Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
Drug Management Review Advisory Board Meeting
August 12, 2010

Meeting Minutes

Voting Members in attendance:
Kimberly Eakle, MD, Patricia Freeman, Renee Girdler, MD, Kathy Hager, DNP, APRN, FNBC, CDE, Samuel Matheny, MD, Gerald Payne, B.S., BHS, PA-C, Clay Rhodes, PharmD, MBA, BCPS, Kathryn Schat, MD, Sarah Smith, PharmD, Glenn Stark, RPh, Carmel Wallace, Jr, MD
Non-Voting Members in attendance:
Thomas Badgett, MD, Chief Medical Officer
Steve Davis, MD
Non-members present from Magellan Medicaid Administration:
Alan Daniels, RPh, Account Manager, Tina Hawkins, PharmD, Clinical Program Manager, Kasie Purvis, Provider Services Manager
Non-members present from Department for Medicaid Services:
Lee Barnard, Assistant Director, Division of Medical Mgmt, Trista Chapman, Contract Monitor

I. Welcome and Introductions of Committee Members

- A quorum was present.

II. Approval of May 13, 2010 Meeting Minutes

- Motion to approve the minutes as presented by Magellan Medicaid Administration.
    - **Passed; 11 in favor, 0 against**

III. Chair/Vice Chair Elections

- Nominations were taken prior to the meeting, and a ballot was presented to Board members.
- Motion to close nomination
    - **Passed; 11 in favor, 0 against**
- Dr. Carmel Wallace, Jr. was elected Chair.
- Dr. Patricia Freeman was elected Vice-Chair.

IV. Speaker Policy

- Motion to allow speakers 3 minutes for presentations to the Board with 2 minutes for questions and answers; a total of 5 minutes.
    - **Passed; 11 in favor, 0 against**

V. <u>Old Business (Slide Presentation is embedded for reference) [slides 5-41]</u>

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Presentation Public C

A. Utilization of Suboxone®/Subutex® (slides 5-8)

- On slide 5, it was noted that prior authorization (PA) was placed on these products 2/1/2010. Despite the addition of PA criteria the claim counts and distinct utilizers remained relatively flat.
- On slide 6, drug costs actually increased slightly after PA criteria were added.
- On slide 7, unique prescribers declined quite a bit in February, likely due to the need for a UIN number, then increased to baseline rapidly.
- Slide 8, contains medical costs pre- and post-Suboxone® for recipients that received Suboxone® for at least 90 days during October 2009 – June 2010.
  - Medical expenditures doubled post-Suboxone®.
  - Is it possible that this increased medical utilization is due to recipients seeking acute care which will eventually decline resulting in a positive return on investment due to the prevention of chronic illnesses?
- It was noted that no hard edits were in place to prevent recipients from using other opioids with Suboxone®; however, there is a soft message to the dispensing pharmacy. It is planned to implement a therapeutic duplication edit. A RetroDUR activity has been done to notify prescribers of this issue.
- Part of the PA process is to ask providers to perform drug screens; however, we do not require proof that drug screens were done.
- The Board asked for the number of patients currently on Suboxone®/Subutex® and another opioid. It was noted that this data may not be exact because patients often do relapse.
- The PA criteria for Suboxone®/Subutex® are:
  - Prescriber must have a UIN number
  - Agree to query KASPER monthly
  - Agree to do urine drug test
  - Undergoing abuse counseling
- It was noted that Medicaid could not reimburse for office visits related to addiction.
- There currently is no limit to duration; however, that should be investigated. As well as quantity limits.
- It was noted that Suboxone®/Subutex® is not indicated for chronic pain. It seems from the utilization data that these drugs may be used for pain. It was noted that the PA criteria does not allow for utilization as a chronic pain management; however, it can be used if treating addiction along with chronic pain.
- Could we only allow certain providers to prescriber Suboxone®/Subutex®?
- Items to go before P&T:
  - 24 mg per day quantity limit
  - Therapeutic duplication edit
  - Mandatory drug weaning
  - Random drug screen checks (require providers send in actual urine drug screen).

B. Utilization of Therapies for ADHD (slides 9-21)

- Utilization by age and payment amount is in the age group expected.
- Intuniv® utilization is increasing very rapidly. It seems to be used for Oppositional Defiant Disorder. Board members felt this utilization was appropriate.

C. Atypical Antipsychotics (slides 22-41)

- Utilization by Age (slides 23-24)
  - This seems to be in line with epidemiology studies.
- Utilization by Drug (slides 25-29)
  - Risperidone has the youngest age approval from the FDA; therefore, it's utilization for children seems appropriate.
- Utilization by Diagnosis (slides 30-34)
  - Bipolar disorder and schizophrenia were by far the most common diagnoses. These were left off of charts so that other diagnoses would be more evident.
  - It was noted that the data are not exact since there are many young patients with a diagnosis of dementia. Medicaid is depending on data input that may be flawed. Now medical claims data is being loaded into the point-of-sale system and may be utilized for claims adjudication. This may help to "clean" the data up a bit.
- Utilization of Multiple Atypicals (slides 35-40)
  - 47% of the patients on Atypical Antipsychotics are on more than 1 Atypical Antipsychotic. This seems high, but the Board was not sure what national averages were.
  - If a hard stop therapeutic duplication edits is put into place, time should be allowed to taper patients off of an Atypical in cases of poor efficacy.
  - It was noted that it is pretty common practice for patients to be on more than one Atypical Antipsychotics; therefore, it was recommended that an edit be placed on these drugs to require PA for patients who are on more than two agents.
  - The goal of this discussion was to create PA criteria that ensures patients are treated appropriately and not over medicated. It is a known fact that many of these patients are being treated non-psychiatrists due to the limited number of psychiatrists and the rural nature of the state.
  - The Board asked if we could determine the number of patients taking Atypicals who are on other drugs that may exacerbate psychosis.
  - It was noted that edits specifically based on specialty have not worked in the past. Therefore, Medicaid and P&T have been very reluctant to place this type of edit on drugs.
  - The Board asked if this class of drugs could be managed utilizing peer-to-peer discussions rather than hard clinical edits.
  - The Board asked for data related to multiple prescribers prescribing Atypicals to the same patient.
- Utilization with Antidiabetic Agents (slide 41)
  - Currently we are inferring a diagnosis based on drug therapy. Now that we have medical claims data in the point-of-sale system we will have better diagnostic data. This may explain why it

appears that there are more patients with a diagnosis of psychosis than diabetes.
    - These data are for fee for service Medicaid patients only. This excludes Passport members.

VI. New Business (Slide Presentation is embedded above for reference) [slides 42-77]

A. Population Statistics (slides 43-45)

B. Utilization Data (slides 46-69)

- Total Population (slides 47-50)
    - It was noted that cost reported here does not take supplemental or CMS rebates into account. It was noted that the Department for Medicaid Services and Magellan Medicaid Administration staff are the only ones who see actual drug costs net of CMS and supplemental rebates. It was also noted that P&T gets a picture of relative cost when reviewing for PDL placement.
- Adult Population (age 19 and above) [slides 52-55]
- Child Population (ages 0 through 18) [slides 57-60]
- Utilization by Disease State-Total Population (slides 62-63)
    - Here behavioral health included antidepressants.
    - It was noted that this information included any patients who received pharmacy benefits through fee for service Medicaid, not Passport.
    - The Board asked that we also include a diagnosis of Chronic Pain and Asthma/COPD when determining utilization by disease state.
    - It was also noted that these data were for the pharmacy benefit only, not all Medicaid expenditures. It is expected that our cost for Diabetes will increase when the glucometers and test strips are moved from DME to pharmacy.
- Utilization by Disease State-Adult Population (slides 65-66)
- Utilization by Disease State-Child Population (slides 68-69)

C. Prospective Drug Utilization Review (ProDUR) [slides 71-73]

- On slide 73, it was noted that 66% of our claims hit a ProDUR edit and almost 16% of those edits result in the drug not being dispensed. The Board was cautioned about overloading the dispending pharmacist with too many edits, increasing the potential for missing significant edits.

D. Review of Retrospective Drug Utilization Review (RetroDUR) Activities [slides 75-76]

E. Future DUR Activities (slide 77)

- It was noted that the patient population treated with Atypical Antipsychotics are known to be non-compliant; therefore, it would not increase the providers knowledge to do this activity.
- A good activity might be to look at patients taking a short-acting beta agonist without a controller medication. An activity like this has been done in the past but can be done again. Currently there is a quantity

limit on short-acting beta agonists of 2 inhalers per month, based on the FDA-approved maximum dose.
- It was noted that cardiovascular disease is a major killer of Kentuckians and should be looked at. Our utilization of aspirin is declining; however, that could be due to reduced indications for prophylactic aspirin therapy.
- The Board asked for reports about over utilization by specific prescribers or recipients of target drugs, such as narcotics and benzodiazepines.
- The Board requested that we add an edit in the system geared toward prevention of over utilization of acetaminophen.
- The Board requested a report on patients with a diagnosis other than epilepsy who are using branded anticonvulsants.
- The top prescribers of benzodiazepines, short- and long-acting narcotics should be looked at.

The following topics were chosen:
- Medications that increase the risk of falls in elderly.
- No metabolic monitoring in patients on Atypical Antipsychotics.
- Utilization of short-acting beta agonists without a controller medication.
- Non compliance with statins after MI.
- Non compliance with cardiovascular meds.

The following data were requested for the next meeting:
- Number of patients on both Suboxone®/Subutex® and another opioid
- Number of patients taking Atypicals who are on other drugs that may exacerbate psychosis
- Data related to multiple prescribers prescribing Atypicals to the same patient
- Diagnosis of Chronic Pain and Asthma/COPD when determining utilization by disease state
- Over utilization by specific prescribers or recipients of target drugs, such as narcotics and benzodiazepines
- Report on patients with a diagnosis other than epilepsy who are using branded anticonvulsants
- Top prescribers of benzodiazepines, short- and long-acting narcotics

VII. Meeting Adjourned

A. Future Meetings
- November 4, 2010
- February 10, 2011

B. Collection of Conflict of Interest Statement

C. Collection of Travel Vouchers