Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
Drug Management Review Advisory Board Meeting
May 12, 2011

Meeting Minutes

Voting Members in attendance:
Kim Croley, Patricia Freeman (Telephone), Vice Chair, Kathy Hager, DNP, APRN, FNBC, CDE, Samuel Matheny, MD, Gerald Payne, B.S., BHS, PA-C, Michael Rager (Telephone), Clay Rhodes, PharmD, MBA, BCPS, Kathryn Schat, MD
Non-Voting Members in attendance:
Steve Davis, MD, Laura Hieronymus
Non-members present from Magellan Medicaid Administration:
Tina Hawkins, PharmD, Clinical Program Manager, Kasie Purvis, Provider Services Manager
Non-members present from Department for Medicaid Services:
Lee Barnard, Assistant Director, Trista Chapman, Contract Monitor

I. Welcome and Establishment of Quorum
- o A quorum was present.
- o Dr. Carmel Wallace has had to step down as Chair. The Board will contact Tina with nominations for Chair and a closed-ballot vote will take place at the next meeting.

II. Approval of November 4, 2010 Meeting Minutes
- o Motion to approve the minutes as presented by Magellan Medicaid Administration.
  - **Passed; 8 in favor, 0 against**

III. <u>New Business (Slide Presentation is embedded for reference) [slides 3-47]</u>

May 2011 DMRAB
Presentation PUBLIC

A. Population Statistics (slides 4-6)
- o On slide 4, it was noted that 16,000 more members, 15,000 of which were children, utilized the pharmacy benefit during 1Q2011 when compared to 1Q2010. This does not reflect new members; just utilizing members.

B. Utilization Data (slides 8-36)

- o Total Population (slides 8-11)
  - On slide 10, it was noted that these data support the theory that cold and flu season was worse this year compared to last. This could also explain why 15,000 more children utilized the benefit this quarter compared to last year. Children usually

present with acute illnesses rather than chronic conditions. The Board discussed ways of encouraging providers not to use antibiotics in patients with viral infections.
        - The Board asked for the percent of children who got flu vaccine, when and where the vaccination occurred. They would like to see a match of children who got flu vaccine in correlation to the prescription for an antibiotic. The Board asked if the Department for Medicaid Services might want to team up with school nurses to educate them about the importance of flu vaccine and how to get flu vaccine covered.
- Adult Population (age 19 and above) [slides 13-16]
    - On slide 15, it was noted that 4 of the top 10 are controlled substances with, “street value”.
- Child Population (ages 0 through 18) [slides 18-21]
    - On slide 19, the significant increase in payment for antivirals was noted. It was also noted that Tamiflu® was on manufacturer backorder last year, which may account for some of the difference in expenditures this year compared to last.
    - The Board discussed the potential of looking at increases in pharmacy expenditures/claims to determine if cost savings were reflected in medical data. For example, maybe our utilization of albuterol went up, but our expenditures for emergency department visits for asthma related complications declined.
- Utilization by Disease State-Total Population (slides 23-24)
    - The Board was reminded that Behavioral Health encompassed depression as well as ADHD in addition to Atypical Antipsychotics.
    - Chronic pain is identified by utilization of a long-acting narcotic. If the long-acting narcotic is present, expenditures and claims for short-acting narcotics are included as well. This would not capture patients on short-acting narcotics long-term.
    - The Board asked for the number of patients on short-acting narcotics for >6 months.
- Utilization by Disease State-Adult Population (slides 26-27)
    - The Board was reminded that patients over the age of 65 were usually Medicare eligible. Therefore, Medicaid was only seeing claims for drugs not covered by Medicare, such as benzodiazepines, barbiturates, OTC drugs and cold and cough products.
    - The Board was also reminded that the long-term-care pharmacy typical bills weekly rather than monthly. Therefore, one monthly prescription will show up in the data as four claims.
    - The Board asked that benzodiazepine utilization be broken down by age.
- Utilization by Disease State-Child Population (slides 29-30)
    - The Board was very concerned about the number of children taking a long-acting narcotic. The Board asked that the top 10 prescribers of long-acting narcotics in children be identified as well as a geographical breakdown.

        - The Board expressed interest in developing prior authorization criteria for long-acting narcotic use in children and lettering physicians who have prescribed long-acting narcotics in children to determine their clinical rationale. Tina will draft a letter for the next meeting.
    - Top 10 Prescribers (slides 32-36)
        - It was noted that the Board could send out a letter to chronic narcotic users about the negative long term effects. However, diverters are likely to be unaffected.
        - In order to ensure that patients get a urine drug screen, it would require that all long-acting narcotics require PA so that the call center could receive a copy of the urine drug screen. An ICD-9 for pain is difficult to implement due to the overwhelming number of ICD-9s that could be used.
        - The Board suggested that a PA only be implemented after a few months of narcotic use.
        - The Board also suggested that significant players, such as the Kentucky Medical and Licensure Boards, and DMS put together a working group so that these issues can be addressed.
        - It was also noted that none of this narcotic use is from a Hospice patient as those claims are not paid for by the pharmacy program.
        - The Board expressed concern over patients taking two long-acting narcotics or two benzodiazepines concurrently. A therapeutic duplication edit requiring a call center override was suggested.
        - The Board suggested an activity that letters these top 10 prescribers.
        - The Board also asked that we identify the prescribers' specialty. It is possible that pain management will not come up as a specialty, but we may be able to infer pain management by their specialty, such as anesthesiology.
        - The Board would like to invite someone from KASPER and the KY Board of Medical Licensure to attend a DMRAB meeting to help the Board determine a good way to identify practitioners that should be targeted.
        - The Board was reminded that there is currently a therapeutic duplication edit on more than one benzodiazepine and long-acting narcotic; however, that edit is able to be overridden by the pharmacy. The Board asked if we could allow one override per 60 days to allow for a change in drug due to allergy or therapeutic failure.

C. Prospective Drug Utilization Review (ProDUR) [slides 38-41]

D. Severity Level 1 Drug-to-Drug Interactions

- The Board was reminded that they had requested to take a look at some of the ProDUR edits to ensure that we are not messaging pharmacies unnecessarily. These drug-to-drug interactions are considered to be severity level 1, meaning these drugs are contraindicated to be given together.

- It was noted that these interactions are assigned by our drug file, First DataBank. They use current literature to assign the interactions and severity level, which is updated periodically.
- Drugs that have been removed from the market are also included here to prevent the need to re-code the interaction if another similar drug that would be expected to have the same interaction enters the market as well as to prevent unnecessary system changes.
- It was noted that the interaction between linezolid and SSRIs was theoretical and should be removed.
- The Board would like for Tina to remove any drug-to-drug interactions involving drugs that are no longer available. They would like to take more time to review the interactions and discuss at the next meeting.

E. Review of Retrospective Drug Utilization Review (RetroDUR) Activities [slides 43-45]

- On slide 43, the Board was reminded that they had originally asked that the threshold be >3 controlled substances. Due to excessive amounts of patients that were on 4 or more, the query was changed to be >4 controlled substances.
- The Board asked that we investigate the possibility of making the envelope distinct to help motivate the provider to open the letter and respond. Possibly put a statement on the front which says, "Response Required."

F. Future DUR Activities (slides 46-47)

- On slide 46, it was noted that the number of patients taking enoxaparin for more than 10 days seemed reasonable. It is common for patients who are pregnant to take the drug throughout pregnancy and there are certain indications which require 14 days of therapy.
- On slide 47, it was noted that the number of patients taking a PPI along with clopidogrel was probably appropriate as well.

G. The following topics were chosen:

- Patients with a diagnosis of diabetes without an ACEI, ARB or Direct Renin Inhibitor
- Pregnancy Category D Drugs given to a patient who is pregnant.
- Patients with a diagnosis of Congestive Heart Failure without an ACEI, ARB or Beta Blocker

H. The following data were requested for the next meeting:

- The percent of children who got flu vaccine, when and where the vaccination occurred
- A match of children who got flu vaccine in correlation to the prescription for an antibiotic
- Number of patients on short-acting narcotics for >6 months
- Benzodiazepine utilization broken down by age
- Top 10 prescribers of long-acting narcotics in children identified
- Geographical breakdown of prescribers of long-acting narcotics in children

IV. <u>Meeting Adjourned</u>

A. Future Meetings

- August 11, 2011
- November 10, 2011

B. Collection of Travel Vouchers