TennCare Drug Utilization Review (DUR) Board Minutes

June 5, 2012

In attendance:
DUR Board: Roland Gray, MD, Rebecca Brewer Mills, PharmD, Michael Keny, DPh, Shelton Lacy, APRN, Denise Barker PharmD
Bureau of TennCare: David Collier, MD, Ray McEntire, DPh, Michael Polson, PharmD, MS, Bryan Leibowitz, PharmD
SXC Health Solutions: Toie Alston, PharmD, Bill Hudson, PharmD, BCPS

Introduction:
The meeting was called to order by Dr. Alston, who welcomed everyone to the TennCare Drug Utilization Review (DUR) Board meeting. DUR Board Appointees, Bureau of TennCare Representatives, and SXC Health Solutions, Inc. Representatives introduced themselves.

Review of minutes:
- The Board was asked to review minutes from March 6, 2011 meeting.
- A motion was made by Dr. Collier, seconded by Dr. Gray to approve the minutes as presented. Minutes approved with no changes.

Dr. Collier gave the following TennCare Medical update

- **Provider Rate Restoration:** Legislation will restore 1.75% of the rate reduction that went into effect January 1, 2012. This will cause rate reduction for FY 12 to be reduced from 9.5% to 7.75%. This rate will be retroactive from January 1, 2012. The MCOs (Managed Care Organizations) are currently working to reprogram their systems to process claims from 1/1/12. It will take some time to program the systems. Since some of the claims will have to be processed manually this may extend to the end of September.

- **TennCare benefit Limits:** Hospital coverage assessment passed the third year. This helped the TennCare program by avoiding cuts and benefit limits. The rate will remain the same at 4.52% of the hospital’s net patient revenue.
  - The State is picking up the cost of the Spend Down for the medically needy category.

- **Long Term Care Services & Supports:** Changes to Long Term Care services, specifically the Level of Care (LOC) in a nursing facility (NF) will be implemented. The two eligibility components for Medicaid reimbursement of Long Term Care services include LOC needed and financial eligibility. These
eligibility components also include recipients requesting Home Care Based Services (HCBS).

- Only one significant deficiency in a specified ADL is sufficient to satisfy the “need for inpatient care” provision. Compared to most other states, Tennessee’s requirements are very generous. Therefore, TennCare plans to raise its NF LOC standards for new applicants effective 7/1/12. This change will allow TennCare to provide services to those in need without being too liberal regarding nursing home services.
- TennCare does not plan to simply raise the number of deficiencies required from 1 to 4. TennCare will use the NF LOC Acuity Scale. This scale will use the same ADLs and clinical criteria used today but will weigh each component on a scale of 0 to 5. The eligibility of NF services will be based on the applicant’s cumulative score. This new criteria will only be applied to new applicants beginning 07/1/12, and will not be retroactive.
- There are 3 major groups of recipients receiving Long Term Care:
  - Choices Group 1: Nursing home care recipients
  - Choices Group 2: Home care recipients (HCBS)
    - Adults 65 years of age and older
    - OR adults 21 years of age and older who have impairments/physical disabilities
  - Choices Group 3: “at Risk” of NF placement. They are eligible to receive home-based care.
    - Not eligible to receive residential care
    - Cost cap: $15,000 per year excluding cost of minor home modifications

- **TennCare PLUS:** A transitioning grant from Medicare-Medicaid Coordination Office (MMCO) at CMS was received to develop and coordinate the care of patients classified as Full Benefit Dual Eligibles (FBDEs). FBDEs are those patients who receive full Medicaid benefits in addition to their Medicare benefits. Under TennCare Plus, FBDEs will receive Medicare services as well as TennCare services from their TennCare MCO and Medicare prescription drugs. The pharmacy services will not be provided by TennCare pharmacy; it will be managed through the TennCare MCOs. The anticipated implementation date is January 1, 2014.
  - Some new benefits services that will be provided to FBDEs that were not previously allowed include: basic dental, hearing, vision care and care management/ care coordination services
  - They will also have all the basic benefits such as hospital and physician services, other physical and behavioral health care, and long-term services and supports (nursing home care and home and community based services (HCBS)), except for ICF/MR services (intermediate care facility services for persons with intellectual disabilities) and HCBS waivers for people with intellectual disabilities. These services will continue to be offered outside of TennCare PLUS.

- **TennCare Waiver:** TennCare is requesting an extension of the TennCare waiver. The extension must be submitted by June 30, 2012. The duration of the extension would run from July 1, 2013 through June 30, 2016. The request will primarily update obsolete sections of the waiver, but will not make any significant changes other than the addition of a transition plan affecting certain eligibility changes required by the Affordable Care Act. The transition plan is for persons currently
enrolled in TennCare who are not eligible for Medicaid, but will become eligible for Medicaid benefits as of January 1, 2014 to move or transition over to a Medicaid eligible status. In the past it has taken a long time to receive a response from CMS. Therefore the request for the waiver is being submitted a year early as required to prevent delays.

- **EHR (Electronic Health Records) Provider Incentive Program Update:** This program is being well received any many providers are taking advantage of it.
  - Year 1: 1,694 Eligible Professionals - paid $37,789,596.00
  - 61 Eligible Hospitals - paid $42,351,905.97
  - Year 2: 14 Eligible Professionals - paid $144,500.00
  - 1 Eligible Hospital – paid $368,198.00
  - Three weeks ago there were only 5 Eligible professionals.

**Dr. McIntire gave an update on the TennCare Pharmacy Program**

- **Final Pharmacy Budget Results and Trend Increase Issue, FY2013:** The result of the 2013 budget doesn’t affect pharmacy at this point. Only one item submitted to the governor was accepted in the final budget this year and that was the enhanced TPL (Third Party Liability) collection of coordination of benefits for people who have other insurance besides TennCare.
  - Enhanced TPL Collection- TennCare’s point-of-sale continuation of benefit (COB) program is already operational, and will continue for the FY 2013.
  - Pharmacy Trend- the pharmacy drug spend began to increase at an alarming rate during the 4th quarter of 2011 and 1st quarter of 2012 TennCare reserves were utilized to meet pharmacy budget. The pharmacy team will continue to monitor the pharmacy trend and adjust to market changes and trends as needed to meet budget demands.

- **Prescription Safety Act of 2012:** Under the past law, the Tennessee Controlled Substance Database (CSD) information was available only to pharmacists actively dispensing controlled substances to a current patient. The law also allowed for TennCare’s Associate Medical Director and TennCare’s Pharmacy Associate Director to access the CSD. However, the Pharmacy Benefit Manager who is required to make decisions regarding approvals of controlled substances were unable to access the CSD during review of a patient’s prescription claims history.
  - A second amendment to the new law allows a dispenser or pharmacist not authorized to dispense controlled substances conducting drug utilization or medication history reviews who is actively involved in the care of the patient to access the controlled substance database. Therefore, TennCare’s licensed pharmacists and clinical pharmacists working for TennCare’s PBM vendor will be granted access to the CSD to conduct drug utilization reviews. This is a new change and the pharmacy department is currently reviewing logistically how this will be implemented within the department, but overall this is a wonderful opportunity to appropriately manage drug utilization including: Lock-In reviews, prior authorization request reviews for controlled substances and fraud investigations.

- **CMS Proposed Pharmacy Reimbursement Changes:** States currently reimburse for covered outpatient drugs based on the estimated acquisition cost (EAC). EAC is currently defined as the agency’s best estimate of the price paid by pharmacies. Currently each state has their own methodology as to how they estimate acquisition
cost (EAC) and there are many different calculations that utilize different pharmacy cost standards, such as Average Wholesale Price (AWP), Wholesale Acquisition Price (WAC), or Actual Acquisition cost (AAC) to obtain an estimated acquisition cost of a drug for reimbursement. In Tennessee EAC is defined as AWP – 13%.

- CMS is proposing for all states’ reimbursement to be based on Actual Acquisition Cost (AAC). According to CMS using AAC will be more reflective of actual prices paid, as opposed to estimates based on unreliable published compendia pricing.
- CMS does not offer a definitive method for agencies to determine the actual price of each individual drug. However they do suggest that an average of the AAC’s from representative pharmacies fits within this definition as data used in the calculation of AAC would be reflective of actual pharmacy purchase prices. Within this framework, states can develop payment methodologies consistent with this regulatory definition for their pharmacy reimbursement. The proposal by CMS was open to comment from each state.
- Three states are currently using AAC—Alabama, Idaho and Oregon, and all of their AAC data is available on the Internet. The listing of each state’s AAC is different, so there are still some issues with reliability of using this method.

- **Proposal for PBM Vendor:** TennCare has finalized the RFP to request bids from prospective pharmacy benefit managers (PBMs) for the TennCare pharmacy program.
  - The RFP will be issued to prospective PBM’s prior to July 1, 2012, and after proposals are received, the vendor will be announced on October 1, 2012. PBM services to begin June 1, 2013 for a 3-year period through May 31, 2016, with 2 optional one year renewals.

- **New TennCare Pharmacy Leadership:**
  - TennCare’s new Pharmacy Director is Bryan P. Leibowitz, PharmD. Dr. Leibowitz earned his Doctor of Pharmacy (Pharm.D.) degree from Rutgers University. His experience includes over 5 years experience in the PBM and Managed Care sector as well as 4 years experience in Home Infusion and Specialty Pharmacy. Bryan came from Medco where he and his team managed the clinical and operational aspects of Coventry, a Health Plan with over 7 million lives. Dr. Leibowitz started with TennCare on March 14, and will be relocating his family to the Nashville area from New Jersey.
  - TennCare also hired an additional Associate Pharmacy Director, Dr. Michael Polson. Dr. Polson received his Doctor of Pharmacy (Pharm.D.) degree from East Tennessee State University, a Master of Science (M.S.) degree in Statistics and a Graduate Certificate in Applied Statistical Strategies from The University of Tennessee and a Bachelor of Science (B.S.) in Mathematical Sciences from East Tennessee State. Dr. Polson previously worked for TennCare from 2005 to 2008. During that time he was the Data Intelligence Manager for TennCare working with the Provider Fraud Task Force, and the IT/Reporting Manager in Healthcare Informatics.
  - Dr. Leibowitz stated he look forward to working with the Board.
• **DUR Meeting Proposal:** Dr. Alston informed the Board that due to significant amount of information being covered the day, time and length of each meeting should be reassessed. Dr. Alston gave several suggestions: go to 5 meetings a year, or stay at 4 meetings and extend the length of the current meeting to 2pm. Dr. Alston opened the floor for discussion.
  - Dr. Gray stated longer less frequent meetings work better for him
  - Dr. McIntire reminded the Board the last couple of meetings were pressed for time and that some of the members have to travel 3 or 4 hours.
  - **Dr. Alston stated a survey will be sent out with possible changes at a later date and more details will be provided at next meeting.**
  - Dr. Alston asked if anyone would be opposed to moving the December meeting to early November before holiday season.
  - Dr. Mills stated longer meeting would be more accommodating for her.
  - Dr. Hudson stated extending the meeting would keep the meetings in sync with quarterly data.
  - Ms. Lacy stated she preferred longer meetings.

**Old Business from June 5, 2012 meeting:**

• **Atypical Antipsychotic DUR Activity Letter:** Dr. Alston stated at the last meeting Dr. Koumchev mentioned that it was challenging to write an aggressive letter based on evidence and standard practice. **This activity will not be tabled; new members at the State will work on developing the letter.**
  - Dr. McIntire gave the Board some background on previous discussion and stated that atypicals are huge right now with CMS and Medicaid based on a study done by the GAO. The study showed foster children received 9 times more atypicals than normal children. Tennessee did a study on this back in 2007 and the results were positive.

**Standing Business:** Dr. Alston informed the Board that more explanation would be given during this part of the meeting to help familiarize the new members with the process.

• **Blocking Non-Participating providers-** Dr. McIntire explained the methods used for choosing providers to review and also provided the Board with a summary of reasons why each of the six providers was being reviewed along with blinded copies of their prescribing histories. Out of the top 100 providers 14 were found to be non-participating, and analysis was done on those 14 providers looking at all claims (paid and rejected) for the last year. 6 of the 14 were outliers compared to only the 14 prescribers using statistical methods. If those 6 were compared to the normal population they would be huge outliers. MCOs gave permission to block all 6 prescribers. Some of the prescribers presented are not as active today as they were the second half of last year so the same analysis does not exist for all 6.
  - **Dr. McIntire presented prescriber #1:** This prescriber is an APRN in a Tennessee pain clinic. The prescriber practices in several different locations. This provider had 1,298 total paid claims, 2,055 total rejected claims, 93.5% of paid claims were controlled substances, and almost 91.7% of paid claims were opioids. 99% of that’s provider rejected claims were for controlled substances. This provider had 1,191 paid claims for C-II opiate and only 1 paid claim for C-III. Provider is a double outlier for C-II to all paid claims. The enrollees don’t have stage 4 cancer and they are paying cash for what TennCare doesn’t cover. Dr. McIntire states this is
not standard of care for chronic pain management, which would involve the use of long-acting opioids, with 10 to 20% of the total daily dose as breakthrough medication via short-acting opioids.

- A motion was made by Dr. Gray, seconded by Dr. Mills to block prescriber #1.
  - Dr. Alston asked if the standard deviation mean was composed specifically of pain specialists or does it encompass other groups?
  - Dr. McIntire stated most of the 14 non-participating prescribers were practicing in pain clinics. The supervising physician has one practice were they are a network provider but has a cash pain clinic on the side. So this would make it hard to remove the supervising physician.
- **Board approved motion to block prescriber #1**
- Dr. McIntire stated TennCare Provider Review Committee asked that the DUR board specify if the provider is practicing outside standards of care.
- **A motion was made by Dr. Gray, seconded by Dr. Mills to amend the previous approval with the addition that the prescriber was not practicing within standards of care. The Board approved amendment to previous motion.**
  
  o **Prescriber #2:** This is a physician that has not been as active in 2012 as 2011. The reason is not known - maybe this physician is no longer seeing many TennCare patients. A summary of this physician pharmacy claim analysis consist of: 346 total paid claims, 564 total rejected claims, 276 paid claims for narcotics, 276 (79%) paid claims for short acting opioids (SAO), 2 time outlier for paid claims percent SAO to total opioids, 275 paid claims for C-II, 2 time outlier for rejected claims ratio of C-II to C-III opiates, 110 paid oxycodone IR 15mg claims, 153 paid oxycodone IR 30mg, and 2 time outlier of paid claims with oxycodone plus hydrocodone to all opioids. This physician had no claims for long acting opioids.
  - Dr. McIntire stated the providers have 30 days to appeal once they receive notice. As of today, no provider has appealed. After the physician has been notified, all the enrollees are informed that TennCare will no longer pay for prescriptions from the provider and given their MCO number to contact for new provider. They have 30 days before this is done. This whole process takes about 3 months before the provider is actually blocked.
  - **A motion was made by Dr. Gray, seconded by Ms. Shelton to block prescriber #2 and add that the prescriber is not practicing within standards of care. The Board approved the motion.**
  
  o **Prescriber #3:** Dr. McIntire stated he reviewed this nurse practitioner 6 months ago. This provider is writing all the opioids and the supervising physician profile is 100% clean. Summary of the provider pharmacy claim analysis include: 423 total paid claims, 89% paid claims for controlled substances, 378 paid claims for narcotics, 62 paid claims for LAO, 316 (74%) paid claims for SAO,
double outlier for number of narcotic rejected claims, outlier for paid claims percent SAO to total opioids, 79 paid claims for oxycodone IR 15mg, and 60 paid claims for IR 30mg. This provider had number of rejected methadone claims and carisoprodol claims. Enrollees had more cash claims than paid TennCare claims.

- Dr. McIntire stated everything is showing this provider as family practice but this provider’s practice could qualify as a pain clinic.
- Dr. Gray mentioned if a provider is prescribing 51% narcotics, benzodiazepines, etc. they have to be registered as pain clinic.
- A motion was made by Dr. Gray, seconded by Dr. Mills to block provider #3 and add that the prescriber is not practicing within standards of care.
- The Board approved the motion.

○ Prescriber 4 and 6: Prescriber 4 is the nurse practitioner and prescriber 6 is the supervising physician. The supervising physician wasn’t much of an outlier but was for one category. They both write for methadone and hydromorphone in addition to oxycodone IR 30mg. With both providers there are approximately 2,000 claims. The majority are controlled substances. Many more SAO than LAO and more C-IIIs than C-IIIIs. They consistently prescribe the highest available strengths. The providers are not submitting prior authorizations for methadone, and therefore they are not cooperating with TennCare programs, when preferred products could be used, and the benefit could be used by the enrollee.
  - A motion was made by Dr. Gray, seconded by Dr. Mills to block provider #4 and #6 for not practicing within standards of care.
  - The Motion was approved by the Board.

○ Prescriber 5: This is a nurse practitioner who works for a pain clinic at several different locations. Prescriber summary of pharmacy claims analysis included: 630 total paid claims, 523 paid claims for controlled substances, 516 (81.9%) paid claims for narcotics, 183 paid claims for LAO, 333 paid claims for SAO, 276 paid claims for C-II, 240 paid claims for C-III, outlier for number of paid claims for controlled substances and outlier for number paid claims for narcotics. Provider prescribes more oxycodone/APAP and hydrocodone/APAP products than C-II non-combination products. There are several other providers in network with this chain of pain clinics. No action can be taken on them because they are network providers. However this person is not in the network and looking at this person as an outlier might shake up the whole group.
  - Dr. Hudson asked “Where is the non-standard of care”?
  - Dr. McIntire stated this one is questionable. We can work with the MCO to have them peer reviewed however, that hasn’t always been successful. Another report will be coming up in a couple of months and this can be reviewed again if needed.

- Dr. Alston Presented TennCare Drug Utilization Data, and introduced new members to the tables by defining each section: TennCare pharmacy data is divided into two sections: TennCare statistics and utilization data. Utilization data involves 3 sections: (1) total population, (2) adult population, and (3) child
population. Within each section the drug class claim and payment amount in addition to individual drug claim volume and payment amount is reviewed.

- TennCare population remains constant at approximately 1.2 million enrollees. Non dual adults increased 4.3%. Utilizing members, prescription count, and payment amount increased over 1Q2011. Average payment per claim and average amount paid per utilizing member increased approximately 14%. Average Payment per claim is $65.62.

- Dr. McIntire mentioned that with the passage of the Affordable Care Act, in 2014 TennCare will pick up another 200,000-300,000 enrollees in addition to the 1.2 million.

- **Average Prescription Payment Amount** - Overall generic utilization continues to increase keeping payment amount down. Currently 84.88% of all claims processed are generic. Although the payment amount is up on brand drugs, utilization continues to decrease. Brand refers to both single source agents as while as co-licensed brands. Brand originator refers to brands with generics available.

- **Utilization Highlights 1Q12** - There’s a slight decrease in narcotic analgesic claim volume however the payment amount decreased 7.48%. This is primarily due to the dose limits place on Suboxone®. Leukotriene Modulators claim volume increased 6% and payment amount increased 28%. The payment amount increased due to an increase in utilization and drug cost, a fraction of the increase in utilization could be a result of early spring. This is the typical claim volume seen during spring. Montelukast is projected to be available in generic form in August. The ADHD agents are up 22.9% and they rank #10 in the top therapeutic class by payment amount for adults. Adult claims have increased 9.23%. The Hepatitis agents’ payment amount increased more than 200%. Incivek® compromises 53% of the cost and since Incivek® must be administered in combination with Pegasys® and ribavirin they also contribute to the payment amount growth.

- **Top 10 Therapeutic Classes by Claim Volume** - remains constant with exception of atypical antipsychotics being added to the list.

- **Top 10 Therapeutic Classes by Payment Amount** - remains stable, with the payment amount equaling the amount paid to pharmacies before rebates and federal matches are taken into account. Here we see a decrease in narcotic analgesic payment amount and an increase in the ADHD agents. The narcotic analgesics class includes opioid agonists, opioid partial agonists, and opioid combinations. ADHD agents include both simulants and non-stimulants such as Strattera® and Intuniv®. The Sympathomimetics class includes beta agonist combination products.
  - Dr. McIntire stated that the monoclonal antibodies class refers to Synagis®.

- **Top 10 drugs by Claim Volume** - remains fairly constant and TennCare’s most frequently used drug is hydrocodone/APAP.

- **Top 10 drugs by Payment Amount** - remains stable. Six of these drugs are mental health agents.

- **Claim Volume Per Age Group** – The highest total number of scripts are in children 0-20 years of age. This is expected since children comprise 2/3 of TennCare population. At this time the highest average number of claims per utilizer per month (PUPM) is in the greater than 45 year of age group.
- **Payment Amount Per Age Group**- The highest total payment amount and the highest average payment per claim are in the 0-20 years of age group.
- **Top 10 Therapeutic Classes by Claim Volume**- in adults remains stable. The PPI’s have surpassed the H2 antagonist claim volume (49,070) seen a year and half ago. TennCare removed clinical criteria from PPIs in October 2010.
- **Top 10 Therapeutic Classes by Payment Amount**- in adults remains consistent with exception of hepatitis agents. As mentioned earlier, this class increased more than 200%.
- **Top 10 Drugs by Claim Volume in Adults**- Hydrocodone ranks number 1 as it did in the total population.
- **Top 10 Drugs by Payment Amount in Adults**- Since the release of generic Seroquel®, quetiapine payment has decreased slightly, however it remains #1.
  - Dr. McIntire mentioned quetiapine was released at the end of March, and next quarter it will not be on the list.
- **Claim Volume for Children**- The highest total number of scripts per month is in those members age 0-6. The highest average number of claims PUPM is in those members age 14-20.
- **Payment Amount for Children**- The highest total payment and highest average payment per claim are in those ages 7-13.
- **Top 10 Therapeutic Classes by Claim Volume for Children**- remains stable. The Penicillins class ranked number 1 followed by ADHD agents, and the narcotic analgesics class ranked number 8.
- **Top 10 Therapeutic Classes by Payment Amount for Children**- remains constant. Only 4 of these classes were listed in top therapeutic class by claim volume: ADHD agents, sympathomimetics, leukotriene modulators, and cephalosporins.
- **Top 10 Drugs by Claim Volume for Children**- correlates to the Top Therapeutic Class by Claim Volume, and is mainly composed of antibiotics, medication for asthma and allergies.
- **Top 10 Drugs by Payment Amount for Children**- dexmethylphenidate is new to the list with 38% increase in utilization.

**Prospective Drug Utilization Review (ProDUR)**: Dr. Alston defined ProDUR edit and reviewed the different types of rejections.
- **Summary of ProDUR Edits**- The ProDUR edits remain constant with the exception of the Geriatric Precaution edit. There are four new drugs topping the geriatric list: warfarin, HCTZ, quetiapine, and trazodone.
  - With warfarin, geriatric patients are more susceptible to the effects of anticoagulants, possibly due to a decrease in the clearance of warfarin with age.
  - Greater sensitivity to the hypotensive and diuretic effects of hydrochlorothiazide is possible in geriatric patients.
  - It is possible that elderly patients may be more sensitive to the sedative, anticholinergic, and orthostatic effects of quetiapine.
  - With trazodone elderly patients appear to be at greater risk for low plasma sodium concentrations and syndrome of inappropriate antidiuretic hormone secretion (SIADH).
- **Therapeutic Duplication ProDUR**- The therapeutic duplication edit checks for therapeutic duplications based on the therapeutic class of the
All edits receive a soft reject response except narcotics, skeletal muscle relaxants, and non-benzodiazepine sedative hypnotics, which receive a hard reject.

- **Early Refill** - The early refill edit contains both “refill too soon” and “duplicate Rx” edits, which both deny at point of sale. The “duplicate Rx” edit checks for exact drug duplication, via the drug’s Generic Product ID (GPI), which is a proprietary code provided by MediSpan, the source of drug data used by SXC. The “refill too soon” edit alerts the pharmacy that a prescription is being submitted earlier than the edit will allow, based on the days supply of the previous fill of the same prescription.
  - Dr. McIntire stated that long acting and short acting narcotics are classified differently; they can be used together and not stop at the point of sale.

- **Max Dose ProDUR Edit** - Doses that are 225% of max dose will soft reject at point of sale, while all other doses over the max dose generates a DUR message only. The percent of claims paid includes the percentage of claims that also hit a soft reject.

- **Drug to Drug** - At the point of sale (POS), the “drug to drug” interaction edits either result in a soft reject or message only, depending on severity. All edits listed have major severity and resulted in a soft reject at the POS.

- **Drug to Inferred Diagnosis Pregnancy** - This edit only messages at the point of sale. The percent of claims that are not paid is due to a different edit such as “refill to soon”, “PA required”, etc.

- **Drug to Gender** - DUR Board voted to change this edit and then amended the decision, and during 1Q12 severity level-1 and -2 resulted in a hard reject at the POS. The edit was then changed to allow tamsulosin and nevirapine to soft reject at the POS, and all other severity level-1 and -2 to continue to result in a hard reject.

- **Geriatric Precautions** - Geriatric precaution edits receive a message or soft reject depending on severity. All drugs listed are minor. No soft rejects were generated this quarter.

- **2012 Beers Criteria Update** - The aim of this project was to update the previous Beers Criteria using a comprehensive, systemic review and grading of the evidence on drug related problems and adverse drug events in older adults. This was accomplished with the help of the American Geriatrics Society (AGS) and 11 Experts in Geriatric Care and Pharmacotherapy. They applied a modified Delphi method to the systematic review and grading to reach consensus. The final criteria incorporated 53 medications or medication classes into 3 different categories:
  - Medications to avoid in older adults regardless of diseases or conditions
  - Medications considered potentially inappropriate when used in older adults with certain diseases or syndromes
  - A new group was added - medications that should be used with caution.

- **Pediatric Precautions** - Pediatric precautions result in either a soft reject or message depending on severity.

- **RetroDUR and Provider Analysis Activities**: Dr. Alston asked the Board if they had any recommendations for future DUR activities.
o Dr. McIntire informed the Board of TennCare DUR activity requirements.

- **Non-Compliance with Immunosuppressant Therapy** - For this review, we used pharmacy claims data to identify TennCare recipients who did not obtain a refill of their immunosuppressant medication within 7 days after the medication supply was expected to run out. We tried to avoid sending this letter in situations where it appeared the patient had been ill or hospitalized or in situations where there had been changes in drug therapy.

- **Statin Risk in Pregnancy** - This review identified women of child-bearing age (21-35) receiving a statin with no contraceptive in their prescription claim history, or demonstrated non-compliance with contraceptive therapy.

- **Singulair® Utilization** - For this activity, pharmacy claims were used to infer a diagnosis. Patients receiving Singulair® who did not have claims submitted for any asthma medications received an inferred diagnosis of allergic rhinitis. The prescriber was targeted with a letter when patients were found with an inferred diagnosis of allergic rhinitis and had no claims history of a first line agent within the last year.

- **Top Narcotic Prescriber** - The top 126 narcotic prescribers were lettered.

- **Short Acting Narcotic Initiative** - For this quarter 800 prescribers where lettered.
  - Dr. McIntire stated there is a Joint Committee on Narcotics however it hasn’t meet in several years. Our new administration will be evaluating this process along with other needs in the upcoming months.

- **Risk of Diabetes with Statin** - This activity reminded prescribers that although published literature notes an increase in hemoglobin (HgA1C) and blood glucose with statin use, it is not recommended to discontinue statin therapy or to avoid initiating statin therapy in patients with diabetes.

- Dr. Barker asked how the activities’ outcomes are determined and if the prescribers push back.

- Dr. Alston stated the prescribers’ response to the activities survey are compiled and presented annually. Prescribers often push back on the “Top Narcotic Prescriber” activity and SAN initiative.

- Dr. Alston stated TennCare has requested a before and after analysis for the SAN initiative to see if patients’ or prescribers’ habits changed.

- Dr. McIntire stated it is a CMS regulation that we have to do these activities and more time should be spent putting dollar figures to them to show savings. Provider educators need to get involved with the outliers found during the DUR activities.

- Ms. Shelton asked how the activities are chosen.

- Dr. Alston stated the activities come from a mixture of sources. Activities derive from DUR Board request, data analysis, and PAC via clinical pharmacists.

- Dr. Hudson stated that in absence of any new ideas we use past activities that were successful.

- Dr. Alston stated when focusing on outcomes, not all outcomes will result in a cost savings. SAN initiative isn’t a cost saving activity; it focuses more on prescribing habits and standards of care. The increased utilization of long acting prescribing narcotics is likely to increase cost.

- Ms. Shelton asked has there been an activity focusing on patients using pain medication for mental health issues such as anxiety (narcotics, neuropathics and antidepressants). These patients are being prescribed
pain medication for pain; however the patient is using the pain medication to treat mental or neurological ailments. Physicians often fail to treat all aspects of pain.

- Dr. Alston stated there has not been an activity focusing on that specific medication/diagnosis combination. The state is able to provide ICD-9 codes to help facilitate this activity.
- Dr. McIntire advised Board members to evaluate their practices and share issues that need to be evaluated by the Board.
- **Overutilization of Short Acting Beta-Agonists (SABA)-** This activity focuses on overutilization of albuterol inhalers - more than two inhalers per month. SABAs should be reserved for relief of acute symptoms, with use >2 days per week indicating inadequate symptom control. Patients will be selected by reviewing TennCare pharmacy claims and identifying patients who have received more than 1 albuterol inhaler per month for a 3 month time frame, with no pharmacy claims in the past 6 months for inhaled corticosteroid maintenance therapy.

- **Insomnia Treatment-** Since the sedative hypnotic quantities have been decreased this is a good time to review insomnia treatment. The review will focus on non-pharmacological treatment as well as pharmacologic treatment and will focus on patients receiving sedative hypnotic therapy for at least 3 consecutive months.

- **Migraine Prophylaxis-** This activity will focus on patients who chronically use abortive medication (more than twice per week) with no preventive therapy. Migraine guidelines emphasize the importance of evaluating migraine sufferers for the use of preventive therapy.

- **Updated Beers Criteria-** This activity will focus on potentially inappropriate medication use in TennCare elderly adults.

- **Zyprexa® Conversion-** This was a request from the clinical pharmacists to help insure there are no delays in therapy. The letter will inform the prescriber that existing prior authorizations (PAs) will be entered for generic drugs and requests for the brand agent will require a new PA effective 6/11/12.

- **Prescribing Multi-Source Agents-** This is a State request.

**Dr. McIntire presented Pharmacy Lock In Program:**

- 50 to 100 enrollees are locked into a pharmacy every month.
- 50 of the people who are currently locked in are re-reviewed every month for potential escalation or removal of the Lock-In edit.

- We are in the final stages of changing communication to the pharmacies.

- Lock-In pharmacies will receive detailed information regarding the Lock-In program, expectations, how to help enrollees. A letter will also go to all the other pharmacies the enrollee was using informing them that are no longer that enrollee’s pharmacy, and expectations.

- TennCare uses multiple Lock-In criteria. Most of the people who are locked in today fall into Criteria-1 or -2.

- “Targeted pharmacies” and “Targeted Prescriber” have been redefined. A ”Targeted Prescriber” is now defined as the top 100 non-participating narcotic providers. “Targeted Pharmacies” have been changed to out-of-state pharmacies and those pharmacies with a history of controlled substance violations. A pharmacy that does not cooperate with the Lock-In program could become a “Targeted Pharmacy”.

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Locked-In recipients are allowed 1 pharmacy change per calendar year.
January and February where clean up months.
For Re-Review, both cash and TennCare claims are reviewed with the exception of drugs that are not covered by TennCare (e.g., benzodiazepines for adults). The enrollee can be escalated to “PA Only” status, where the enrollee needs a PA for every fill of every controlled substance. We have found that in some cases, the prescriber does not make PA requests, and the enrollee ends up paying cash for all the controlled substances. 1Q12 Re-Review results:

- 146 enrollee profiles selected for Re-Review,
- 85 remain locked-in
- 4 remain on “PA Only” status
- 20 escalated to “PA Only” status
- 35 removed from Lock-In.

Patient may be removed from “PA Only” status if they are utilizing only 1 physician, 1 pharmacy, and no cash prescriptions for medications covered by TennCare.
There were 82 Lock-In change requests: 44 approved, 38 denied.
Lock-In pharmacy change requests exceptions include:
- Pharmacy does not have medication in stock.
- Pharmacy is closed.
- Recipient has moved
- Recipient has been voluntarily dismissed by their pharmacy

Dr. Barker stated there have been times during TennCare business hours when an out of stock medication override was needed and the call to the TennCare Help Desk would time out. The patient had to wait until after hours to get the override from SXC.
Dr. McIntire stated that the call should have been directed to a provider educator in Nashville.
Dr. Gray asked has a provider ever tried to justify prescribing Suboxone® with a narcotic.
Dr. McIntire stated the prescribing is there, however no one has ever tried to justify it.
Dr. Collier asked the Board if the Lock-In program was realistic, and if pharmacists know their customers? With the bigger chains there doesn’t appear to be much personal touch.
Dr. Barker stated “I know my patients. I have called in the past to have someone locked-in”.
Dr. Alston stated it really depends on the environment you work in. If you’re filling 600 to 700 scripts daily the only way you will know a customer personally is if that person is needy or a problem customer.
Dr. McIntire stated it depends on the pharmacist.
Dr. Barker stated if pharmacists had more input on who gets locked-in, we could find better fit for the members.

Meeting was adjourned at 11:45pm

Next DUR Board Meeting scheduled for September 11, 2012