MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE NOVEMBER 15, 2012 MEETING

DUR Board Members:	Present	Absent
Allison Bell, Pharm.D.	✓	
Logan Davis, Pharm.D.	✓	
Edgar Donahoe, M.D.	✓	
Lee Greer, M.D.		✓
Antoinette M. Hubble, M.D.	✓	
Sarah Ishee, Pharm.D.	✓	
Cherise McIntosh, Pharm.D.	✓	
Mark Reed, M.D. **(Chair)**	✓	
Sue Simmons, M.D.	✓	
Dennis Smith, R.Ph.	✓	
Cynthia Undesser, M.D.	✓	
Vicky Veazey, R.Ph.	✓	
Total	**11**	**1**

Also Present:

DOM Staff:
Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; David Dzielak, DOM Executive Director

MS-DUR Staff:
Kyle Null, Pharm.D., Ph.D., Clinical Director; Nancy Jones, Project Coordinator, Mary Morgan Alexander, UM Student on DUR rotation.

ACS Staff:
Leslie Leon, Pharm.D.

Visitors:
Kim Elston, Novo Nordisk; Robert Pearce, Teva; Callista Goheen, MedImmune; Jeff Cameron, Dyax Corp.; Brian Berhow, Sunovion; Phil Hecht, Abbott; Joey Giamfortone, Reckitt Benckiser.

Call to Order:
Dr. Mark Reed, Chairman of the Board, called the meeting to order at 2:02 pm. Dr. Reed welcomed the new Board members and asked for introductions by all of the Board members. Dr. Reed then asked members for additions or corrections to minutes. Dr. Undesser made a motion to approve the minutes from the August 2012 meeting. Motion seconded by Ms. Veazey and was unanimously approved.

Resource Utilization Review:
Dr. Null reviewed the resource utilization report and oriented the new Board members to the reporting format. Dr. Null briefly reviewed the hemostatic drug class following a question by Mr. Smith about fluctuation in monthly prescription fills. Dr. Null explained the fluctuation was primarily driven by a variation in the number of claims per patient. Since hemostatics dosing is a function of the patient's

body weight and blood levels, it is not uncommon to see multiple distinct claims for the same drug. Additionally, the monthly prescription benefit limit for these patients is relaxed because of their EPSTD status. Dr. Donahoe asked how children were put into that category. Ms. Hardwick and Dr. Leon explained how the EPSTD functioned as it relates to SmartPA and prescription benefits. Ms. Hardwick further discussed the EPSTD benefit to the Board, explaining that SmartPA would allow for prescriptions beyond the monthly benefit limit for children with qualifying chronic diagnoses. Dr. Null continued the resource utilization review by pointing out the increased use of amphetamines and adrenals, namely budesonide and prednisolone, due to expected seasonal trends. Dr. Null concluded by stating that the drug utilization was fairly consistent with notable exceptions being preferred drug list (PDL) status changes and seasonal fluctuations. There were no further comments or questions about the resource utilization report.

Pharmacy Program Update:
Ms. Hardwick began the Medicaid update by asking the Board members to sign conflict of interest and confidentiality forms, as well as travel reimbursement forms. Ms. Hardwick reviewed two changes which become effective January 1, 2013. First, the new PDL will be in effect and will be revised once a year instead of twice yearly. Second, Medicare Part D changes to benzodiazepine and barbiturate coverage will affect Medicaid beneficiaries who are dually eligible for Part D. CMS announced that Medicare Part D plans will have to cover benzodiazepines as well as barbiturates for beneficiaries with diagnoses of epilepsy, cancer, and chronic mental health disorders. Ms. Hardwick mentioned that the Board would need to elect a co-chair at the February DUR Board meeting.

Dr. Null reviewed the DUR process and Board responsibilities for the new Board members. Dr. Null highlighted the main duties of the DUR Board: oversight for the Division of Medicaid, evaluating practitioner prescribing patterns based on clinical guidelines, developing exceptions monitoring criteria, recommending educational interventions, and reviewing policy issues. Dr. Null mentioned that some CMS initiatives, including a move towards measuring quality in the Medicaid program, would be the focus of the upcoming year. Dr. Null further explained the exceptions monitoring process and how educational interventions relate to exceptions monitoring. Dr. Null also reviewed some typical special project examples for the new Board members. He mentioned that there has also been an increased focus on issues relating to fraud, abuse, and misuse of drugs that the Board will continue to review in the coming year. Dr. Null closed by discussing the current focus of the education program related to giving Medicaid providers program information helpful to their practice, but the future focus would shift to include more educational outreach related to quality initiatives in the Medicaid program driven from exceptions monitoring.

New Business:
Special analysis projects:
Revatio Use in Children and Adolescents
Dr. Null reviewed the FDA safety labeling change related to a dose-dependent increase in mortality in children and adolescents using Revatio. MS-DUR reviewed the prescription claims data and found that only 7 beneficiaries under the age of 18 were on the drug. Because of the nature of this FDA safety labeling change, no action was being requested from the Board and the DOM was working to implement an age edit to deny Revatio at the point-of-sale (POS).

Monitoring Suboptimal Respiratory Control
At the October P&T meeting, the issue was raised as to how short-acting beta2 agonist rescue inhalers were being used in the Mississippi Medicaid population. The P&T asked that the DUR Board review this

issue. Dr. Null discussed the importance of finding an operational definition that could be used to identify "inappropriate" use of rescue inhalers in administrative claims data. He noted that after a review of the literature, the Pharmacy Quality Alliance (PQA) had proposed to the National Quality Forum (NQF) quality measures related to suboptimal asthma control with and without appropriate controller therapy. Dr. Null reviewed the two measures and noted that adopting a nationally recognized framework to assess this issue would be fruitful since there is already supporting evidence in the literature of its use. He explained that the measures would be aggregated at the health plan (i.e., Medicaid) level and that targeted provider education could be utilized to help address possible suboptimal asthma control. He also mentioned that this process is similar to the way exceptions monitoring are handled. Dr. Null mentioned that quality-based initiatives would be an increasing focus of the DUR Board's activities over the coming year. Dr. Null said that MS-DUR is seeking a directive from the DUR Board to review the asthma quality indicators as described for the February DUR Board meeting. Dr. Ishee raised the issue of possibly denying short acting beta2 at the POS based on days supply or the number of canisters dispensed over a period of time. Dr. Null informed the Board that Medicaid currently allows up to two canisters per month on the basis that one could be used at school and one at home. Dr. Donahoe mentioned Medicaid had tried intervention with asthma patients in the past and that patients go through periods of exacerbation, where they will need access to rescue inhalers. Dr. Donahoe mentioned that prescribers do not have access to information on how the patient is filling the medications. The Board discussed the availability of inhalers with and without counters. Dr. Donahoe said it would be a good idea to send out reminders based on clinical guidelines about the importance of controller medications to encourage providers to prescribe controller therapy when appropriate. He also mentioned that it would be helpful to let providers know that it is being monitored by DOM as a quality measure.

Dr. Simmons asked about the providing patient education information on how to use the inhaler properly. Mr. Smith asked about existing retrospective criteria on how to identify frequent rescue inhaler use and concurred that monitoring asthma control based on the outlined criteria is something MS-DUR should do. The benefit vs. harm of implementing a "hard edit" was discussed and the general consensus of the Board was that such an edit may not be in the best interest of the patient experiencing an exacerbation and that it may be better handled through DUR initiatives.

Dr. Davis asked about the availability of benchmarks set by PQA or other groups. Dr. Null replied that part of the process would be to establish a benchmark on these quality indicators and to educate providers that the goal should be to improve the quality measure relative to the benchmark. He continued that reaching "100%" of a quality measure is not necessarily the goal, because such a goal would ignore individual treatment decisions, possible contraindications, etc. Dr. Null asked the Board if there was agreement on the definitions of suboptimal respiratory control quality measures. The Board members agreed.

Dr. Bell asked if there would be any value in having MS-DUR to evaluate ER visits and hospital stays associated with the exceptions identified by the quality measure. Dr. Hubble raised some issues of identifying ER visits and hospital stays. Dr. Donahoe commented on inclusion criteria considerations for inpatient and outpatient hospitalizations. Dr. Davis asked about the value of evaluating plan cost in addition to ER visits and hospital stays, emphasizing the value of having cost savings data driven from moving the quality measure through benefit control measures and education. Mr. Smith asked about the feasibility of partnering with a pharmaceutical company to provide unbranded educational material to physician offices and patients, since the primary educational outreach from MS-DUR was directly to prescribers and not ordinarily focused on specific patient care issues (e.g., appropriate inhaler

technique). Dr. Null described the educational materials provided to providers and noted that they were generally about the Medicaid prescription drug benefit and specific therapeutic considerations derived from exceptions monitoring.

Provider Outreach for Potential Control Substance Abuse/Misuse
Dr. Null reviewed the history of DUR Board activity related to monitoring controlled substance abuse and misuse. He noted that this topic had been discussed over several quarterly meetings. At previous meetings, the DUR Board had provided feedback on criteria used to identify potential cases of controlled substance abuse/misuse to send to Medicaid's Program Integrity (PI) for further review for lock-in. The current criteria for PI review are based on beneficiaries who receive select controlled substance prescriptions from a combination of 7 unique prescribers and pharmacies. Dr. Null mentioned that the Board had previously discussed lowering the "cut point" for the purpose of educational outreach to providers. MS-DUR is seeking a formal directive from the DUR Board to start a prescriber educational outreach letter campaign about patients receiving select controlled substances from 4 unique pharmacies and prescribers in a 90 day period. Dr. Ishee noted that the data being reviewed was only Medicaid fee-for-service claims and did not include managed care or cash paying claims. Dr. Null confirmed that and also noted that some prescribers have access to the prescription drug monitoring program (PDMP). He further noted that this initiative would be a supplement to the PDMP program and not a replacement. Dr. Simmons said that she remembered receiving a letter from the DUR about a patient who was shopping pharmacies for Darvocet. Dr. Davis asked if Medicaid could put a comment on the third-party return message about the patient being monitored by PI. Dr. Leon replied that Xerox and Medicaid are working on edits to allow ease of use for the pharmacists. Dr. Null noted that the current criteria exclude beneficiaries with a diagnosis of cancer. Some discussion ensued regarding whether to exclude beneficiaries with a diagnosis of sickle cell; however, the general consensus was to leave sickle cell beneficiaries in the criteria. Dr. Ishee noted that letters sent based on these criteria would be valuable for pharmacies. Dr. Donahoe motioned to accept the 4 prescriber / 4 pharmacies the limit for provider letters and to notify PDMP to review patient use of drugs when MS-DUR identifies beneficiaries with high potential for abuse. Dr. Reed seconded the motion and all voted in favor.

Update on Suboxone SmartPA Implementation
Ms. Hardwick reviewed the history of the Suboxone protocol and noted that the implementation of the new electronic protocol is going well. Ms. Hardwick noted that the primary purpose of moving the Suboxone criteria from manual prior authorization (PA) to electronic was to reduce the administrative burden on the PA unit and provider's offices. She noted that MS-DUR and DOM is continuously monitoring and reviewing the claims data to identify potential problems with the criteria. Ms. Hardwick mentioned that the electronic process has eased PA process, has shortened the time that a patient waited to receive a prescription as compared to the manual PA, and has not adversely affected patient access to Suboxone based on the data provided in the report. Ms. Hardwick also noted that she has had very positive response from prescribers and pharmacies regarding the new protocol. Ms. Hardwick discussed the work to try and step patients off of the drug by using a cumulative 24 month limit for Suboxone and dosage titration limits. Dr. Null concluded by stating that the manual PA process conversion to electronic has gone very well and has not adversely affected patient access based on the data presented in the report.

Exceptions Monitoring
Dr. Null explained exceptions letters from MS-DUR and what they look like. Dr. Null also mentioned that future exceptions monitoring would include criteria based on the quality measures being reviewed,

citing the asthma measures as an example. Recommendations were taken as a block vote. The motion was made by Dr. Reed and seconded by Mr. Smith. The motion was unanimously approved.

Other Business
Ms. Hardwick noted Ms. Clark could not be at the DUR Board meeting because she was in deposition and Terri Kirby was absent due to some required training. Ms. Hardwick also acknowledged that Dr. Dzielak, the Division of Medicaid Executive Director, was present for a portion of the meeting.

Next Meeting Information:
Dr. Reed announced next meeting date is February 21, 2013 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 3:10 P.M.

Submitted,
Evidence-Based DUR Initiative, MS-DUR