Board beginning with the multiple drug classes report. Lynn 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. Of the six members identified in the last quarter, three members received an alert, one member was locked in, and two members were currently suppressed due to a recent lock-in letter being sent.

Lynn then presented graphs for the percentage of adults and children on stimulant medications. 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 on stimulants has been down since the public health emergency but seems stable. For the first time in a few years the percentage of children in the entire Medicaid population on stimulants is above the percentage of adults. The percentage of adults on stimulants within the adult population has been increasing the past few quarters.

A comparison graph of children and adults within the total Medicaid population shows that the greatest increase of members receiving stimulants since 2020 has been within the adult population. There is a recent dip though in the number of adults on stimulants in the last three quarters.

Both the children and adult membership numbers decreased in the past three quarters, with a steeper decrease in the number of adults.

Additional DUR alert trend graphs were presented. Lynn noted that most of the alerts are stable. There has been a slight

downward trend in the patient age alert that may possibly be due to the seasonal use of cough/cold products. A trend graph for high cumulative dose was also presented. Lynn discussed the high cumulative dose alert, and the changes associated to the October 2021 implementation of a soft alert in place of the informational alert. Pharmacists are required to respond to the soft alert and alert trends have shifted because of this change. Lynn noted that the percentage of overrides has remained stable.

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 50% of paid claims are paid with no DUR alerts. She also noted that less than 1% of paid claims have multiple DUR alerts. Slides were presented to review claim count changes. Claim volume continues to decrease. Lynn noted that the changing member population and policy changes could be a component of the decreasing claims volume. Decrease in claims of about 500,000 from a year ago.

Trend graphs for average morphine milligram equivalents (MMEs) per member per day and members utilizing buprenorphine from 2021 - 2024 were also included. The average MME remains below 45 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 three quarters. While this may be a result of enrollment changes, the trend was further investigated with the introduction of a new graph to reveal that when looking at the percentage of members on buprenorphine, there is still an increase in use over time. Naloxone usage remains steady with a slight increase in use for the last quarter.

Two graphs were presented to the Board looking at naloxone member trends from 2021-2024. Naloxone usage has continued to be steady with a slight increase during the most recent quarter. 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 second graph with data on the use of naloxone in non-opioid use members revealed that the majority of these members are on buprenorphine. Lynn presented a slide which was introduced at the December 2022 meeting, tracking naloxone fills for members at 90 MME or greater. From Q3 2021 to Q2 2024, we saw a reduction in members with 90 MME as well as an increase in naloxone dispensed. The average percentage of members with 90 MME or greater and receiving a naloxone fill in Q2 2024 was 11%, with the average fill rate being 11%. Additionally, a second slide tracking naloxone fills for members receiving buprenorphine for opioid use disorder (OUD). From Q3 2021 to Q1 2024, we saw an increase in members with OUD as well as an increase in naloxone dispensed. There was a slight, but not significant, decrease from Q1 2024 to Q2 2024 in both members and naloxone fills. The average percentage of members with OUD and receiving a naloxone fill in Q2 2024 was 8%, with the average fill rate being 10%. It was noted that the slight drop in members and naloxone fills may be a result of the enrollment changes.

Opioid Script Limit

Lynn began by presenting the average MME by override graph. There was a slight increase in the average MME by override over the last quarter that was a result of two members on higher MMEs due to cancer pain. There is a process in place to review high MME outlier claims. The top five claims are reviewed each quarter for possible intervention. The percent 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

Lynn began by reminding the Board that for this quarterly intervention, the methodology has recently changed as of Q1 2022. The new methodology identifies members who are concurrently receiving at least one medication from each of the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants, and are receiving 45 or more actual days' supply of each of the four medications during 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 refresh of all identified members is done in the second quarter each year. For Q2 2024, there were 156 members on all four drugs, 80 members with 45 or more total days' supply, and 80 members were selected for intervention. Lynn reminded the Board that all of these numbers can be located and will be updated quarterly on the continuing intervention spreadsheet.

High MME Discussion

Lynn began the discussion by reminding the Board of the two interventions utilized to address high MME concerns, one is the prospective claims edit and the other is the retrospective intervention that currently identifies members on 150 MME or more per day for a prescriber letter. She indicated to the Board that a change will be made to the retrospective criteria that will identify members on 120 MME or more per day beginning in October 2024. She went on to review the timeline of changes to the MME parameters of this criteria since the original implementation in 2019 and shared the updated alert message in the letter that reflects the change to 120 MME per day. She also reminded that Board that data for this intervention is available on the Continuing Interventions spreadsheet.

Polypharmacy of Sedating Medications in Children

Dr. Copeland began by reminding the Board of the screening criteria and drug groups included in the parameters of this intervention. He noted that screening criteria identifies children ages 0-18 who have been on agents from three or more of the drug groups for at least 80% of the time in a 180-day period are considered for a letter. He provided an overview of this intervention noting the move from provider outreach calls only to sending provider letters, including changes to the drug groups utilized in the identification of members. He also discussed the past mailings and how providers were identified to receive letters. Dr. Copland went on to discuss the letter and case review plan for the data from 2024. Data from Q1 and Q2 of 2024 will be used to send provider letters in September 2024. The data from Q3 and Q4 of 2024 will be used to identify new prescribers for a possible letter and to evaluate member cases for potential outreach.

Next, Dr. Copland reviewed several slides that provided an overview of letter counts to date and number of member/prescriber combinations for the intervention, as well as the member counts by age group for the recent intervention letters. This was followed by slides that gave a review over time of the top drugs identified by age group for this intervention. Notably, the top drugs remained mostly the same over time and over age groups, with changes only to the ranking of the top drugs within certain age groups. He went on to discuss the evaluation process for identifying higher risk members that may qualify for a provider outreach call. Providers of the members with the highest number of ongoing sedating medications were contacted for an outreach call. This set of provider outreach calls included five prescribers. All the providers were receptive to the call and appreciated the opportunity to discuss complex cases with another mental health practitioner. These prescribers likely represent a set of prescribers that could benefit from ongoing consultation. The key points noted from the outreach calls are that generally multiple medications are prescribed by a single provider and that many of the overlapping medications are being used in transition as opposed to being used long-term. Additionally, these calls revealed that use of multiple antipsychotics in children is a potential issue to monitor.

Quantity Limits of Short-Acting Opioids Discussion

Lynn began the discussion by reminding the Board that short-acting opioid quantity limits were last discussed at the December 2019 meeting. As a result of SUPPORT Act requirements, changes to the drugs included in the claims edit were made and implements in 2020. The current cumulative quantity limit is 360 units. She reviewed with the Board the medications included in the edit and functionality of the edit. The edit currently allows for a cumulative 360 units in a rolling 30-day time frame. Lynn reminded the Board that the quantity limit can be overridden in certain situations by the DAPO call center. Based on reviews of quantity limit thresholds utilized in other states, the cumulative quantity limit for short-acting opioids will be decreased to 240 units in 2025. Approximately 150 members may be impacted by this change. Board discussion included the time frame for notifying prescribers of this change and concern for possible needed dose changes. The Board was reminded that the DAPO call center can provide one-time overrides in special situations and that system changes will be discussed internally to try to align dates appropriately.

Late Refill/Underutilization Discussion

Lynn began the discussion by reminding the Board of the prospective DUR late refill alert presentation at the June 2024 meeting. She reviewed how the prospective DUR alert is triggered and the therapeutic categories included in the alert. She shared a slide that shows the top drugs triggering the late refill alert include certain antidepressants and leukotriene receptor antagonists. She noted that based on this slide, Acentra performed a focused underutilization intervention for the following medications: citalopram, escitalopram, fluoxetine, sertraline, duloxetine, vilazodone, vortioxetine and montelukast. Katie went on to give an overview of the criteria parameters to identify a member for an underutilization letter for the antidepressants and for montelukast used in asthma patients. She also shared the volume of members identified for review, the number of members reviewed, and the number of members selected for intervention. It was noted for the antidepressants there was an average of 78% intervention rate, and 86% intervention rate for montelukast. Rationale as to why a member may not have been selected for intervention was discussed, including fill dates and dose or medication changes. Katie concluded by informing the Board that further underutilization reviews will be done in

September to another subset of antidepressants. She also indicated that the full group of drugs from July and September will be reviewed in January 2025 and analyzed for presentation to the Board later in 2025. Board discussion included a suggestion to review additional asthma controller medications. This will be discussed by the DUR core team for further action.

Benzodiazepine Intervention Discussions
Lynn reminded the Board that there are several ongoing benzodiazepine interventions. Two of these interventions are more recent and were discussed at the June 2024 meeting. These interventions include the long-term use of high dose benzodiazepines and concurrent use of buprenorphine and benzodiazepines. Lynn provided an overview of the parameters for inclusion for each intervention. The long-term use of high dose benzodiazepine letters were previously mailed in March of 2023 and March of 202. A third set will be mailed in September 2024. The data for this intervention will be run every six months, and an impact analysis will be presented in March of 2025. The concurrent use of buprenorphine and benzodiazepine interventions is new and will have the initial mailing to providers completed in September 2024. A second set of letters will be considered in three to six months. Lynn shared the outgoing provider letter for this intervention with the Board. Both interventions will be tracked on the Continuous Intervention spreadsheet provided to the Board at each meeting.

Continuing Interventions Discussion
Katie began the discussion by reminding the Board of the monthly retrospective drug utilization review volume and how those reviews are selected. She indicated that the reviews are based on pharmacist selected interventions and DUR core team scheduled interventions. She went on to discuss how an intervention may become a scheduled intervention, including legislative requirements, DUR Board action, and areas of clinical concern noted by the DUR core team. The Board was then reminded that there are two classes of interventions, focused and targeted. Focused interventions are those processed systematically by Acentra and are generally less complex due to system limitations. Targeted interventions are a result of data complied by Gainwell Technologies and can be more complex due to data manipulation capabilities.

Katie continued with an overview of all of the scheduled interventions. There are two sets of focused monthly interventions. One set that addresses high MME values, naloxone use, and several antipsychotic concerns are a result of requirements from the SUPPORT Act. The second set of monthly interventions that address multiple utilization concerns are a result of past DUR Board action addressing use of duplicate gabapentinoids, utilization of butalbital, utilization of narcotic cough syrups, and utilization concerns in sickle cell disease. The two quarterly focused interventions, buprenorphine/opioid use and duplicate anticholinergic use are a result of DUR Board action. There are multiple targeted interventions that have different schedules. The quarterly interventions are a result of utilization concerns and include review of multiple CNS depressants, multiple drug class use, and combination opioid/benzodiazepine use. The remaining targeted interventions are currently under review for the appropriate letter frequency. These interventions are also a result of utilization concerns and include review of concurrent use of buprenorphine and benzodiazepines, concurrent use of sedating medications in children, long term use of high dose benzodiazepines, and opioid prescribing by dental providers.

CMS Annual Report & PDMP Survey
Lynn began by reminding the Board that CMS requires each Medicaid program to submit an annual report detailing the DUR activity for the federal fiscal year. Each year this report is due June 30th. A link to the CMS website for viewing annual reports was provided. A review of the report for the Board members is being done to aid in understanding how the decisions of the DUR Board and the annual CMS report are related. She went on to review the sections contained in the annual report and indicated that the “Fraud, Waste and Abuse” section is the largest and most detailed section of the report. This section addresses many of the topics discussed at today’s meeting, including, but limited to, MME requirements, opioid quantity limits, and opioid claim limits. An additional reporting item included in the “Fraud, Waste, and Abuse” section is information on the Prescription Drug Monitoring Program (PDMP). Lynn provided background information on this section indicating that the SUPPORT Act of 2018 required all providers to check the PDMP prior to prescribing controlled substance medications for a Medicaid member. Additionally, it is required that the Medicaid programs report compliance with this regulation to CMS as part of the annual report. To fulfill this requirement, DHS contracted with Mercer to administer a survey regarding PDMP use by Wisconsin Medicaid enrolled prescribers The survey was used to determine the self-reported frequency that prescribers check the PDMP prior to prescribing controlled substances. Provider inclusion parameters were based on controlled substance prescribing data from October 2022 to

September 2023. A statistically significant number of prescribers were selected for inclusion in the survey. Opportunities to complete the survey online or via fax were provided for a four-week period in February 2024. The survey results indicate that prescribers are checking the PDMP prior to writing a prescription for a controlled substance 83% of the time.

Adjournment

Mike Ochowski motioned to adjourn the meeting. The meeting adjourned at 4:00 p.m. Upcoming meetings are on the following Wednesdays: December 4, 2024, March 5, 2025, and September 10, 2025.

Guests: John Bullard, Alexion; Kimberly Eggert; Gary Parenteau, Dexcom; Robert Robey, Indivior; Akesha Coleman, Johnson & Johnson; Kelly Ruhland, Lilly; Laura Etheridge, SK Life Science; Shannon Meece, Pfizer; Sherry Betthauser, Jazz Pharma; Robyn Bruining, Sanofi; Kellie Murry, Neurelis; Kelly Hamilton, Takeda; Danielle Brolsma, Teva.