

Alaska Medicaid DUR Committee Meeting Minutes

Friday, January 19, 2018

Frontier Building, 3601 C Street; Room 890/896

1:00pm

January 19th 2018 Drug Utilization Review Committee

Members Present	Non Members Present
Dr. Bob Carlson, MD	John McCall RPh , Magellan
Dr. Denise Eavey, PharmD	Elaine Edwards RPh, Magellan
Dr. Jenna Heistand, MD	Rene Tanganon, Senior Director Magellan
Dr. Erin Narus, PharmD (DHSS)	
Dr. Heath McAnally, MD	
Dr. Ryan Ruggles, PharmD	

Introduction

- Erin Narus announced that the November 2017 meeting minutes will be circulated to members for review via e-mail. Pharmacy students introduced. Transition announced with clinical manager as John McCall's last day was announced and thanks were given to John for all his commitment and work he performed over the last couple of years. Erin introduced Elaine Edwards who will be replacing John McCall as Clinical Manager with Magellan who is not new to the account with Magellan. Appreciation also given by Erin Narus to all committee members for their time and commitment.

Prospective Drug Utilization

- New Prescription Medication for Qutenza 8% patch (from November) containing capsaicin 8% was reviewed. It is dosed up to 4 patches/treatment, and not to be repeated for ≥ 3 months. A request for prior authorization for 1 patch for 30 days was received for prior authorization which was exceeding dosing limits and also rejected for cost over \$7500.00 in a claim. The patch has specific use limitations and can be applied up to 4 patches at a single time for 60 minutes and removed, which cannot be reapplied for 3 months. Erin Narus proposed to restrict medication to billing as a physician or health care practitioner administered status rather require prior authorization through pharmacy point of sale. The impact of the outcome of this would be fairly significant. This is a pain management use concern also with opioid initiatives ongoing as we search for alternative therapies. Toxicities are a concern. We would not require a prior authorization for physician administration and deny at the outpatient pharmacy POS. The goal is to allow billing as a professional claim and lock the claim from point of sale. We would allow up to 4 patches to be filled no more than every 30 days. The cost is upwards of \$22,000.
- Comments from committee were stated. Dr. Carlson commented concern that application of a Lidoderm patch should be required to anesthetize the area first due to pain associated with administration or provide education on package insert for administration and use. Erin Narus stated there are alerts and multiple stops in the process of claims that are in place to ensure proper administration. A motion was made by Ryan Ruggles to accept the proposal. The motion was seconded by Dr. Carlson to restrict medication to physician or health care practitioner administered rather than through pharmacy point of sale. Motion was carried unanimously to accept as proposed.

Prospective Drug Utilization- Physician Administered Medications- HCPCS to NDC Crosswalk

- This is a prospective drug utilization review to propose utilization of CMS Crosswalk to HCPCS to NCD Crosswalk and would affect ambulatory infusion centers. This takes the HCPCS and matches with the NDC. Erin Narus explained this topic is less clinical and more from a utilization review and financial side of things. The impact can wreak havoc with our requirement to maintain our federal rebating mandated through Medicaid rules of law for the program. If we have incorrect billing we want to ensure we have defined processes in place. Erin Narus is proposing to utilize the CMS NDC

crosswalk and this will allow provision of education to physicians and medical centers who do outpatient physician administration of medications. Service provisions also include for ambulatory infusion centers where we will be looking at a variety of different cost exceeds. This process will build an overall framework. Documents for review will be available in the Drop Box. The NDC crosswalk requires at billing conversion to take the J-code (Medicare uses) and match the billing unit with specific NDC unit (Medicaid uses) for that particular product. Dual eligible patients have both Medicare and Medicaid. Erin reviewed slide for modifier conversion factor codes to be used with billing. A conversion factor is used and providers are asked to provide a J-code and convert to NDC. The concern was providers would not get paid for their claim with J Codes. We can apply this process through the adjudication system and match values that are submitted for the claim to pay. Conduent is responsible for providing the education crosswalk information that is published by CMS to providers to show how to convert and calculate the conversion. Providers will need to double check the math.

Standards of Care, Status review Hemophilia

- The goal is to approve treatment plans in advance and minimize administrative burden for a more efficient process. We have not put out everything yet and work is not fully implemented the new 3 month process. Forms are being developed. Hemophilia treatment centers will be transitioning patients over to the new system. The process is now on a fill by fill basis. Amount prescribed matches the prescription filled. The goal is to minimize the administrative burden. The change will move toward and emphasize a more treatment plan or holistic managed process.

Opioids – Initiatives (ICD-10, Methadone, Dental, Gold Star, MAT – Medication Administered Therapies)

- ICD-10 Diagnosis Code on Claims, status review by John McCall. Slides presented with information show basically what exactly is being treated with opioids. Data shows over 40% ICD10 code compliance. Amazingly many are compliant with written RXs (75%) vs electronic submission of ICD10 codes. Large clinics, MD offices and hospitals reviewed show high written ICD-10 code submitted compliance. John stated next step is to reach out to the providers. Committee discussion occurred over how we can increase the code compliance and obtain ideas that will improve compliance of the submitted codes. The goal is to encourage ICD-10 usage however not make it mandatory. We can leverage the technology to determine appropriateness of drug use with ICD-10 code submission. Hard copy fax prior authorization forms to figure out at what level to leverage this electronic technology and information in the system. We want to identify areas to decrease administrative burden. In concert with this the opioid initiatives and other

drug utilization will be advantaged with ICD-10 code usage. Is there a way we can encourage more ICD-10 code usage to move forward to utilizing electronic data? Web based PA platforms will be capable with ICD-10 information and placed in a decision tree PA review electronically. The information with codes will decrease administrative burden. Magellan will facilitate moving toward this web based process. Balancing the technology piece with oncology and opioid use is a challenge. ICD-10 compliance with RX submission will facilitate telling us if patients are oncology patients and ensure a paid claim regardless of the education of the Web PA user at time of fill. Currently the override codes used at the pharmacy point of sale that are available may or may not be performed and are dependent on the user's education. Manual override codes may not always be utilized by staff entering the prescription where the ICD-10 technology edit will provide a suitable outcome independent of user education with overrides. The next step to be moving toward is a challenge since we do not want to adversely impact the patient.

- Bree Collaborative developed by Washington State looks at prescription trends, Overdose death, Overdose recoveries, and metric regardless of payer type (MCO, private pay). This can identify areas of opportunity to compare the payer programs. Nothing formal was presented at this meeting however the project will be discussed later.
- Gold Star Credentialing, status review- Erin stated work on this initiative is ongoing. If prescribers are credentialed they will no longer require prior authorization to provide medication administered therapy. Any more information for consideration with this panel will be sent out prior to the March meeting. Questions or concerns were taken. Dr. Carlson had a question to inquire if we are focusing on opioid use with multiple providers and multiple sources of opiates to get large quantities. Erin Narus mentioned Lock-in to pharmacy candidates. Qualis within Anchorage and outlying areas connect with patients in metro area. Med Expert is outside of the Anchorage area. Both contractors provide additional case management. This care coordination program is being piloted for a couple of our patients. We need to find a larger number to be referred into the voluntary program. If members do not participate then how do we manage this? If patient decides they want to get into a treatment program that is best for them this coordination can help them get help and link them up with desired services. Housing, transportation, etc can be challenges for these members. The AMCCI – Alaska Medicaid Coordinated Care Initiative program can facilitate coordination of services.

Hepatitis C – Mavyret Approval Update from September Meeting

- After 3 months graph of drug use showed dollars spent, total claims and total patients treated. This presented Hepatitis C drug utilization showing 250 patients treated with Harvoni at a cost of 21.7 million dollars, Epclusa treatment for 73 patients at cost of 5.1 million dollars, with over 3 months treatment of Mavyret for 71 patients at 1.4 million

dollars. So if drug utilization stays the same we would have treated the same number of patients treated with Harvoni in total with Mavyret at a significant cost savings. Patients with Mavyret also include patients with all fibrosis scores.

Opioid Cough Medications

- FDA Regulation changes have been recently mandated to limit use of these products for patients under 18 years of age affecting family practice and pediatrics. Previously we placed an edit in the system for codeine and tramadol products. In 1969 Dr Carlson noted there have been 24 children that have died of codeine which may actually be under reported. Now due to the regulation change it will also include cough and cold medications that include Codeine and Hydrocodone. Erin notified the committee that we will be putting another edit in the system as well for cough preparations with hydrocodone. What are the committee's thoughts regarding cold medicines? Ryan Ruggles mentioned Tylenol with Codeine use of cough. Denise stated there is not much use of cough products but postop use is higher. Now edit in place captured codeine but now cough and colds preparations are specific. This edit will be going in place. Dr Carlson mentioned abuse and safety factors regarding street value are higher for hydrocodone use instead of codeine. Dextromethorphan (DM) suppresses quite well. The abuse concern for higher street value will be lessened with this edit.

Oral antibiotics with same day antifungals

- Erin Narus stated there are prescribers that will provide antibiotics for whatever clinical reason and prescribe fluconazole concurrently to counteract a yeast infection in females. Concern is raised for antifungal stewardship that could possibly cause liver toxicities and there should also be an awareness for antifungal resistances. Not much is talked about it and it is hard to find guidelines for what is happening as a result of immune-competency. John McCall pulled a wide variety of claims specific to females and prescriber same day fills, same prescriber, and no immune-competency). Of top prescribers >5 RX of the antifungals within 4/1/17- 1/11/18 showed claims 8% of prescribers prescribed 30% of the combination of fluconazole and antibiotics. The antifungal may not be needed. Medical necessity is a concern. Erin cited 2 articles she has seen and more education is needed.

Trend Reports

- Drug classes spent vs total paid presented. In 2015 Antivirals, Anti-Arthritics, Tranquilizers, Bronchodilators, Anticonvulsants, Narcotic Analgesics, Stimulants, and Antidepressants are in the top 10. In 2016 top heavy on Antivirals, Anti-Arrhythmics moved up over Anti-Arthritics, Bronchodilators, Anticonvulsants, Narcotic Analgesics, and Stimulants. For 2017 3 months made a difference and Antivirals went to #2, Anti-

Arthritics, what was up was Electrolytes-Nutrients (Number drug class 87). Moving up are Antineoplastics with Narcotic Analgesics dropping some. The increase in Electrolytes Nutrients went up 1 million dollars. We must investigate the reason for this. We need to look at this since it could be just one drug. The call center will receive prior authorizations for drugs just under cost of \$7500 when the prices increase. This effect occurred in January with drug price increases. We need to look at the early warning of percentage increase in WAC pricing. Percent of increase will be important with the magnitude of the cost of the drug. Even a small percentage of high cost drugs can make a difference when factoring volume utilization changes. Magellan can help us for January price changes in the month from the change in December the year before. In addition, dosing changes specific to certain drug categories can change over time especially with Anti-Arthritics (Humira). At what point would newer drugs decrease cost when compared to higher dosing needed of older drug therapies.

- Medicaid enrollees overall encompass 26% of the population (197,000 of 742,000) since the Medicaid expansion. Most coverage is in the Anchorage region somewhere between 20 and 25% of Medicaid patients. As you move out into more rural areas there is a greater percentage of Medicaid coverage as compared to the overall patient population. This awareness in coverage could impact our DUR and clinical decisions regarding prior authorizations. Consideration must be made to special deliveries and packaging or care limitations in rural areas.

Retrospective DUR - Opioids

- Total amount paid for CII scheduled are predominant paid claims over Schedule III and then Schedule IV drugs. If looking at CII claim count went down 1000. With opioid claims the claim count value must be considered higher since more prescriptions per month are prescribed for this drug class. Discussion over partial fills started by Dr. Heistand and compliance is mandated by federal rules with one copay. Full dispensing fee is applied to the first fill and the copay would be taken at the front end with no copay or dispensing fee. This will keep drugs off the street since compensation has been given in full to the pharmacy to decrease losing money for pharmacies on partial fills.

Adjournment 3:51pm

Next meeting in March to be determined by Doodle Poll which is scheduled March 16th, 2018.

Motion for meeting to be adjourned made by Ryan Ruggles and seconded by Dr. Heistand.