Maryland Medicaid Pharmacy Program
Drug Use Review Board
Thursday, September 7, 2017
Meeting Minutes

Drug Utilization Review (DUR) Board Members: K. Dodge, K. Fink, G. Herpel, C. Lefebvre, L. Moricle, J. O'Leary, D. Riedel, W. VanWie
Maryland Medicaid Pharmacy Program (MMPP): A. Alexandrou, M. Closson, P. Holly, M. Joglekar, S. Kazmi, D. Shah, S. Singh
Provider Synergy: H. Peltier
Xerox Government Healthcare Solutions: J. Lafranchise
Health Information Designs, LLC: R. Boyer, N. Osei-Boateng
Bishop House of Annapolis (Minutes): K. Holland

The Drug Utilization Review (DUR) Board meeting was called to order at 9:20 a.m. on Thursday, September 7, 2017 by the chairperson of the Board.

Introductions
Members of the Drug Utilization Review (DUR) Board and other attendees introduced themselves.

Minutes
The minutes from the June 1, 2017 DUR Board were approved with no changes.

Maryland Medicaid Pharmacy Program (MMPP)

As mentioned at the June meeting, effective April 1, 2016, MMPP implemented the Unified Corrective Managed Care (CMC) program, which addresses aberrant use of controlled substances, regardless if a recipient is a fee-for-service (FFS) or a managed care organization (MCO) member. Under the program, there are uniform lock-in criteria so that participants enrolled in the CMC program remain locked in whether they move from FFS to a MCO or from one MCO to another. As of the end of July 2017, there are 802 members who have been locked in to one pharmacy. This represents an increase of 18.3% compared to the previous quarter.

Since May 2016, the Department has been working with the eight Maryland HealthChoice MCOs and the FFS program to implement minimum standards that would be applied by both the FFS and MCO programs in order to combat the overdose epidemic which affects our members. The minimum standards were implemented on July 1, 2017 and included coverage of non-opioids to be considered first-line treatment for chronic pain, and prior authorization for all long acting opioids, fentanyl, methadone for pain, and any opioid prescription that results in a participant exceeding 90 morphine milligram equivalents per day. In addition, a standard 30-day supply quantity limit for all opioids is set at or below 90 morphine milligram equivalents per day. The standards do not apply to participants with cancer, sickle cell anemia or those who are receiving palliative or hospice care. In order to inform and educate prescribers and pharmacy providers about these standards, the Department and the MCOs engaged in an extensive outreach campaign, which included letters to providers and webinars.

A dedicated website was created with information about the opioid epidemic landscape in Maryland and included resources for providers and managed care organizations, which are available for improving the opioid prescribing process in the effort to reduce opioid misuse, dependence, overdose and death. For those prescriptions that exceeded the minimum standards and therefore required a prior authorization by the provider, the FFS program and the MCOs originally decided to allow a 60-day soothing period, which allowed a pharmacy provider to obtain a one-time fill of the current prescription (up to a 30-day supply), in the event that they were unsuccessful in contacting the prescriber to inform them that they needed to obtain a prior authorization. The soothing period was ultimately extended by an additional 30 days, at the request of hospitals. The Department is monitoring the volume of calls, prior authorizations by prescribers and pharmacy providers and any challenges related to this initiative on a weekly basis. It was announced that the program has been progressing as anticipated.

The DUR Board members were thanked for their service.

Xerox Government Healthcare Solutions

Xerox provided information related to Preferred Drug List (PDL) new Prior Authorizations (PA) requests and prospective drug use review (ProDUR) edits completed for the second quarter of 2017.

Regarding therapeutic duplication of clonazepam with another benzodiazepine, Xerox reported that a clear majority of these alerts are overridden at the point of sale by the pharmacy provider. These findings are consistent when compared to previous quarters.

Opiate dependence treatment agents continue to be the top agents with requests for PDL PAs, with requests for Suboxone® (buprenorphine/naloxone) as the number one requested agent requiring a PA.

Claims information was presented for therapeutic duplications, early refill alerts and drug-drug interactions. For the second quarter of 2017, it was noted that almost half of all therapeutic duplication alerts relate to antidepressants and anticonvulsants. Over one third of early refill edits were for antidepressants. Most of the drug-drug interactions reported were for antidepressants with almost half of all drug-drug interaction edits related to selective serotonin reuptake inhibitors (SSRIs). A summary of intervention codes related to therapeutic duplications, early refills and drug-drug interactions was provided.

In closing, Xerox also reported cost avoidance information as well as call center volume information for this quarter.

Health Information Designs, LLC

HID presented a review of action items from the June 2017 meeting, an overview of active interventions, a retrospective DUR (RDUR) intervention summary for the second quarter of 2017, and information related to future RDUR interventions for the Maryland Medicaid FFS population.

MARYLAND Department of Health

Review of action items from June 2017 DUR Board meeting:

The recurring monthly intervention related to therapeutic duplication of sedative/hypnotic agents continues to provide a significant decrease in duplicate use of these agents. This intervention will continue to be performed on a monthly basis, with results provided at each meeting.

Outcomes from the RDUR intervention related to opioid use greater than 50 morphine milligram equivalents per day were presented. Intervention letters were sent in October 2016. After a standard six-month suppression period, it was shown that an overall 50% reduction in use was seen over the evaluation period by FFS participants. It was noted that due to the small number of participants who remained in the FFS program for follow-up may have contributed to an underestimate of the change in prescribing patterns. Also, in addition to this retrospective intervention, there were other programs running concurrently to address opioid use. This intervention is complete at this time.

Overview of Active Interventions:

Active interventions during the second quarter of 2017 include the therapeutic duplication of sedative/hypnotics, opioid use greater than 50 milligrams per day of morphine oral equivalents, therapeutic duplication of immediate-release stimulants, non-adherence to antiretroviral agents for treatment of HIV and concurrent use of an opioid, benzodiazepine and carisoprodol. Six-month outcomes will be reported as they become available.

RDUR Quarterly Summary:

For the second quarter of 2017, educational intervention letters were sent to prescribers and pharmacies related to therapeutic duplication of sedative/hypnotics and concurrent use of an opioid, benzodiazepine and carisoprodol. Of the 433 letters sent, response rates were 23% for prescribers and 20% for pharmacies for therapeutic duplication of sedative/hypnotics. For the concurrent use of an opioid, benzodiazepine and carisoprodol letters, the response rate was insignificant. It was noted that only one participant met criteria for this intervention and two letters were mailed for that case. The most common response from prescribers for the duplicate sedative/hypnotics intervention stated that the prescriber did not write the prescription attributed to him/her or that the participant was never under the provider's care. Upon further investigation, it was determined that the provider had miscoded the response and did not realize another provider was also prescribing duplicate therapy. For pharmacist responses, the most common response was that the participant would be counseled at the next visit. In instances where the pharmacist noted disagreement, it was found that therapy had already been changed to the use of one agent or there was documentation on file from the prescriber to provide rationale for duplicate use.

Future RDUR Intervention Discussion:

New criteria available from HID for RDUR review was presented to the Board. For the third quarter of 2017, the recommended criteria to add relates to non-adherence to various medications, including Vemlidy®, Orkambi®, AirDuo Respiclick™, Synjardy® XR, Trulance® and Qtern®. These criteria would be

added to existing therapeutic class edits. The DUR Board agreed to add all recommended criteria for these drugs to the current RDUR analysis for monitoring and potential future educational interventions.

Discussion occurred regarding future intervention ideas for the FFS population. The DUR Board decided to intervene on underutilization of antilipemic therapy, including non-adherence or missing therapy when clinically indicated. This intervention will occur during the 3rd quarter of 2017.

Other Business

Updates regarding the annual live continuing education program were provided to Board members. Various aspects of the current opioid epidemic will be explored, including the safe and appropriate use of opioids, management of pain with other comorbidities or history of substance use disorder, as well as legislative updates and initiatives from the Department. Registration will open once final approval of the CE program is provided by the appropriate accrediting organizations.

It was noted that several Board members will complete their second-term at the end of 2017. The Department is open to any recommendations for replacements by outgoing members and is currently recruiting for new members.

The next DUR Board meeting will be held on Thursday, December 7, 2017.

There was no additional business, and the meeting was adjourned at 10:24 a.m.