



STATE MEDICAID DUR BOARD MEETING
 THURSDAY, October 11, 2012
 7:00 a.m. to 8:30 a.m.
 Cannon Health Building
 Room 125



MINUTES

Board Members Present:

Joseph Miner, M.D.

Mr. Kumar Shah

Cris Cowley, M.D.

Tony Dalpiaz, PharmD.

Kathy Goodfellow, R.Ph.

George Hamblin, R.Ph.

Neal Catalano, PharmD.

Board Members Excused:

Brad Hare, M.D.

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

Robyn Seely, PharmD.

Tim Morley, R.Ph.

Lisa V Hunt, R.Ph.

Heather Santacruz, R.N.

Marisha Kissell, R.N.

Merelynn Berrett, R.N.

Other Individuals Present:

Joanita Lake, UofU

Gary Oderda, UofU

Lori Howarth, Bayer

Mathew Chin, UofU

Bryan Larson, UofU

Charissa Anne, J&J

Spencer Brown, UofU

Scott Larson, BMS

Meeting conducted by: Neal Catalano, PharmD

1. Welcome - Neal Catalano opened the meeting.
2. Housekeeping – Robyn Seely directed guests and board members to sign in.
3. Tim Morely presented on ACO’s and how they will affect the DUR Boards future. He started off by defining ACO’s as Accountable Care Organizations and how they relate to Managed Care Organizations. While the medical side of Medicaid has been under managed care beginning 1/1/13 pharmacy will be under managed care too for the four metropolitan counties of Weber, Davis, Salt Lake, and Utah. Most of the rural counties will not be under managed care and will continue their pharmacy benefit under fee for service.

It has been proposed that the P&T committee do a review of the ACO’s proposed Preferred

Drug Lists (PDL)'s for safety, efficacy, and access. Also reviewed will be each plans transition plan on how they will assure continuity of care for clients who will need refills of drug products that ACO will be requiring a prior authorization. This will be necessary because each of the plans will be allowed to have their own PDL. The P&T Committee will then report back to the DUR Board any concerns identified and/or recommendations for approval. The four identified ACO's to date are Molina, Select Health, Healthy U, and Health Choice.

Lisa Hunt gave an overview of how the plans will be presenting their proposed PDL's to the P&T Committee, two in November and two in December. The P&T Committee will have the ability to ask the plans how they will handle any identified concerns in the classes of medications where their PDL differs substantially from ours. We are planning on providing the plans with utilization and state prior authorization information on their enrolled Medicaid clients.

The drugs which will remain fee for service for all Medicaid clients are the mental health products, transplant therapy immunosuppressives, antihemophiliac products, and drugs used to treat addiction like Vivitrol, Suboxone, and Subutex. The other clients that will remain fee for service will include new enrollees for the three or so months that it takes to enroll them into a plan, clients who go into nursing homes will be un-enrolled from the ACO's within 30 days, and clients who live in rural areas. An unofficial estimation is that this will leave approximately 50,000 to 100,000 clients in fee for service.

This all came about through Senate Bill 180 and makes the ACO's accountable for the patient's outcomes.

The Board discussed a concern that the work that has been previously done by the Board will not be applicable to the clients being managed under ACO's. However, the Board can always bring up and make recommendations to the State on any concerns that come up with the plans. The State will still be providing over-site for Medicaid managed care.

Information will be available on the client's cards and pharmacy providers can call into the State or the plan for information. Medicaid will be disseminating information on the plans and their bin numbers for and effective date of 01/01/12. Quantity limits may change if the plans decide to manage products differently from how the state has historically done so.

Each of the plans will have their own pharmacy networks and will establish their own contractual reimbursement rates for pharmacy services. Plans will have to adhere to current copay structure.

Mental health services will still be capitated to community mental health centers and are separate from the ACO plans. The hemophilia program will also stay separate from the ACO plans. Utah Medicaid has around 240,000 to 300,000 clients yearly.

Board members had questions about if all of the work they have done will no longer apply. It was explained that around 30% of clients will remain fee for service. Questions were asked about plan shopping. Will clients be able to change plans monthly? They will only be able to change plans annually during open enrollment.

It is important that the DUR Board has over view of the ACO formularies and make any recommendations to Medicaid should a concern arise. The P&T Committee will do the review of the ACO formularies and a report will be given back to the Board.

The P&T Committee was set up as a subcommittee of the DUR Board to make recommendations on Utah Medicaid's PDL. Dr. Miner made a motion to have the P&T Committee look at the proposed ACO PDL's and make a recommendation to the Board for approval or to express concerns on safety, efficacy, and/or access. Tony Dalpiaz, seconded the motion and all approved.

4. P&T Committee will be looking at topical steroids, but we will be having two months where we will not be looking at specific classes but instead looking at whole formularies as proposed by the ACO's. Each plan will be given about 10 minutes to give a high level overview of their PDL's and then the P&T Committee will have 5 to 10 minutes to ask questions. It is anticipated that each of the plans will be asked to describe how they will handle transitions, provider education, coverage of classes including OTC's along with criteria for coverage of non preferred products. The committee will also most likely ask about how the plans will transition patients.
5. September meeting minutes. George Hamblin asked what are the capabilities of Medicaid's new POS system to give messages to pharmacies? This is still being investigated by the pharmacy team. The September meeting minutes were reviewed and approved; there were no corrections identified. Mark Balk made a motion to approve, Joseph Miner seconded the motion and all approved.
6. Nuvigil and Provigil review. Robyn Seely gave an over view of these two enantiomers. Provigil is a mixture of R and S enantiomers, while Nuvigil only contains the R enantiomer. The R enantiomer is more active and so Nuvigil requires a dose $\frac{3}{4}$ of that of Provigil. Handout information included similarities and differences. Should step therapy be required before approval of Nuvigil? Provigil went generic in March of this year. Provigil's criteria starts with use down to age 9 but Nuvigil requires children be at least 17.

It is believed that the generic is more cost effective. PA requests show Provigil had 150, Nuvigil 200, and modafinil 80, however more were approved for modafinil than for Nuvigil. Dr. Minor recommends approval of criteria for PA with the addition that Provigil must be tried and have failed prior to approval of Nuvigil, unless a contraindication exists. Existing clients will be grandfathered. Kathy Goodfellow seconded and the motion and it was approved.

7. The topic of Androgens was moved to the next meeting since only 5 minutes of meeting time remains.

8. The Board discussed how continuity of care be maintained when clients go into ACO's for pharmacy benefits and how will pharmacist know that they will have to have contracts with the ACO's if they want to continue to provide services to all Medicaid clients. Utah Medicaid will be providing information to pharmacy providers as well as the ACOs. Staff will also be presenting at the Utah Pharmacists Association on ACOs. The Board discussed how Medicaid could avert some of the problems that Medicare had when they implemented part D.
9. The next DUR Board meeting is scheduled for Thursday, November 8, 2012.

Minutes prepared by Lisa Hunt.