MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE MAY 17, 2012 MEETING

DUR Board Members:	Present	Absent
Gera Bynum, R.Ph.	✓	
Edgar Donahoe, M.D. **(Co-Chair)**		✓
Laura Gray, M.D.		✓
Antoinette M. Hubble, M.D.	✓	
Cherise McIntosh, Pharm.D.		✓
Lee Merritt, R.Ph.		✓
Paul Read, Pharm.D.	✓	
Mark Reed, M.D. **(Chair)**	✓	
Dennis Smith, R.Ph.	✓	
Cynthia Undesser, M.D.	✓	
Vicky Veazey, R.Ph.		✓
Total	**6**	**5**

Also Present:

DOM Staff:
Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; Terri Kirby, R.Ph., DOM Clinical Pharmacist; Otis Washington, Jr. Program Integrity; Tammy Bailey, RN, BSN, Program Integrity; Tamiko Young, Program Integrity.

MS-DUR Staff:
Kyle Null, Pharm.D., Clinical Director; Ben Banahan, Ph.D., Project Director; Thomas Chapman, M.S., Analyst.

ACS Staff:
Leslie Leon, Pharm.D.

Goold Health Systems (GHS) Staff:
Chad Bissell, Pharm.D., Account Manager; James Clair, CEO

Visitors:
John Harris, Abbott; Steve Curry, Meda Pharmaceuticals; Callista Goheen, Medimmune; Pat Harvey, Sunovion; Lee Ann Griffin, Pfizer.

Call to Order:
Dr. Mark Reed, Chairman of the Board, called the meeting to order at 2:00 pm. Dr. Reed noted there were not enough members present for a quorum, so no official business could be conducted. Minutes from the February 2012 meeting will be tabled for approval at the next meeting.

Resource Utilization Review:
Dr. Null provided an overview of Synagis® utilization during the 2011-2012 RSV season. Dr. Null noted this last season ran from October 2011 to March 2012, based on epidemiologic data from the Center for

Disease Control (CDC). Each beneficiary was eligible for a total of 5 injections, based on the 2009 Redbook guidelines. Dr. Null mentioned the cost per beneficiary being somewhat higher this year. This appears to be related to (1) an increase in "second season" babies being treated, (2) an increase in number of doses received per beneficiary, and (3) five high risk babies over the age of 24 months being treated.

Dr. Null noted that no major shifts or trends were found in resource utilization report.

Pharmacy Program Update:
Ms. Hardwick passed out a list summarizing the PDL changes that will go into effect in July 2012, and noted the list is also posted on the DOM website. Ms. Hardwick also pointed out a provider education sheet (posted on the MS-DUR and DOM websites) related to the proton pump inhibitor PDL changes and their use in PEG tubes.

Ms. Clark noted that effective July 1, 2012 all injectable antipsychotics will be reimbursed only through medical benefits and no longer through point-of-sale (POS), except in the case of long term care residents. Ms. Clark mentioned that when office administered drugs first came to market many of the community mental health centers were not able to bill on a medical claim for these drugs, so in order to allow for access, injectable antipsychotics were able to be billed through POS. Ms. Clark continued by stating that the DOM has been systematically moving any office-administered drug to be billed through the medical claims. Ms. Clark noted that billing these drugs through the POS would take up a "mark" for the month, reducing the total number of drugs the beneficiary could receive for the month. She noted that this will be included in the next DOM Provider Bulletin.

Ms. Hardwick informed the DUR Board that effective July 1, 2012 DOM will begin accepting ICD-9 codes through pharmacy POS for drugs that currently have clinical edits for diagnosis. This will be a pilot program in 2012 in preparation for required implementation of ICD-9/10 codes being required on prescription claims. Ms. Clark noted that this effort will prevent providers from having to submit paper prior authorizations on the drugs included in the pilot program. She noted that this information will be included in the next DOM Provider Bulletin.

Ms. Clark discussed safety issues raised by the FDA on long-term use of PPIs, specifically the increased incidence of *C. difficile* and fractures. Currently, DOM has a quantity limit but no duration limit on PPIs. Several other states have already adopted duration of use limits and DOM will be working on development and implementation of duration of use limits for PPIs. She asked for input from Board members with respect to criteria that might be appropriate for new guidelines. Data will be provided for a discussion at the next Board meeting and if the analysis indicates significant problems DOM will take action before then.

Ms. Clark informed the Board that there has been a lot of activity from the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS) related to antipsychotic use among foster children. A state plan is being developed and may be implemented shortly. Ms. Clark noted that the DOM DUR program will be responsible for monitoring the use of antipsychotics and other mental health drugs in this population. Dr. Undesser noted that many of these children appear to be enrolled in MS-CAN. Ms. Clark pointed out that DOM cannot be responsible for monitoring use if the children are enrolled in MS-CAN, but the DUR Board would focus on DOM beneficiaries. Ms. Clark mentioned that she will be attending another meeting with the state Department of Human Services (DHS) later in the week as part of the ongoing development of the state

plan. Ms. Clark informed the Board that Dr. Sabeen Javaid, a psychiatry resident at UMC studying with Dr. Undesser, has been provided data by DOM and MS-DUR to support a presentation on this issue at Grand Rounds in June.

New Business:

Special analysis projects:

Review of Sedative Hypnotic Therapy Switches

Dr. Null noted that the review of sedative hypnotic switches came from the prior authorization (PA) team. The PA team started seeing a large number of PAs after a rejection in SmartPA for sedative hypnotics based on the current criteria for implementing the quantity limits on these drugs. MS-DUR analysis indicated that many of these rejections are the result of dose changes and therapy changes causes new prescription fills to exceed the current quantity limit criteria. MS-DUR is seeking Board input on potential changes in the current algorithm to eliminate this problem. MS-DUR is recommending a change that would allow one therapy change (dose change or drug change) in a 12-month period. Ms. Bynum suggested that it might be necessary to allow one dose change and one drug change per year. Dr. Paul Read reported that he sees changes such as these fairly frequently. Dr. Mark Reed noted that proposal was reasonable. The DUR Board members present concurred that implementing this change had merit; however, an official motion would be sought at the next meeting due to lack of a quorum.

Dr. Mark Reed inquired about the possibility of achieving a quorum through electronic means, so that action would not have to be suspended due to lack of a physical quorum. Ms. Clark replied that the attorney general's office currently does not allow for public meetings to be held in an electronic forum. Dr. Mark Reed noted that it might be a good idea to address this idea. Dr. Undesser noted that "Go to Meeting" will be considered a billable patient contact beginning on July 1, 2012 so it would make sense that other official business may be conducted in such a way. Ms. Clark noted she would inquire about it.

Pharmacy Lock-in Program Recommendations for Program Integrity

Ms. Clark explained how DOM has various bureaus that handle different components of the overall program. Program Integrity (PI) is responsible for auditing and assuring compliance with DOM policies and procedures. Staff from the PI introduced themselves to the DUR Board. Ms. Clark noted that nationally, there is a big push to better monitor and manage controlled substance use. PI has initiated a beneficiary lock-in program and would welcome reports from DUR and the Pharmacy Bureau for potential diversion problems that need to be further evaluated for possible enrollment in the lock-in program. Ms. Clark requested that PI speak to the DUR Board. Otis Washington thanked the DUR Board for having them as guests at the meeting and acknowledged their desire to have MS-DUR recommend beneficiaries to the pharmacy lock-in program, based on discussion with the DUR Board and working directly with PI to identify appropriate criteria based on retrospective claims review by MS-DUR.

Dr. Null noted that one of the recommendations for addressing drug diversion from CMS is to look across programs, including Medicare Part D data, which can be made available for program purposes. PI noted that would be a good approach. Dr. Null reviewed the analysis by MS-DUR on unique pharmacies and unique prescribers being used by beneficiaries for narcotic analgesics. Input was sought from the Board on what drugs should be included in this analysis, as well as a "cut point" for the number of unique prescribers and pharmacies to identify potentially inappropriate activities by beneficiaries. Ms. Clark noted that the NPI number may be associated with a clinic and not necessarily with an individual prescriber. Dr. Null concurred with Ms. Clark, but also noted when filling a prescription, especially for a controlled substance, that he would personally check that the NPI matched a prescriber and not a clinic. Dr. Banahan noted that one limitation of a claims-based approach is that DUR is only able to identify the

prescribers and pharmacies based on the NPI numbers submitted on the claims. Dr. Banahan also pointed out that the number of unique pharmacies and prescribers was selected to reduce the possibility of false positives and to provide PI with a manageable list of beneficiaries to review. Dr. Banahan noted the need for a set of criteria that would identify outlier beneficiaries that would warrant a manual review by PI.

Dr. Mark Reed suggested that it might be helpful to eliminate post-surgery care for 10-days to 2 weeks. PI indicated that having a diagnosis in the reports would be helpful. Mr. Smith posited that the muscle relaxants would closely match the analgesics. Dr. Null noted that in a separate analysis not reported to the Board the distribution of unique prescribers/pharmacies only changed slightly when including/excluding other drug categories. Dr. Null also noted that this analysis was limited to narcotic analgesics, but that it would be expanded to other categories for the PI reports. Ms. Bynum noted that this analysis only includes Medicaid FFS claims and not claims paid for by cash. Dr. Banahan asked the staff from PI what would be most useful for them to receive from MS-DUR. Mr. Washington replied that the current discussion and report included some of the same elements they had been discussing internally. Mr. Washington asked that drugs such as [benzodiazepines] be included. PI noted that it would be helpful to include Medicare Part D data from these beneficiaries in such an analysis, as well as diagnosis codes from the medical claims. Dr. Null noted that MS-DUR does not have access to the prescription drug monitoring program (PDMP) database to allow for combining it with the Medicaid claims data, but that Medicare Part D data for Mississippi residents may be available for use in such a way. Ms. Clark noted that combining Medicaid data with Medicare Part D data would be helpful. Ms. Clark noted that dual-eligibles taking benzodiazepines are currently paid for by Medicaid, even though benzodiazepines are not typically covered in the Medicaid fee-for-service program.

Dr. Null asked for comments on using findings from these routine drug abuse analyses for coordination of care or other provider outreach. Dr. Undesser commented that getting letters notifying prescribers and pharmacies about patients getting multiple prescriptions from multiple prescribers would be helpful to the providers. Dr. Paul Read commented on the current quantity limits associated with some of the drugs of abuse and noted that it was a very helpful, preventative measure already in place. Ms. Bynum noted that the presence of multiple prescribers was not as concerning as multiple pharmacies or the combination multiple prescribers and multiple pharmacies. Dr. Mark Reed proposed an alternative method of identifying beneficiaries by taking a distribution-based approach and targeting the outliers, rather than the count-based approach. Dr. Banahan noted the data are highly positively skewed, with most individuals using 1 or 2 prescriber/pharmacies. Items identified as possible additional criteria for analysis include variation in zip codes for pharmacies, possible identification of multiple stores for the same chain, and diagnosis codes such as surgeries. PI noted that beneficiaries remain in the pharmacy lock-in program for one (1) year, which entails receiving all medications from one pharmacy and visiting only one general practitioner. Specialist referrals are allowed from the primary general practitioner. Ms. Clark indicated DOM and MS-DUR will conduct the initial analysis, provide a report to PI, and report on results of this initiative at the next Board meeting.

Utilization of Provigil/Nuvigil

Dr. Null noted that Tennessee had a spike in Provigil/Nuvigil use a year ago and reported this at the American Drug Utilization Review Society (ADURS) annual meeting. The issue was examined by MS-DUR to determine if Mississippi had a similar trend. The clinical criteria for Mississippi is very similar to Tennessee's, with the exception that Tennessee requires failure of a continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP). The analysis indicated that Mississippi's total

utilization appears to be trending downward. As a result, MS-DUR does not recommend any changes at this time because of this trend and the existing criteria that are in place.

Valturna (aliskiren/valsartan) Withdrawal
Valturna is being pulled from the market for use in diabetics patients as of July 20, 2012. MS-DUR ran an analysis and determined that there will be minimal impact in the Medicaid program and concluded that no additional action is required.

Exceptions Monitoring
Review and action tabled until a quorum is reached at next meeting.

Other Business
Ms. Clark reported on changes in CMS requirements that penalize state Medicaid programs for newer line extensions of existing products, e.g., XR or CR versions of products. The final ruling has not been released, but DOM has already begun addressing this issue with changes that will be made in the PDL list effective July 2012. Ms. Clark introduced Chad Bissell from Goold Health Systems (GHS), the PDL vendor for Mississippi Medicaid, and requested that he comment on the new PDL list and line extension ruling from CMS. Dr. Bissell reported that the changes regarding rebates and line extensions will be retroactive to January 2010, requiring back-payment to CMS for line-extensions paid since that time. Gould Health Systems is working with DOM to minimize the impact of the new regulations.

Mr. Smith asked for clarification on why some products were recently removed from the 90-day list. Ms. Clark reported that the legislature defines the prescription limits for Medicaid. DOM is allowed to have a 90-day list for a limited number of medications. A recent review by an outside consultant recommended that the change with lovastatin be made because more effective drugs in the same category have been made available generically since the 90-day list was last updated. Mr. Smith indicated that use of the 90-day list was a great way to help patients manage the prescription limits. Dr. Null indicated that the new 90-day list was mailed out to the top 300-plus prescribers using the products on the list as part of the education surrounding this change.

Next Meeting Information:
Dr. Reed announced next meeting date is August 16, 2012 at 2:00 P.M. and thanked everyone for making the effort to attend the DUR Board meeting in order to have a quorum. The meeting adjourned at 3:17 P.M.

Submitted,
Evidence-Based DUR Initiative, MS-DUR