



STATE MEDICAID DUR BOARD MEETING
 THURSDAY, January 11, 2007
 7:00 a.m. to 8:30 a.m.
 Cannon Health Building
 Room 125



MINUTES

Board Members Present

Mark Balk, PharmD, BCPS
Lowry Bushnell, M.D.
Derek Christensen, R.Ph.
Karen Gunning, PharmD.

Colin B. VanOrman, M.D.
Bradley Pace, PA-C
Dominic DeRose, R.Ph.

Bradford Hare, M.D.
Joseph Miner, M.D.
Don Hawley, D.D.S.

Board Members Excused:

Jeff Jones, R.Ph.

Wilhelm T. Lehmann, M.D.

Dept. of Health/Div. of Health Care Financing Staff Present:

Rae Dell Ashley, R.Ph.
Tim Morley, R.Ph.
Merelynn Berrett
Jennifer Zeleny, CPhT.

Sue Allgaier R.N.
Nanette Waters
Richard Sorenson, R.N.

Other Individuals Present:

Mandy Hosford, AstraZeneca
Roy Linfield, Schering
Shannon Beatty, Medimmune
Steve Farmer
Tim Smith, Pfizer
Joe Busby, Eli Lilly
Charles Hall

Dyan Alexander, AstraZeneca
Tom Holt, Schering
Paul Nelson, Medimmune
Michael Cobble, M.D.
Byron Bair
Jeff Buel Johnson&Johnson
Reed Murdoch, Wyeth

Linda Craig, AstraZeneca
Gery Shiohita, Schering
Pierre Thoumlin
Alan Bailey, Pfizer
Oscar Fuller
Allen Shih
Joseph Yau, M.D., VMH

Meeting conducted by: Lowry Bushnell

1. Minutes for December 14, 2006 were reviewed, corrected, and approved.
2. Housekeeping: No items
3. Comprehensive NeuroScience Program Report: Dr. Bair addressed the Board. The goal of his group has been to impact the use of psychotropic medications in adult and child populations. His report will address the changes that have occurred during the period from January 2004 to January 2006. CNS has quality indicators such as multiple

benzodiazepines or multiple opioids. For example, the multiple benzodiazepine quality indicator will be triggered if a patient receives two or more benzodiazepines for over 60 days in the adult population. During the last six months, CNS has sent out multiple mailings about the appropriate use of benzodiazepines in adults. During this same period of time there was a 68% decrease in the number of patients triggering this quality indicator. An example of a quality indicator in the child population is multiple prescribers of any psychotropic medications for more than 45 days. During the last six months, there has been a decrease of 64% in the number of patients triggering this quality indicator. With regards to multiple prescribers for opioids, there has been a 65% decrease in the quality indicator in adults, and an 89% decrease in children. CNS has about 20 quality indicators that are followed for the Medicaid population.

Utilization data for Utah is currently being compiled. Dr. Bair presented comparison data from Missouri, which parallels Utah in terms of effectiveness. When utilization of psychotropic drugs is impacted, it is important to look at overall utilization of services within the Medicaid program to understand the overall impact on costs. In the comparison group from Missouri, there was a drop in hospitalization rates of 7.3% during the intervention period. The comparison group that did not have an intervention showed no change in prescribing habits or rates of hospitalizations. During the same period the total non-pharmacy costs of the target group were also analyzed to ensure that no shifting of costs occurred. The target group experienced a \$1,000 per patient decrease in overall costs during the six month intervention period. The non-target group had an approximate per patient decrease of \$300. Therefore, the intervention saved the Medicaid program approximately \$700/patient during the intervention period.

The conclusion that can be drawn from this data is that CNS is not only saving Medicaid money by promoting better prescribing habits, but also by promoting more appropriate utilization of services. Dr. Bair accepted questions.

Karen Gunning asked how many of the adult patients that were targeted for intervention were now in the Medicare Part D program. Tim Morley replied that approximately 20,000 clients went from Medicaid to Medicare Part D, but was not certain how many of those clients were utilizing atypical antipsychotics.

Dr. Bair was asked to clarify whether or not the CNS program targeted appropriate usage of atypical antipsychotics. Dr. Bair stated that the preceding discussion of benzodiazepines and opioids was only a small sample of what CNS has been studying. CNS has been working with prescribers to teach appropriate prescribing habits for all psychotropic medications. CNS recognizes that there will always be outliers and difficult-to-treat patients that are utilizing psychiatric services. In the future, CNS would like to examine the utilization of the top 100 patients on psychotropic medication to assist prescribers in appropriately prescribing for these frustrating cases. CNS would like to handle these difficult patients on an institutional level to see what can be improved in how the care is delivered to these patients.

Dr. Hare asked if some of the cost impact that Dr. Bair has shown is a result of the shifting of costs to Medicare Part D. Dr. Bair stated that there was an overall favorable impact on Medicaid expenditures as a result of Medicare Part D, but that the data that he presented took into account this shift.

RaeDell Ashley stated that the overall response to the peer-review of prescribing habits by CNS has been favorable. She asked Dr. Bair to talk to the Board about how the peer-review takes place. Dr. Bair stated that CNS has learned to present clinically relevant data in a succinct manner by using bullet points and keeping letters no longer than one page. He also stated that prescribers respond favorably to useful information regarding patients such as multiple prescribers prescribing the same drug.

Don Hawley asked for a general overview regarding the process of how CNS reaches out to the prescribers once clinically relevant data is gathered. Dr. Bair replied that CNS has a process of running data pulls from the Medicaid pharmacy claims data against the approximately 20 quality indicators that CNS has in place. If prescribers trigger the quality indicators, they are targeted for intervention. CNS has also found that some of the providers are attached to a particular system of care. If this is the case, CNS will target them for an institutional intervention. CNS will ask to present the outlier patients at institutional conferences and ask for the prescribers and their colleagues to review the care that has been received by the outlying patient. This has been favorably received. CNS has also promoted group conferencing about difficult patients within a healthcare delivery system. This allows prescribers to feel safe in bringing up difficult cases to ask for suggestions in how to deliver care. This also allows institutions to analyze the 100 most difficult-to-treat patients to recognize what types of things are needed institutionally to deliver more effective care to them.

Dr. Miner stated that very often the patient's primary care provider may be listed as the prescriber on the prescriptions received by a patient receiving psychotropic medications, even though there is a psychiatrist consulting on the patient's care. He asked how CNS ensures that the consulting psychiatrist is actually going to receive interventional materials that are sent to the primary care physician or institutional director. Dr. Bair stated that this is actually a common complaint received in the feedback loop when materials are sent out, and that RaeDell Ashley and Tim Morley then track down the actual prescriber of the particular medication so that the intervention can be delivered to the appropriate prescriber. Pharmacy order entry errors have also contributed to clinicians being erroneously targeted for interventions. It appears that pharmacy accuracy is improving in this area.

Don Hawley asked for a dollar figure of how much revenue the CNS program is generating. Dr. Bair stated that CNS has contracted with a data analysis group called Mathematica to compare physicians in the intervention group to comparable physicians that have not been targeted for interventions to determine the fiscal impact of their program.

Dr. VanOrman stated that he has received interventional material due to his use of anticonvulsants as a neurologist. He asked if CNS realizes that some of the physicians that are being targeted with interventional material are not prescribing certain medications for behavioral reasons. Dr. Bair stated that there is a method of notifying CNS that the condition being treated is not behavioral through the feedback loop that they have in place so that the prescribing physician's name can be removed from the list.

4. Review of Anti-psychotic Covered ICD-9 List: Tim Morley addressed the Board. Medicaid would like to have a discussion about the ICD-9 codes that are currently enabled for use with the anti-psychotic medications. The Board was provided with a list of prescriptions and ICD-9 Codes used during CY 2006. Medicaid has chosen to provide the Board with data from CY 2006, since that is the only year in which dual-eligible clients have been excluded from Medicaid prescription coverage. Medicaid feels that there is a need to pare down the list, since the atypical anti-psychotics are only indicated for a narrow realm of psychiatric conditions. The reports provided by Medicaid indicate the magnitude of usage for certain ICD-9 codes.

Don Hawley asked if Medicaid currently has the computer programming in place to restrict the available ICD-9 codes. RaeDell Ashley answered that this programming is in place.

Dr. Bushnell indicated that when the atypical anti-psychotics first came to market, the Board was under pressure from psychiatrists and mental health advocacy groups to keep access open for almost any reason. The resulting ICD-9 list included a large number of diagnoses, such as anxiety and sleep disorders, that are not appropriate indications for the medications. There are some negatives associated with these medications that one should not unnecessarily expose patients to. They are terribly expensive to get to sleep on. Rather than coming up with a decision on how to change the list, the Board was instructed to look over the current ICD-9 list to think about how the list should be changed in the future.

Karen Gunning addressed the Board. She stated that many pharmacies probably have the list of approved ICD-9 codes by their computer and are selecting any codes to get the prescriptions through the system rather having the psychiatrists write the ICD-9 code on the prescription like they are supposed to. She questioned the necessity and appropriateness of the list, since the pharmacies may not be utilizing the system correctly. Dr. Bushnell oversees psychiatry and feels that there is a great determination to use these agents off-label within the specialty of psychiatry. Karen Gunning did not feel that this was as troubling as the use of atypical anti-psychotics by primary care physicians.

RaeDell Ashley stated that Medicaid has been looking for articles published on atypical anti-psychotic use for certain off-label indications such as senile dementia. Karen Gunning asked if the CNS group could research this. The federal government has very strict criteria regarding the use of medications off-label, such as having published studies appear in certain areas. Some of the indications that are currently on the ICD-9 list do not appear anywhere.

Dr. Yau addressed the Board. The list of the diagnoses seems to be long, but many of the diagnoses appear within groupings such as “bipolar disorder”, so the list is actually not as long as it seems. The advocacy groups would like access atypical anti-psychotics to remain open. In terms of FDA approval versus some reports of being used, there is definitely some off-label use as a community standard. For example, someone specifically mentioned senile dementia, which is often associated with agitation. These medications are often used in this population to control agitation. The person prescribing these medications needs to be aware of the increased risks associated with these medications such as stroke, diabetes, and other disease states. It is important that atypical anti-psychotics remain available for these conditions where their use is an accepted practice.

Tim Morley stated that one thing that Medicaid would like to determine from the available data is what sort of community standard exists. For example, in the data there are nine prescriptions for six clients with an ICD-9 code for “anxiety states not otherwise specified” last year. Does that mean that there is no community standard for that, or if pharmacies are using a different diagnosis code, or that physicians are not using that diagnosis code when the condition exists? This is the type of problem that Medicaid has with the available data. Karen Gunning also pointed out that one client may have any number of co-morbid diagnoses which Medicaid’s system does not currently take into account.

Tim Morley asked what other types of data would assist the Board in making a decision regarding the ICD-9 codes. Karen Gunning stated that her cynical impression is that the data that is available is flawed due to the questionable ways in which ICD-9 codes are obtained. Dr. Bushnell suggested that perhaps the list of ICD-9 codes could be tightened to include only the root diagnoses so that the data is not spread over so many questionable diagnoses.

Dr. Hare asked if the newer anti-psychotics have demonstrated any condition of superiority over the more traditional drugs. Dr. Lowery stated that he didn’t believe that it has been demonstrated since the use of Zyprexa versus Thorazine as a “chemical straight-jacket” has not been studied. He also believes that there are some unique anti-psychotic advantages and some unique negative symptom advantages. However, he does not believe that there is an advantage to someone who is demented, sundowning, agitated, and does not have psychosis. Karen Gunning thought that the adverse effects are also very significant for many of these. Dr. Hare felt that the issue of cost and adverse effects are important issues to raise, since these drugs are not safer. Don Hawley felt that some of the adverse effects, such as diabetes, are so profound, that they may actually cost Medicaid even more money.

Dr. Yau felt that in clients with dementia, agitation is a very common presentation. For managing this symptom, there are many things. In terms of medications, there are anti-convulsants, which need to be titrated and may not be tolerated by the patients. Titration also takes maybe one to two months. When a patient is agitated and has a mood disorder,

anti-depressants may give a good response. Benzodiazepines may calm the patient down, but are associated with falls. Atypical anti-psychotics used carefully and in a lower dose may give desirable results. Dr. Hare asked if there was a benefit of the newer atypical anti-psychotics. There are benefits in terms of short-term side effects such as less EPS and fewer anticholinergic side-effects. In younger populations, patients often prefer atypical anti-psychotics because there is less of a dulling effect. The clients want less cognitive decline, which atypical anti-psychotics can provide. Dr. Yau also wanted to address a question posed to Dr. Bair as far as savings since the BPMP program. There was at one time a graph showing projected costs. Since the implementation of the BPMP program, the actual cost curve separated from the projected costs and demonstrated a 3% decrease from the projected costs.

Dr. Bushnell also wanted to bring up a concern that he has in terms of how some patients are managed in their milieu with drugs. Very often, in his hospital, there will be patients sent from nursing homes who are considered unmanageable. He stated that very often they are admitted for three weeks, and that during the three weeks he does not see problems despite the fact that they are not using any medications. He worries that chemical restraint is becoming a replacement for good staffing and good training.

5. Statin Step Therapy: Dr. Bushnell addressed the Board. He stated that Medicaid only wanted to accept comments and not make decisions or take votes during this meeting. Tim Morley stated that the Board has been provided with utilization data for lipotropics for CY 2006. He also wanted to present information on the ATP3 guidelines and some other studies that have come out since those guidelines. The Board will also accept comments from audience members who wish to talk about “statins”

Dr. Mandy Hosford, a research scientist from AstraZeneca addressed the Board. AstraZeneca is committed to improving pharmaceutical care, and would like to point out that some patients need more potent and efficacious “Statins” when they have a more aggressive lipid goal. “Statins” that are not available in generic form may not always be potent or efficacious enough for these patients.

Dr. Mike Cobble addressed the Board. Dr. Cobble stated that psychotropics should be used for what they are FDA-approved for. He has written for both first and second-generation anti-psychotics for twenty years, and feels that the second-generation products are superior in both positive and negative symptoms. He stated that it has been wonderful to have second-generation anti-psychotics available through Medicaid for his patients with schizophrenia or severe bipolar disorder. Dr. Bushnell asked that Dr. Cobble proceed to his comments about “Statins”.

Dr. Cobble stated that the Stellar Study indicated that generic “Statins” will result in goal achievement in approximately 20% of patients, where as brand-name “Statins” will result in goal achievement in approximately 70-80% in patients. He felt that if patients were restricted to generic “Statins”, starting doses would have to be higher. Dr. Bushnell asked if this was meant to imply that once a drug goes off-patent it becomes less efficacious.

Dr. Cobble stated that the LDL reductions achieved with older agents was inferior to the LDL reductions achieved with newer agents. Karen Gunning stated that the majority of prescriptions that were paid for by Medicaid were actually for low doses of Atorvastatin. Assuming that these patients are at goal, they would actually be good candidates to be switched to a generic product. Dr. Cobble indicated that some physicians may, then, write for inappropriately low doses of older “Statins”. Karen Gunning indicated that she did not believe that the Board wanted to select a single product that would be used for all patients. Instead, the Board would like to maximize the utilization of generics. Dr. Cobble suggested that the Board members should look at the Stellar data. He also stated that it is poor practice for clinicians to prescribe “Statins” without ensuring that patients achieve goal. Karen Gunning replied that Medicaid cannot ensure that a patient is at goal; however, Medicaid can provide clinical education. Dr. Cobble stated that in high-risk patients may need to start on more potent “Statins”. Karen Gunning replied that appropriate usage guidelines are promoted by Medicaid, even if that means an increase in cost for a particular patient.

Dr. Hosford stated that Utah lags behind the rest of the nation in lipid goal attainment in patients with diabetes. These are high-risk patients who are not getting to goal on low doses. It is not clear whether it is an access or provider issue. However, highly efficacious and branded “Statins” should be available to these patients without them having to go through many months of titrations and drug failures, as it is discouraging and risky for the patients.

Gery Shiohita, PharmD. with Schering Plough addressed the Board. He would like to ask that Medicaid keep access to Zetia and Vytorin unrestricted for the reasons that have been discussed earlier as far as goal attainment. Vytorin has a goal attainment of 50% to 85% and effects two sources of cholesterol - absorption and synthesis. The addition of Zetia to a “Statin” regimen can be described as side-effect sparing and causes an additional drop in LDL of about 20%. Gery Shiohita left information regarding Vytorin and Zetia with the Board.

Dr. Bushnell re-stated that this had been only a discussion for Medicaid to accept comments, and that no decisions regarding the restriction of lipotropics would be made at this time.

Meeting adjourned

Next meeting set for February 8, 2007

The DUR Board Prior Approval Sub-committee convened and considered 6 petitions. Drug histories were for 12 months unless otherwise noted.

Minutes prepared by Jennifer K. Zeleny

