MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE August 6, 2015 MEETING

DUR Board Members:	Nov 2013	Feb 2014	May 2014	Aug 2014	Nov 2014	Feb 2015	May 2015	Aug 2015
Allison Bell, Pharm.D.**	✓	✓	✓	✓		✓	✓	(✓)
James R. "Beau" Cox, Pharm.D.	✓	✓		✓		✓	✓	✓
Logan Davis, Pharm.D.	✓	✓		✓	✓	✓	✓	✓
Antoinette M. Hubble, M.D.		✓	✓	✓	✓	✓	✓	✓
Cherise McIntosh, Pharm.D.	✓	✓	✓	✓	✓	✓	✓	
Jason Parham, M.D.	✓	✓	✓	✓	✓	✓	✓	✓
Bobby Proctor, M.D.		✓		✓	✓		✓	✓
Sue Simmons, M.D.**		✓	✓	✓		✓	✓	(✓)
Dennis Smith, R.Ph. (Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Cynthia Undesser, M.D.		✓	✓	✓		✓	✓	✓
TOTAL PRESENT	**7**	**12**	**7**	**11**	**6**	**9**	**10**	**7(9)**

** Board members nominated for reappointment but not yet approved. These members participated in discussions but were not included in official voting.

Also Present:

DOM Staff:
Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Terri Kirby, R.Ph., DOM Clinical Pharmacist; Cindy Noble, Pharm.D., MPH, DOM DUR Coordinator; Sue Reno, DOM Program Integrity; Andrea McNeal, DOM Program Integrity

MS-DUR Staff:
Ben Banahan, Ph.D., MS-DUR Project Director; Shannon Hardwick, R.Ph., MS-DUR Clinical Director; Mr. Sujith Ramachandran, MS-DUR Graduate Assistant, Mr. Kaustuv Bhattaharya, MS-DUR Graduate Assistant

Xerox Staff:
Ashleigh Holman, Pharm.D.

Coordinated Care Organization Staff:
Conor Smith, R.Ph., Magnolia

Visitors:
John Young, Ph.D., University of Mississippi Department of Psychology; Phil Hecht, Abbvie; Janet Ricks, D.O., Jackson; David Large, Supernus; Mark Stephens, Pfizer; Blake Bell, Capital Resources; John Kirby, Sanofi; Jeff Knappen, Allergan; Doug Wood, ViiV Healthcare; Brian Berhow, Sunovion; Roger Grotzinger, Bristol-Myers Squibb; Greg Martin, Bristol-Myers Squibb; Calista Goheen, AstraZeneca; Tim Hambacher, Otsuka; Cody Tawater, UM Pharmacy Student

Call to Order:
Mr. Dennis Smith, Chairman of the Board, called the meeting to order at 2:02 pm.

Old Business:
Dr. Hubble noted a correction needed to be made about the next meeting date in the minutes. The minutes were approved unanimously with this correction.

Resource Utilization Review:
Dr. Banahan explained the temporary gaps in the claims data have been due to transitioning to new data file formats which are for the files obtained monthly from Xerox. Programming adjustments have been made. DOM has provided to MS-DUR on Aug 6, 2015 the historical files in the new format. The new data installation will be completed in the next two weeks and resource reports will be finalized and reported to DOM. MS-DUR is also preparing a new format for the resource reports that will be incorporated for review into the next DUR board packet. Mr. Smith asked if the reports on top categories could be modified to include more information about the drugs included in the therapeutic categories reported. Ms. Clark suggested that MS-DUR explore how the therapeutic categories reported in the resource report could be aligned with the categories in the Universal Preferred Drug List (UPDL). Dr. Banahan highlighted the shift in Medicaid beneficiaries from the fee-for-service (FFS) program to the Coordinated Care Organizations (CCOs). This shift should be complete for the quarter reported in the next board packet.

Pharmacy Program Update:
Ms. Clark explained the status of reappointments to board and introduced Dr. Cindy Noble, as the new DUR Coordinator. DUR Board members were asked to complete the annual confidentiality statement in their packets and review materials that have been included in the DOM Preferred Drug List Changes effective August 1, 2015. Ms. Clark noted that due to several labelers terminating their participation in the national and Mississippi rebate programs their products will no longer be reimbursable by the DOM. DOM and Xerox have completed work on a searchable NDC list for OTC products reimbursed by Medicaid. This list is available on the Xerox Envision Web Portal.

Feedback and Discussion from the Board

The board had no new issues for feedback or discussion.

New Business:

Synagis Utilization Summary – 2014-2015 Season

Dr. Banahan provided an overview of analysis completed by MS-DUR. Results were consistent with what was projected based on the DOM's adoption of the American Academy of Pediatrics (AAP) 2014 "Updated Guidance for Palivizumab Prophylaxis Among Infants and Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection.". Overall, Medicaid had a 39% reduction in total payments for Synagis in the 2014-15 season as compared to the 2013-14 season. The number of beneficiaries treated decreased 42%, with a 39% decrease in expenditures and the amount paid per beneficiary increased by 4.5%. MS-DUR is working on an analysis of how the APP's guidance change may have affected the rate of hospital admissions for RSV related pneumonia and bronchitis in this patient population. Significant limitations with the use of only administrative claims data in being able to identify the specific target population affected by the change were noted. DUR Board member Dr. Davis indicated that his company had some data that might be helpful and he would be glad to work with MS-DUR on this analysis if it would be beneficial.

Patterns of Prescription Use of Triazolam

Ms. Hardwick presented results on a triazolam analysis MS_DUR conducted following a request made during the May 2015 P&T Committee meeting and post discussion. Prescriptions for triazolam should be written for short-term use (7 to 10 days) and it should not be prescribed in quantities exceeding a 1-month supply according to indications and usage guidance in the prescribing information. The failure of insomnia to remit after 7 to 10 days of treatment might indicate the presence of underlying psychiatric and/or medical illness conditions that should be evaluated. MS-DUR evaluated the number of beneficiaries having a prescription for triazolam, the length of therapy, and the number and type of triazolam prescribers.

Results from the analysis found a total of 320 unique beneficiaries identified as having filled a prescription for triazolam in 2014. Approximately 7% had prescriptions from more than 1 prescriber and approximately 14% had 3 or more prescription fills for the product. Overall, the average days supply/prescription fill was 8.6 days with an average 31.6 total days supply/beneficiary. However, these averages varied significantly among the three pharmacy programs (FFS and CCOs). Triazolam was prescribed by a wide variety of prescriber types. Family Practice, Internal Medicine, Family Practice Nurse Practitioners and Mental Health Nurse Practitioners prescribing patterns indicated use of triazolam on a long-term basis. Currently the UPDL has triazolam listed as a preferred product with the brand product as non-preferred.

After discussion, Dr. Parham moved that the DUR Board approve the recommendations provided by MS-DUR. Dr. Undesser seconded the motion and the following recommendations were passed unanimously:

1. The DUR Board recommends to the P&T Committee that triazolam be changed to non-preferred status unless supplemental contract requirements exist to prevent this change.
2. MS-DUR initiate an educational intervention on appropriate triazolam prescribing with clinicians who exceed the following treatment guidelines:
    a. Beneficiaries having more than two triazolam fills in a year that exceed a total of 30 days supply
    b. Beneficiaries having two or more prescriptions for >15 days supply
3. DOM implement the following clinical edits to assure more appropriate use of triazolam:
    a. Quantity limit of 10 day supply per month
    b. Cumulative quantity limit of 60 days within a 365 day period

Ms. Clark noted that there were no contract requirements that would prevent the change in status for triazolam.

Methadone Use in Mississippi Medicaid Program

MS-DUR's results were presented from the analyses on methadone utilization performed in response to the May 2015 DUR Board request related to safety concerns noted in the April 2015 Pew Charitable Trust report. Safety issues related to the use of methadone and criticism of state Medicaid programs for having methadone listed as a preferred drug were a focus of the report In 2014, 154 unique beneficiaries were treated with methadone with a total of 1,341 prescription claims. Based on figures for the first quarter of 2015 utilization is projected to increase by as much as 45% this year. Results by

prescriber type, prescriber location, and pharmacy location indicate that problems exist with respect to heavy use of methadone by some providers and perhaps an overuse of methadone for pain treatment. Methadone is currently a preferred drug on the UPDL. After considerable discussion about the safety problems associated with the use of methadone for pain management, Dr. Davis moved that the recommendations below from MS-DUR be accepted. Dr. Parham seconded the motion and the board unanimously voted approval of the following recommendations:

1. The DUR Board requests that the P&T Committee consider changing methadone from preferred to non-preferred status due to beneficiary safety concerns.
2. The DUR Board requests MS-DUR continue to perform analysis to monitor changes in methadone use and implement educational interventions.

Ms. Clark suggested that if the status of methadone on the UPDL was changed, MS-DUR should notify current prescribers of the change in status. The board suggested that an educational intervention focus on the safety concerns and that the DOM and MS-DUR work with an expert in substance abuse and/or pain management to develop the educational information.

Quality of Care Assurance in Use of Antipsychotics in Children

Dr. Banahan reminded the board of the background information provided in the May 2015 the Office of the Inspector General (OIG) of the Department of Health and Human Services report titled, " Second-generation Antipsychotic Drug Use Among Medicaid Enrolled Children: Quality of Care Concerns." MS-DUR reviewed related Texas and Florida utilization guidances developed by Florida and Texas Medicaid program and identified quality measures related to the criteria areas reviewed by the OIG. The intent of the review and discussion presented is to provide the board an overview Mississippi Medicaid's performance on these criteria, current DUR efforts to address these criteria, and to gather input from the board on additional DUR efforts that the DOM should consider to assure proper use of antipsychotics in the population.

Appropriate dosage: The Florida and HEDIS guidelines for appropriate dosing were presented and discussed. After considerable discussion, Dr. Undesser pointed out that if maximum dosage edits were implemented, the most likely prior authorization (PA) criteria would be that a psychiatric consult was required for other provider types to use higher doses. Consensus of the board was that with the severe shortage of child psychiatrists available in the state and participating in Medicaid, such a PA requirement would impose a significant burden on providers and could limit beneficiaries from obtaining needed care. After further discussion, the board did not recommend that changes be made on dosage limits but did recommend that MS-DUR further explore the extent of the problem.

Duration of use: The OIG report advised to plan for dose reduction and discontinuation of treatment with antipsychotics over time. It was noted that the Florida Medicaid guidance includes a recommendation that after 6-9 months of stable therapy, dose reduction and potential titration to discontinuation should begin. During discussion, it was noted that not all practitioners agree with this treatment approach. After discussion, it was the consensus of the board that it was not practical for the DOM DUR to monitor this since it would require medical record review

Indication for use: It was reported that several organizations have considered quality measures related to appropriate diagnoses being recorded for the use of antipsychotics but this has not emerged as a formal quality measure. It was the consensus of the board that it was not practical to address this

criteria through DUR as that medical record review would be required to accurately assess an appropriate indication for use.

Monitoring: It was noted that in the OIG study, medical chart audits were conducted to evaluate whether appropriate monitoring took place. The HEDIS measure: "the percentage of children having a follow-up visit with the prescriber within 30 days of initiating therapy with an antipsychotic medication" is one method for DUR to evaluate monitoring. MS-DUR analysis of this HEDIS measure found that only 14% of children starting antipsychotics had follow-up visits within 30 days. The board discussed the supply problem of child psychiatrists to perform appropriate monitoring and evaluation and concluded that no prospective actions could be used in the POS system to assure appropriate monitoring. Since an appropriate evaluation of monitoring would require chart audits, no recommendations for further actions were made by the board.

Polypharmacy: The OIG report indicated that all guidelines recommend that monotherapy be tried before multiple drugs and that there needed to be clear documentation of the rationale for using multiple antipsychotics with children. MS-DUR conducted an analysis of performance on the HEDIS measure for the percentage of children on antipsychotic medications who were taking two or more antipsychotics concomitantly. At the February 2015 DUR Board Meeting, recommendations were approved for (1) a prospective electronic clinical edit to force a manual prior authorization for any beneficiary that would be taking 3 or more antipsychotics concurrently and (2) manual review criteria be developed which would require a recommendation by a psychiatrist for any beneficiary to receive 3 or more antipsychotics concurrently. It was noted that it would be difficult to be more restrictive due to the limited number of child psychiatrists in the state.

Side effects: The OIG report described the importance of monitoring for side effects and indicated that evaluating this criteria would require medical chart audit. There are two HEDIS measures that address conducting metabolic monitoring: 1) when treatment with an antipsychotic is initiated for children and 2) while children are on treatment with an antipsychotic. During the February 2015 DUR Board Meeting performance on one of these measures was reported and recommendations were approved that MS-DUR should initiate an educational intervention program regarding the importance of metabolic monitoring. This initiative is currently underway and performance on the measure will be reevaluated in several months. MS. Clark stated that DOM is awaiting finalization of the Affordable Care Act (ACA) Federal Upper Limits (FUL) for multiple source drugs rule. This rule gives states the option of using NADAC or National Average Drug Acquisition costs rather than FUL for multisource generic drugs. When this occurs, DOM hopes to make changes in pharmacy reimbursement. DOM is supportive of reimbursement for pharmacists' cognitive services. One such example could be metabolic testing with concurrent use of atypical antipsychotics. The board was very supportive of possible pharmacy reimbursement for metabolic testing. During discussion it was pointed out that it would not be practical to put a hard edit in place to force metabolic monitoring due to interruptions in therapy that could result. It was the consensus of the board that this criteria was being addressed as well as could be as part of DUR.

Patient age: The OIG report emphasized the need for age limits for the use of antipsychotics. In July 2013, MS-DUR reported to the board on DOM's performance on a Pharmacy Quality Alliance measure regarding use of antipsychotics in children under age five years. Mississippi is close to the national average on this measure. It was noted that DOM currently has electronic PA criteria in place for product specific age limits and a manual PA is required for waiver of these age limits. It was the consensus of the board that DOM was adequately addressing the age criteria at this time through prospective DUR.

The board did not recommend any new DUR actions that needed to be undertaken at this time. During discussion, Dr. Undesser noted that DOM did need to continue exploring the disparities in utilization rates that exist between foster and non-foster children and evaluating whether these differences are appropriate or represent disparities in quality of care. Dr. Parham noted that many of the issues that need to be monitored or evaluated concerning antipsychotic use among children cannot be managed through DUR criteria as it requires greater involvement of psychiatrists and there is a critical shortage of child psychiatrists to perform evaluations and consultations. He suggested that if the DOM wanted to go much further with monitoring this issue it might be necessary to hire a child psychiatrist to work at or consult with at the DOM.

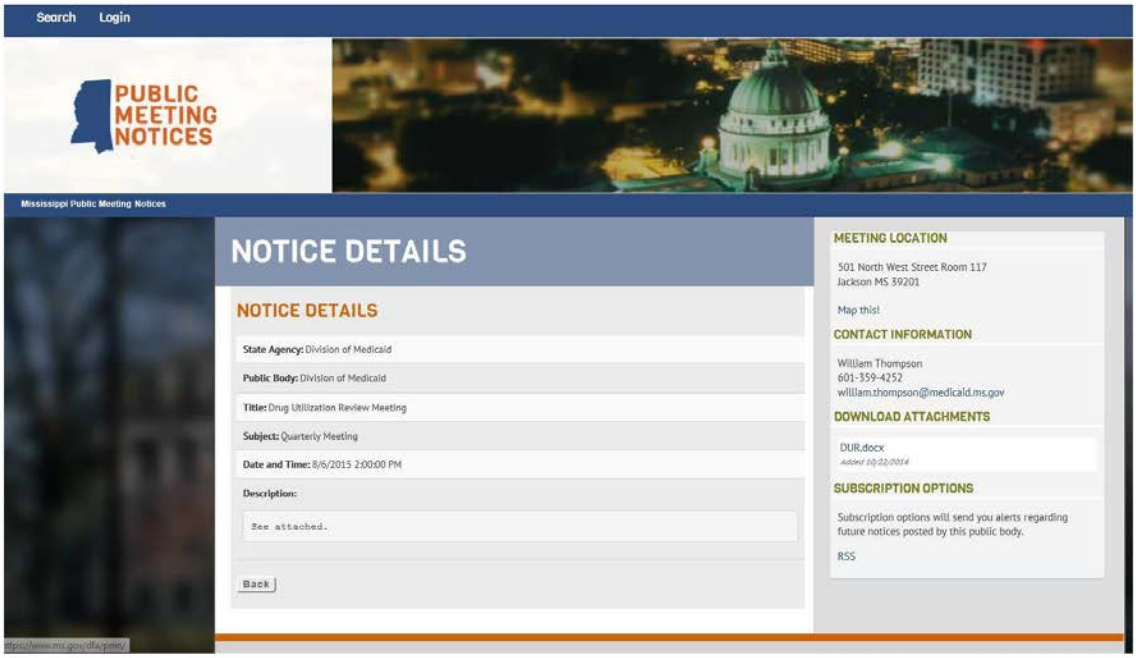
Other Business

Ms. Clark told the board about activities currently underway to integrate medical and pharmacy to address issues in pain management and to coordinate this activity with the CCOs. Medical licensure has pain management practice registration. DOM will continue to work with CCOs and integrating medical and pharmacy to better manage pain management treatment and appropriate use of lock-in programs.

Next Meeting Information:

Mr. Smith announced that the next meeting date is November 5, 2015 at 2:00p.m. He thanked everyone for making the effort to attend the DUR Board meeting and having such good discussion. The meeting adjourned at 3:44 pm.

Submitted,
Evidence-Based DUR Initiative, MS-DUR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