Minnesota Department of **Human Services**

Drug Utilization Review (DUR) Meeting March 11, 2015

Members Present
Matthew Beatty, PA-C, Pierre Rioux, M.D, Allyson Schlichte, Pharm.D., MBA, and Amy Sapola, Pharm.D.

DHS Staff Present
Mary Beth Reinke, Pharm.D., Sara Drake, RPh, and , Fitsum Teferi, Pharm.D. candidate.

Other attendants
Larry Dent, Pharm.D., Xerox

Public Comments: None

Approval of Minutes: Yes

Old Business: None.

New Business:
DHS Pharmacy Program 2014 Overview – Sara Drake, R.Ph., Deputy Director, PSD
The Medicaid FFS pharmacy is governed by title 1927 of the social security act and Minnesota Statue 265B.0625. All FDA-approved legend drugs are covered with an exception of those who doesn't participate in the CMS rebate program, drugs without federal funding, hair growth, weight loss, fertility, impotence or erectile dysfunction and DESI products. There are also selected OTC (with the exception of smoking cessation products), cough and cold products covered. Medical foods, investigational drugs and drugs for dual-eligible beneficiaries are not covered by Medicaid and appear to be a source of confusion. All this is reviewed by the Drug Formulary Committee (DFC) that is governed by the MN statue 256B.0625, subd. 13. All the roles of DFC were listed and discussed.

2014 highlights include expansion of Medical Assistance (MA) to include adults without children up to 133% of poverty, implementation Minnesota Care effective 1/1/2015, MNSure health exchange, implementation of diabetic testing supply Point of Sale (POS) starting 01/01/2014, implementation of 340B policy and pricing methodology and formation of the uniform pharmacy policy work group which is a collaboration with contracted PPHPs to develop uniform policy for high risk and high impact drugs. Uniform opioid criteria were implemented January 1, 2015.

Summary program statistics were presented for calendar year 2014.

- There was a 17% increase in total MHCP FFS enrolment and dual eligible in FFS decreased by 1% when compared to last year.

- The average number of medication utilizers increased by only 6%. This is small increase considering the 17% increase in enrollment. This is possibly due to more enrollees not using medications.
- The total annual drug reimbursements to pharmacies increased by 13%, total FFS rebates from drug manufacturers increased by 23% and total number of prescriptions increased by 1.5% when compared to last year.
- Twenty-five percent of pharmacy spending was on specialty drugs with a trend towards increasing hepatitis B/C treatment, more drugs for orphan and rare conditions, and more specificity in target population.
- During 2014, the Prior Authorization (PA) Program received a total of 48,081 PA's.
    - No action taken on 25% of the PA's since the majority sent to DHS by mistake.
    - 37% of the requests were approved.
    - 18,455 (38%) were denied.
    - Of 1571 reconsiderations received, 75% ultimately approved.
- The top 10 most commonly requested prior authorized drugs (35% of PA requests) were Lyrica, Intuniv, Lidoderm/Lidocaine patch, Suboxone, OxyContin, Volatren, Zolpidem ER/Ambien CR; Vimpat, Celebrex, and lansoprazole/Prevacid.
- The total reimbursement for home infusion pharmacy was $6.2M which was up 3% from the previous year. The five top drugs accounted for over 75% of costs. This included Elaprase, Synagis, Xyntha, Hizentra, and Myozyme. Reimbursement for TPN which is not included in home infusion amounted to $745,934.
- Drugs billed via medical claims were $12.41 per member per month (pmpm). The combined pharmacy claims and medical drug claims pmpm was $80.
- The following trends were reported:
    - Per member per month (pmpm) pharmacy spending continues to decline.
    - Per user per month pharmacy spending has been relatively flat since 2010.
    - Rebates have continued to keep net prices down in 2014.
    - The combined savings from implementing the Diabetic Testing Supply Program in 2014 and Medicare's competitive bid rate in the dual eligible population was $500,000.

2015 priorities include open procurement of PA, DUR and e-prescribe vendors, implementation of electronic PA capability by 1/1/2016, systems improvements to identify inpatient and outpatient overlap, analysis and policy proposals for new or updated pricing methodology dependent upon CMS rules, ICD-10 implementation, robust analysis of hepatitis C utilization and outcomes, improved claims editing for third party liability and ongoing efforts to improve prescribing of mental health medications for children (particularly children in foster care).

RetroDUR – outcomes for three population based interventions

Gastrointestinal Drug Utilization Outcomes Assessment

The purpose of this intervention is to promote safe, cost-effective use of anti-secretory agents in the management of gastrointestinal disorders, including peptic ulcer disease (PUD) and gastroesophageal reflux disease (GERD).

Letters were mailed to 1,248 prescribers regarding 3,286 recipients on May 2, 2014. The post-intervention period was 06/01/2014 to 11/30/2014. The adjusted number of targeted recipients was 2,858. Because of the large number of the population that uses these drugs there was also a

control group of prescribers and their respective recipients. The adjusted control group of recipients was 1,238. Clinical indicator results are in the table below.

Table 1. Changes in clinical indicators for GI Drug Utilization Outcomes

Clinical Indicator	Target			Control		
	Baseline	Dec-14	% Change	Baseline	Dec-14	% Change
Adverse Drug Effect	1,311	1,122	-14.4%	500	396	-20.8%
Dosage	663	475	-28.4%	312	226	-27.6%
Duplicate	21	7	-66.7%	5	4	-20.0%
Duration	619	475	-23.3%	316	227	-28.2%
Total	2,614	2,079	-20.5%	1,133	853	-24.7%

Overall, clinical indicators decreased by 20.5% in the target group compared to 24.7% in the control group. The business analysis is shown in Table 2. There was an annualized savings of $48,357 for the target group.

Table 2. Six-month post intervention financial outcomes for GI Drug Utilization

Savings Calculation Intervention related Drugs	
Target Group: Actual Average Paid Amount Per Patient Per Month (Baseline)	$74.50
Target Group: Actual Average Paid Amount Per Patient Per Month (Post)	$71.57
% Change in Target Group from Baseline to Post	-3.92%
% Change in Control Group from Baseline to Post	-2.03%
Estimated Paid Amount Per Target Patient Per Month if No Intervention	$72.99
Estimated Savings per Patient Per Month	$1.41
Total Number of Target Patients	2,858
6-Month Total Savings	$24,178.68

Atypical Antipsychotic Therapy in Adults Outcomes Assessment

The purpose of this intervention is to assist prescribers in the evaluation of atypical antipsychotic therapy, specifically, when multiple prescribers and other health care providers are involved. Commonly encountered situations include multiple prescribers and duplicate therapy, use in diabetic and/or obese patients, clinically significant drug interactions, and injectable options to improve adherence.

Letters were mailed to 1,261 prescribers regarding 1,554 recipients on February 28, 2014. The post-intervention period was April to September 2014. The adjusted number of targeted recipients was 1,261. Clinical indicator results are in the table below.

Table 3. Changes in clinical indicators for Atypical Antipsychotic Therapy in Adults Outcomes

Clinical Indicators	Target (N = 1,232)		
	Baseline	Sep-14	% Change
Medication Non-Compliance	53	39	-26.4%
Increased Risk of ADE	553	484	-12.5%
Duplicate Therapy	1,362	1098	-19.4%
Total	1,968	1621	-17.6%

Overall, clinical indicators decreased by 17.6% in the target group. The business analysis is shown in Table 4. There was an annualized savings of $60,494 for the target group.

Table 4. Six-month post intervention financial outcomes for Atypical Antipsychotic Therapy in Adults

Savings Calculation:	
Targeted Group: Actual Average Paid Amount Per Patient Per Month (Baseline)	$423.32
Targeted Group: Actual Average Paid Amount Per Patient Per Month (Post)	$427.42
% Change in Target Group from Baseline to Post	0.97%
Estimated Savings Per Patient Per Month	($4.09)
Total Number of Targeted Patients	1,232
6-Month Total Savings	($30,246.92)

Sedative/Hypnotic use in Adults Outcomes Assessment

The purpose of this intervention is to promote prudent prescribing of sedative/hypnotic medications in adults.

Letters were mailed to 1,055 prescribers regarding 1,350 recipients on December 18, 2013. The post-intervention period was 02/01/2014 to 07/31/2014. The adjusted number of targeted recipients was 1,101. Clinical indicator results are in the table below.

Table 5. Changes in clinical indicators for Sedative/Hypnotic use in Adults Outcomes

Clinical Indicators	Target		
	Baseline	Jul-14	% Change
Duration	749	617	-17.6%
Dosage	375	295	-21.3%
Increased Risk of Adverse Drug Event	91	79	-13.2%
Total	1,215	991	-18.4%

Overall, clinical indicators decreased by 18.4% in the target group. The business analysis is shown in Table 6. There was an annualized savings of $72,727 for the target group.

Table 6. Six-month post intervention financial outcomes for Sedative/Hypnotic use in Adults

Savings Calculation:	
Target Group: Actual Average Paid Amount Per Patient Per Month (Baseline)	$31.14
Target Group: Actual Average Paid Amount Per Patient Per Month (Post)	$25.64
% Change in Target Group from Baseline to Post	-17.68%
Estimated Savings Per Patient Per Month	$5.50
Total Number of Target Patients	1,101
6-Month Total Savings	$36,363.30

Minnesota Medicaid Program Assessment – Larry Dent, Pharm.D., Xerox

Using results from their clinical criteria algorithms, Xerox provides an annual assessment with their recommendations for the next year's population-based interventions. The supporting rationale for each recommendation is provide below.

Psychotropic drugs

- Previous mailings include:
  - Atypical antipsychotics in adults 2/28/2014
  - Sedative/hypnotics 12/18/2013
  - Excessive dose of ADHD drugs in children and adolescents 7/15/2013
  - Excessive dose of atypical antipsychotics in children and adolescents 1/11/2013
  - Antidepressants 2/29/2012
- Ranked #1 in overall expense for $46.7 million or 24% of program's total drug expense
- Within psychotropic drugs, the second generation antipsychotics (SGA) ranked the highest in amount paid accounting for 56% of expenses for this class (13% of the total drug expenses).
- Clinical algorithm analysis identified 38,584 opportunities for SGA drugs. Recommended intervention would be Atypical Antipsychotic Optimization of Use.
- 10,149 for bipolar disorders associated with monitoring and extended use. Recommended intervention would be Bipolar Disorder Management.
- High dose and overutilization of stimulates. Recommended intervention would be ADHD Management.

Gastrointestinal (last mailing May 2014)

- Ranked 7th in overall expenses accounting for $8.4 million and 182,379 claims.
- Overall there were 9,075 opportunities for improving care.
- Opportunities include identification of long-term use of gastric acid suppression agents, recommendations for H. pylori testing, and avoidance of drugs that exacerbate GI disorders

Polypharmacy (last mailing September 2011)

- There are 4,067 opportunities for potential discontinuation of drug therapy that may be no longer be necessary. Table 7 below shows the details of the associated indicators.

Table 7. Polypharmacy indictors with number of occurrences

Indicator: POLYPHARMACY ANALYSIS	4067	4067	100.0%
PolyRx 10 and Dr Shopper Opiates-Tramadol	15	4067	.4%
PolyRx 10 or greater drugs (with CA/HIV/or CRF)	973	4067	23.9%
PolyRx 10, 1 MD	258	4067	6.3%
PolyRx 10, 2 MDs	537	4067	13.2%
PolyRx 10, 3 or > MDs	1302	4067	32.0%
PolyRx 10, 3 or > MDs and Pharm	145	4067	3.6%
PolyRx 15 and Dr Shopper Opiates-Tramadol	6	4067	.2%
PolyRx 15, 1 MD	34	4067	.8%
PolyRx 15, 2 MDs	123	4067	3.0%
PolyRx 15, 3 or > MDs	441	4067	10.8%
PolyRx 15, 3 or > MDs and Pharm	50	4067	1.2%
PolyRx 20, 1 MD	8	4067	.2%
PolyRx 20, 2 MDs	32	4067	.8%
PolyRx 20, 3 or > MDs	122	4067	3.0%
PolyRx 20, 3 or > MDs and Pharm	21	4067	.5%