Idaho DUR Board Meeting Minutes

Date: October 17, 2019 **Time:** 9am-12:00pm

Location: Idaho Medicaid, 3232 Elder Street, Boise, Idaho, Conference Room D-West

Moderator: Magni Hamso, M.D.

Committee Member Present: Sabrina Allen, Pharm.D., Wayne Baures, RPh, Dawn Berheim, Pharm.D., Perry Brown, M.D., Chris Owens, Pharm.D., Chris Partridge, M.D.

Others Present: Tami Eide, Pharm.D., Suzanne Fox, Jane Gennrich, Pharm.D., Chris Johnson, Pharm.D., Mark England, Pharm.D.[☆]

[☆]Magellan Rx Management

AGENDA ITEMS	PRESENTER	OUTCOMES/ACTIONS
➢ **Call to Order**	Magni Hamso, M.D.	Dr. Magni Hamso, Chairman, called the meeting to order.  DUR_10_17_2019_Final (2).pdf
➢ **Review of Minutes from July 18, 2019**	Magni Hamso, M.D.	Minutes were approved as written.
➢ **State Guidance for Medicaid DUR Provisions Included in Section 1004 of the SUPPORT Act**	Tami Eide, Pharm.D.	**Slides 2 – 12** Dr. Eide presented information for the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (AKA SUPPORT Act). This act is designed to reduce opioid related fraud, misuse, and abuse. Section 1004 is specific to State Medicaid Programs and strategies

		included are required to be implemented by October 1, 2019 with reports to Congress with information from states' fiscal year 2020 DUR Reports. CMS is requiring a State Plan Amendment by December 31, 2019. On August 5, 2019 CMS published State Guidance for Implementation of Medicaid Drug Utilization Review (DUR) provisions included in Section 1004 of the SUPPORT Act. Dr. Eide detailed the Safety Edits and Claims Review Automated Processes that will be required. Currently Idaho Medicaid is complying with safety edits including early, duplicate and quantity limits as well as Maximum Daily Morphine Milligram equivalents (MME) Safety edits. Concurrent utilization alerts for opioids in combination with benzodiazepines and opioids in combination with antipsychotics are required to be done as retrospective review but may also have prospective review. Dr. Eide presented utilization numbers for both these concurrent utilization alerts and provided CMS rational for looking at these two areas. There are permitted patient exclusions (Hospice or Palliative Care Patients, Cancer Treatment Patients, Long-term Care Facility Residents); however, CMS clarified that while states are not required to apply standards to these patient groups they may do so voluntarily. Part 2 of Section 1004 of the SUPPORT Act requires that each state report annually on activities carried out on individuals not more than the age of 18 years old generally, and children in foster care specifically receiving antipsychotic medication. Idaho has been doing this annually since 2011. Part 3 refers to Fraud and Abuse Identification Requirements. The state must have in place a process that identifies potential fraud or abuse of controlled substances for: individuals (i.e. participants),

		enrolled prescribers, and dispensing pharmacies. Mechanisms may include the use of the PDMP, lock-in programs, and use of data analytics. Idaho Medicaid currently does this as well and will be working with their Fraud and Abuse Team to further develop these activities. The next step for Idaho Medicaid is to submit an amendment to their State plan for CMS review and approval for implementation of these DUR requirements including giving appropriate tribal notification. The plan amendment must include: Claims Review Limitations, Monitoring of Antipsychotic Medications by Children, and Fraud and Abuse Identification.
➢ **Follow-up to Previous Reviews**		
• **Butalbital DUR**	Jane Gennrich, Pharm.D.	**Slides 14 – 22** Dr. Gennrich presented the background information for the Butalbital DUR including the concern around prescribing of butalbital containing products for treatment of migraine as it is a controlled substance with abuse potential, overuse often leads to medication overuse headaches, and butalbital is not considered a first-line drug to treat migraines. Effective June 1, 2019, a requirement for prior authorization for all butalbital containing medications was instituted as well as deceasing the quantity allowed to 12 tablets/30 days. Dr. Gennrich presented data showing a comparison between August 2018 and August 2019. The number of claims decreased from 223 to 113, with the number of patients decreasing from 195 to 107 and the number of prescribers decreasing from 165 to 87. In terms of the overall number of tablets dispensed there was a

		drop from 9,150 to 2,152. She also showed a breakdown of the total number of tablets per claim between the two-time periods. With the instituted quantity limit reduction, most claims in 2019 are for 12 tablets or less. Dr. Gennrich reported that there was a total of 235 PA requests between 6/1/2019 and 8/30/2019 on 221 patients. Most of these requests were for patients already on butalbital medications. Dr. Gennrich then presented two case studies as examples of the requests the Idaho Clinical Call Center is receiving. The DUR Board requested that the Department follow up on these patients to see if there was a decrease of headache occurrences and if the patients were switched to other medications and what the utilization of prophylactic medication was in this population.
• **Anticoagulants**	Chris Johnson, Pharm.D.	**Slides 23** The DUR Board requested that the Department evaluate whether patients were being continued on loading doses rather than being switched to maintenance doses for Eliquis and Xarelto. Dr. Johnson reviewed the previous 4 months of claims data for these two medications and reported that there were no incidences of the loading dose being used for chronic treatment.
• **Testosterone Injection**	Chris Johnson, Pharm.D.	**Slides 24** The DUR Board requested that the Department look at the use of the 10ml vs. 1ml vial of testosterone injection.

		Dr. Johnson reviewed claims data from January 1, 2019 through August 31, 2019 and found no indication of mis-use in these products. 10ml vials were being dispensed every 3-4 months indicating that the patients were using multiple doses out of the larger vials spread out over time.
➢ **Ongoing Reviews**		
• Idaho Medicaid Equivalent Dosing Project	Mark England, Pharm.D.	**Slides 26 – 41** Dr. England presented an update on the Idaho Opioid Equivalent Dosing Project to the DUR Board. Dr. England presented data from 3Q2019 to the Board and explained that the MME 90 edit was made operational on July 19, 2017. There was also quarterly data presented showing trends from 1Q2017 through 3Q2019. There has been a 33% decrease from 1Q2017 to 3Q2019 in Members on Opioids and a 37% decrease in Opioid Members on > 90 MME during this same time period. Additional information was provided on the concomitant use of opioids and benzodiazepines and concomitant use of opioids and antipsychotics. More detailed data was also shown on the number of members on concomitant opioids > 90 MME and antipsychotics.
• Methadone DUR	Chris Johnson, Pharm.D.	**Slides 42 – 53** Dr. Johnson presented background data on methadone nationally. He then reviewed the American Society of Interventional Pain Physicians (ASIPP) Guidelines and their recommendations.

		He reported that historically methadone was the preferred pain reliever for most state Medicaid programs because of cost. Idaho Medicaid removed methadone from preferred status October 2015 and prior authorization was required going forward. Idaho Medicaid informed methadone prescribers of implementation of the methadone prior authorization requirements and requested tapering off methadone in January of 2016. It was noted that many of the patients prescribed methadone had continued to receive methadone prescriptions and were paying cash outside of their Medicaid benefit to obtain. A new state rule was implemented in July 2019. IDAPA 16.03.09 Sec. 663.07 Prohibition Against Cash Payment for Controlled Substances prohibits pharmacy providers from accepting cash as payment for controlled substances from persons known to be Medicaid participants. Prescribers writing prescriptions for "cash" were required to submit prior authorizations for those patients. This allowed Medicaid to capture methadone claims that were previously undetected due to cash purchases and not billed to Medicaid pharmacy services and enables more complete monitoring and case management of high dose methadone use moving forward. Dr. Johnson presented a review of Methadone utilization since implementation of the cash payment rule. The Methadone DUR review looked at Total unique patients, Total claims, Total unique prescribers, and Total daily dose. Methadone utilization has increased since initiation of the cash prohibition rule. There was an increase in claims for methadone doses greater than 40 mg a day due to new patients who previously paid cash for high dose methadone prescriptions. Dr. Johnson also noted that there are new concerns with cash payment of high dose methadone for use in opioid use disorder rather than pain by

		practitioners not part of authorized opioid treatment programs. Methadone is highly regulated, and can only be prescribed, dispensed, and administered in certified Opioid Treatment Programs.
➢ **Current Interventions/Outcomes Studies**		
• Naloxone Utilization	Jane Gennrich, Pharm.D.	**Slides 55 – 61** Dr. Gennrich presented Naloxone Utilization data. She reviewed the number of pharmacy claims from 2018 Q2 to 2019 Q3. There was a slight uptick in 2019 Q1, but has since dropped off. The same trend was also seen in the unique number of patients. The number of prescribers has remained consistent over the past year. In terms of the number of patients filling naloxone more than once per quarter, it is very limited ranging from 3 to 7 patients. It was noted that 96% of claims are for Narcan nasal spray.
• High Dose Opioid Use Participants and Naloxone Use	Tami, Eide, Pharm.D.	**Slides 62 – 76** Dr. Eide began by providing National Statistics for Opioid Overdose Deaths. She then shared statistics for pharmacy-based naloxone dispensing in the United States for 2012-2018. On August 6, 2019 the CDC issued a press release that stated, "Nearly 9 million more naloxone prescriptions could have been dispensed in 2018 if every patient with a high dose opioid prescription were offered naloxone". The lowest rate of naloxone dispensed per high dose opioid prescription among providers was spread across Primary Care Providers, Nurse Practitioners, Physician Assistants, Pain Medicine Specialists and Surgeons.

		All states and DC have passed legislation increasing naloxone access and the naloxone access laws that grant authority to pharmacists to dispense naloxone have been associated with reduced fatal opioid overdoses. Dr. Eide then shared with the DUR Board, the Idaho Statute (July 1, 2019) 54-1733B Opioid Antagonists. It States that any Health Professional licensed or registered under this title (Pharmacist or Pharmacy Technician) may prescribe and dispense an opioid antagonist to: • A person at risk of experiencing an opiate-related overdose • A person in a position to assist a person at risk of experiencing an opiate-related overdose • A person who, in the course of his official duties or business may encounter a person experiencing an opiate-related overdose • A person who, in the opinion of the health professional licensed or registered under this title, has valid reason to be in possession of an opioid antagonist She then went into detail on the specific risk factors for opioid overdose to identify possible recipients. Looking specifically at Idaho Medicaid Opioid and Naloxone Utilization data, she shared those numbers with the DUR Board. A very low percentage of potential candidates received a naloxone prescription. She also looked at patterns of number of high risk patients per prescriber and per pharmacy to identify specific pharmacies or prescribers to look at it in more detail. The Idaho Medicaid Pharmacy Unit plans to send out a Pharmacist Educational Interventional Letter that will be addressed to the

		Pharmacist in Charge. The letter will provide brief background information on opioid overdose statistics, risk factors to help identify appropriate patients to receive naloxone with an instructional video link for naloxone administration. English and Spanish Naloxone sample educational brochures will be included. The letter will also emphasize that Idaho Medicaid will pay if they dispense to a patient, family member, caregiver, or close friend and include information on how to bill Medicaid – emphasizing that there is NO COPAY. A list of specific patients including MID# and their current opioid prescriptions will be included. Pharmacists will be asked to complete a response form detailing if naloxone was offered and dispensed or refused. For patient on methadone, the targeted pharmacist letter will be included with their current methadone case management correspondence. Dr. Eide suggested that in the future the Board may want to include those with a diagnosis of opioid use disorder in these interventions. Some pros and cons of this were discussed.
➢ **NASP (National Association of Specialty Pharmacies) 2019 Annual Meeting**	Jane Gennrich, Pharm.D.	**Slides 77 – 91** Dr. Gennrich reported on her attendance at the annual meeting of the National Association of Specialty Pharmacy in September. Dr. Gennrich gave an overview of the National Association of Specialty Pharmacy (NASP) and their mission. She noted that although there is no standard definition for "specialty drug", NASP defines them as follows: Specialty drugs or specialty pharmaceuticals are a recent designation of pharmaceuticals that are classified as high-cost, high complexity, and/or high touch. She noted that based on this definition the number of drugs included in this definition have increased. In 1990 there were 10 specialty drugs on the market, in the mid-1990s there were fewer than 30, by 2008 there were 200, and by 2015 there were 300. By 2015

		specialty medications accounted for one-third of all spending on drugs in the United States, up from 19 percent in 2004 and heading toward 50 percent in the next 10 years. Dr. Gennrich highlighted specific presentations she attended throughout the meeting that fell into one of three tracks; clinical, regulatory, or operational. The keynote speaker was from CMS and had the following points. • Only speaker to comment that drug prices are extremely high. • U.S. is the only developed country that does not regulate health care costs – not just drugs but all of health care. • U.S. spends 1/3 of healthcare budget on wellness and mental health and 2/3 on care for sick patients. The rest of the world spends the reverse ratio. • The healthcare system needs to stop being revenue driven and switch to optimizing outcomes. • The two most powerful political lobbies are the pharmaceutical industry and the tobacco industry. Currently there are no data standards for specialty pharmacies. Proposed standards include turnaround time to dispense the drug, specific outcomes defined for each drug or drug class and adverse event monitoring. Dr. Gennrich concluded with a list of pipeline drug categories in the specialty environment which include chronic fatigue, weekly growth hormone injections, Hemophilia A and Hemophilia B, oral chemotherapy drugs, and gene therapy for multiple disease states.

➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	**Slide 92** Ideas from the DUR Board included; butalbital patient outcomes, initial starts and duration of new starts with opioids, and a follow-up on the naloxone DUR.
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	**Slides 93 - 94** Dr. England reviewed the quarterly ProDUR trends. No significant changes in trends were noted.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	**Slide 95** Dr. Eide provided a quick update on the status of Medicaid Expansion.
➢ **Adjourn, 12:00pm**	Magni Hamso, M.D.	

Next Meeting: January 16, 2020