

MEDICAID DRUG UTILIZATION REVIEW PROGRAM

**ANNUAL REPORT
OF THE
NEW YORK STATE
DRUG UTILIZATION REVIEW BOARD**

2007

REPORT TO THE GOVERNOR AND LEGISLATURE

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2007 ANNUAL REPORT
MEDICAID DRUG UTILIZATION REVIEW PROGRAM

I. EXECUTIVE SUMMARY

The Drug Utilization Review (DUR) Program was established in 1993 to help ensure that prescriptions for outpatient drug therapies in the Medicaid Program are appropriate, medically necessary, and not likely to result in adverse medical consequences. During 2007, the DUR Program underwent significant changes. Administration of the program was transferred from the Office of the Medicaid Inspector General (OMIG) to the Office of Health Insurance Programs (OHIP). Case reviews that were formerly conducted by OMIG staff are now conducted by the University of Massachusetts Medical College's Clinical Pharmacy Services Program through a subcontract administered by the State University of New York (SUNY) and a Memorandum of Understanding between the Health Department and SUNY.

New York's DUR Program has two separate but complementary components, the Retrospective Drug Utilization Review (RetroDUR) Program and the Prospective Drug Utilization Review Program (ProDUR). Under RetroDUR, predetermined criteria are used to generate case reviews of selected Medicaid patients from paid prescription drug claim data. The patient's most recent drug utilization is examined for safety and appropriateness of therapy. If it is suspected that the patient has received inappropriate drug therapy, an alert is sent to prescribers and pharmacists detailing potential drug therapy problems due to the therapeutic duplication, drug-to-disease contraindications, drug-to-drug interactions, incorrect drug dosage or duration of drug treatment, drug allergy reactions and/or clinical abuse/misuse. The RetroDUR Program is designed to improve prescribing trends by educating physicians and alerting them to potential problems. The Department continued to use alert letters based on DUR Board approved criteria to educate prescribing practitioners of potential drug-related problems among their patients and in October 2007 increased the number of cases reviewed each month from 500 to 1,000. In 2007, the Department's RetroDUR vendor, Health Information Designs (HID), created 5,653 prioritized cases for clinical review resulting in 6,603 alert letters sent to prescribers and 1,691 alert letters sent to pharmacies. The RetroDUR Program saved \$2,325,354 as a direct result of reduced drug costs and an additional \$10,049,456 from avoiding medical costs associated with adverse drug events.

Under ProDUR, the pharmacist enters information at the time of sale regarding each prescription and that information is automatically compared against such information as previously dispensed drugs, duplicate prescriptions, drug-to-drug interactions, over and under dosage and drug-to-disease alerts. If

the verification process detects a potential problem, the pharmacist receives an on-line warning or rejection message. The pharmacist can then take the appropriate action, such as contacting the prescribing physician to discuss the matter. The outcome might be that the drug is not dispensed, the dosage is reduced, or a change is made to a different medication. A study of the ProDUR in 2007 shows that overall, 11.4 percent of all pharmacy claims result in ProDUR messages to the pharmacist, with the pharmacist deciding not to dispense the medication in 22.5 percent of the alerted cases. The cost of drugs not dispensed averaged \$73 per claim, totaling \$132,974,837 in cost avoidance.

These results, which were calculated in accordance with guidelines issued by the U.S. Department of Health and Human Services, demonstrate the success of the DUR Program in improving quality of care and patient safety and in avoiding the significant prescription drug and medical costs associated with adverse drug events.

Section 369-bb of the Social Services Law authorizes a 13 member DUR Board to be appointed by the Commissioner of Health. Duties of the Board include but are not limited to developing and applying criteria and standards for DUR; developing and assessing interventions that are not punitive in nature to improve quality of care; and establishing agreements with other agencies and boards. During calendar year 2007, the DUR Board met multiple times to discuss a wide range of issues consistent with its statutory responsibilities. A summary of Board meetings is included as an attachment to this report. Highlights include implementation of criteria for Elidel/Protopic which resulted in a decrease in the number of prescriptions; projects related to duplicate therapy for antipsychotics; publication of articles for Medicaid prescribers; cooperative agreements with the State Office of Mental Health related to the appropriate prescribing of mental health drugs; and approval of new criteria for use in the DUR Program, among others. The efforts of the Board demonstrate New York State's leadership in the field of DUR and the innovative use of technology to meet NY Medicaid's goal of providing quality care and safeguarding financial resources.

II. INTRODUCTION

Drug Utilization Review (DUR) programs help ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical consequences. This objective is consistent with NY Medicaid's goal of assuring beneficiaries access to cost-effective, high quality health care.

DUR programs use professional medical protocols, computer technology, and data processing to assist in the management of data regarding the prescribing of medicines and the dispensing of prescriptions.

The benefits of DUR include:

- Improved health and quality of life
- Reduced drug and medical costs
- Reduced hospital admissions
- Reduced drug diversion
- Better coordinated health care
- Informed providers who prescribe drugs more appropriately

DUR programs help to ensure that the patient receives the right medicine at the right time, in the correct dose, and dosage form. While improved patient care and provider education are the primary goals of DUR, significant cost savings have been realized as a result of its implementation. Prospective Drug Utilization Review (ProDUR), which occurs at the time the prescription is filled, and Retrospective Drug Utilization Review (RetroDUR), which occurs after the claim is paid, work in concert to achieve better patient care.

In January 1993, in accordance with the federal Omnibus Reconciliation Act of 1990 (OBRA), New York implemented a Retrospective Drug Utilization Review Program (RetroDUR) for Medicaid beneficiaries. Eighteen months later, in June 1994, New York implemented an electronic, on-line Prospective Drug Utilization Review program (ProDUR). The use of a ProDUR system became mandatory for all pharmacies participating in Medicaid in March 1995. Infusion pharmacies are exempt from the ProDUR on-line requirements, because they do not service typical ambulatory pharmacy patients.

During 2007, the DUR Program underwent significant changes. Administration of the program was transferred from the Office of the Medicaid Inspector General (OMIG) to the Office of Health Insurance Programs (OHIP). Case reviews that were formerly conducted by OMIG staff are now conducted by the University of Massachusetts Medical College's Clinical Pharmacy Services Program through a subcontract administered by the State University of New York

(SUNY) and a Memorandum of Understanding between the Health Department and SUNY. The volume of retrospective DUR (RetroDUR) case reviews increased twofold from 500 per month to 1,000 cases per month.

III. DRUG UTILIZATION REVIEW INTERVENTIONS

A. RetroDUR

Under RetroDUR, predetermined criteria are used to generate case reviews of selected Medicaid patients from paid prescription drug claim data. In particular, the patient's most recent drug utilization is examined for safety and appropriateness of therapy. If it is suspected that the patient has received inappropriate drug therapy, an alert is sent to prescribers and pharmacists detailing potential drug therapy problems due to the therapeutic duplication, drug-to-disease contraindications, drug-to-drug interactions, incorrect drug dosage or duration of drug treatment, drug allergy reactions and/or clinical abuse/misuse. The RetroDUR Program is designed to improve prescribing trends by educating physicians and alerting them to potential problems. In extreme cases, RetroDUR can result in a referral to the Recipient Restriction Program which limits a beneficiary's access to one pharmacy.

Since the inception of the RetroDUR Program in 1993, the Health Department has used the services of a software vendor and the DUR Board to develop a drug monitoring and decision support system that identifies patients whose pharmaceutical therapies place them at high risk for adverse drug induced conditions of exacerbated illnesses.

During 2007, 5,653* high risk profiles were reviewed resulting in multiple cases being selected for provider alerts. Further, 8,294 alert letters were sent to providers including 6,603 to prescribers, and 1,691 to pharmacies for the following reasons:

Drug-to-Disease Interactions	24%
Drug-to-Drug Conflicts	24%
Over-utilization of Therapy	21%
Clinical Appropriateness	24%
Under-utilization of Therapy	4%
Miscellaneous	3%

***A profile may result in multiple alert letters**

B. ProDUR

ProDur allows pharmacists to perform on-line, real-time eligibility verifications and Electronic Claims Capture (ECC), and alerts the pharmacist at the point of sale of potential drug-induced illnesses and adverse drug reactions and interactions.

ProDUR uses a national standard for DUR message transmission of on-line pharmacy claims developed by the National Council for Prescription Drug Programs (NCPDP). New York State's adaptation of this standard was modified subject to the approval of NCPDP to meet Medicaid's unique needs.

An important feature of New York's ProDUR Program is that it allows pharmacists to submit claims electronically through a process known as Electronic Claims Capture (ECC). ECC offers numerous benefits over submitting claims on paper or magnetic media. When claim information is submitted electronically, the manual processing associated with claim forms and magnetic media is no longer required, claim preparation time is reduced, and pharmacies know the claim has been accepted shortly after it is transmitted. ECC also allows individual claims within an electronic submission to be rejected without causing the entire submission to be denied. Actual on-line adjudication for pharmacy claims commenced in November 2002 as part of the phase-in of components of the Replacement Medicaid System for New York State. A study of the ProDUR/ECC in 2007 shows that overall, 11.4 percent of all pharmacy claims result in ProDUR messages to the pharmacist, with the pharmacist deciding not to dispense the medication in 22.5 percent of the alerted cases. The cost of drugs not dispensed averaged \$73 per claim, totaling \$132,974,837 in cost avoidance.

IV. DUR BOARD

Pursuant to Section 369-bb of the Social Services Law, appended to this Report as Attachment B, the DUR Board was created in 1992 to establish and implement medical standards and criteria for RetroDUR and ProDUR. Board members are appointed by the Commissioner of Health and serve three year terms. In accordance with State law, the DUR Board is comprised of 13 health care professionals actively practicing in New York including: five physicians, one of which has a specialty in mental health; five pharmacists, two persons with expertise in drug utilization review; and one State employed designee of the Commissioner. Board membership represents the geographic diversity of the State. A list of DUR Board members can be found in Attachment C. As specified in Section 8 of the relevant statute, the DUR Board is responsible for a wide range of duties including but not limited to developing and applying criteria and standards for DUR; developing and assessing interventions that are not punitive

in nature to improve quality of care; and working with other state agencies and boards. During calendar year 2007, the DUR Board met multiple times to discuss a wide range of issues consistent with its statutory charge. A summary of each of the DUR Board meetings can be found in Attachment C. Highlights include implementation of criteria for Elidel/Protopic which resulted in a decrease in the number of prescriptions; projects related to duplicate therapy for antipsychotics; publications of articles for Medicaid prescribers; cooperative agreements with the State Office of Mental Health related to the appropriate prescribing of mental health drugs; and approval of new criteria for use in the DUR Program among others.

In addition, the Board:

- Performed ongoing evaluation of the ProDUR and RetroDUR systems to develop requirements for eMedNY, the State Medicaid Management Information System.
- Extracted and analyzed Medicaid data from multiple databases, including Health Information Design, the Medicaid Data Mart and eMedNY, to identify and prioritize populations for current and future drug-disease initiatives.
- Increased clinical case reviews from 500 to 1,000 prioritized RetroDUR cases monthly in October 2007 for Medicaid patients potentially at risk of adverse drug outcomes.
- Detected potential Medicaid fraud cases through the DUR Program systems and referred such cases for further investigation.
- Updated clinical criteria for RetroDUR systems.
- Hosted, in collaboration with the Albany College of Pharmacy, the Twelfth Annual North Eastern DUR Conference. This conference is for state Medicaid DUR boards and program staff and provides clinical updates and professional continuing education relevant to Medicaid DUR programs.

V. ASSESSMENT OF IMPACT AND COST SAVINGS

The Guidelines for Estimating the Impact of Medicaid DUR (Guidelines) were published in 1994 by the U.S. Department of Health and Human Services (HHS) to enable states to prepare the annual report required by the federal government. Developed by a panel of advisors having extensive experience in both DUR and program evaluation studies, these Guidelines produce legitimate estimates of the cost savings associated with DUR programs and help DUR programs analyze and improve operations.

The Guidelines state the DUR Program should:

- Review a single target drug or drug class
- Examine interventions separately, even if two interventions target the same drug or drug class
- Select recipients using the target drug before the intervention and track over time
- Select a group of patient's risk of inappropriate use of the target drug and monitor their experience
- Organize possible effects into three levels
 1. a pre-period that is immediate prior to the DUR intervention
 2. a time period that includes and immediately surrounds the intervention and alert letters sent to providers explaining the therapeutic problems
 3. a post-period interval during which any effects of the intervention are likely to occur

Medicaid's DUR vendor, Health Information Design (HID), adheres to the recommendations in the Guidelines and uses database criteria in all computations and reports. HID uses pharmacy claim dollar amounts as well as medical claim dollar amounts in their assessments. HID follows the Guidelines recommendations by using comparison groups before and after intervention comparison. According to the Guidelines, this is the most valid method.

The method used by the Health Department to determine actual RetroDUR drug savings is case comparison of Medicaid drug expenditures in the three-month period immediately prior to and after the mailing of a prescriber intervention alert letter. The expenditures are compared to a control group who received no DUR interventions. The savings realized under the RetroDUR program may fluctuate from year to year because of the differences in selected review criteria. Using this method, DUR programs resulted in savings as described in the following sections.

A. Retrospective Drug Utilization Review (RetroDUR) Savings

As previously described in this report, the Drug Utilization Review Program provides an important federally mandated quality assurance service to Medicaid enrollees. Enrollees identified by this program are at an increased risk of dangerous side effects or drug induced issues. Some of the therapy issues identified by the RetroDUR Program are:

- Drug-to-Disease Interactions
- Under-utilization of Therapy
- Clinical Appropriateness
- Drug-to-Drug Conflicts
- Over-utilization of Therapy

The RetroDUR Program alerts providers to therapy risks, and in many cases providers will discontinue unnecessary medications, reduce quantities of medications prescribed, or change to a safer therapy profile. Reductions in medication expenses as well as decreases in acute care, emergency room visits, and hospitalizations are sources of savings realized because of RetroDUR.

In 2007, 86.7 percent of patient profiles examined resulted in criteria exceptions significant enough to warrant the production of a case for review. Further, 8,294 alerts were sent to prescribing providers and pharmacies in 2007. These letters contain the patient's profile as well as a provider response form that may be returned to the Health Department. These intervention letters resulted in an average response rate of 33.4 percent from prescribers and 48 percent from pharmacies. Savings realized through RetroDUR for 2007 amounted to \$2,325,354.

In addition to reductions in medication expenses, the Department working with HID identified medical claim savings as a result of RetroDUR amounting to \$10,049,456. This savings was determined by tracking RetroDUR cases and comparing medical costs incurred after intervention letters were sent to prescribers, with the medical costs incurred during the same period for a comparison group with no interventions. This comparative study examined each recipient's claims record and calculated the exact difference in medical expenditures.

B. Prosepective Drug Utilization Review (ProDUR) Savings

The ProDUR/ECC system maintains an on-line record of every Medicaid recipient's drug history for at least a 90-day period. The pharmacist enters information regarding each prescription and that information is automatically compared against such information as previously dispensed drugs, duplicate

prescriptions, drug-to-drug interactions, over and under dosage and drug-to-disease alerts. If the verification process detects a potential problem, the pharmacist receives an on-line warning or rejection message. The pharmacist can then take the appropriate action, such as contacting the prescribing physician to discuss the matter. The outcome might be that the drug is not dispensed, the dosage is reduced, or a change is made to a different medication.

The Health Department estimates that ProDUR generates an average of \$2,557,208 in gross drug savings per week due to the avoidance of therapeutic duplications and drug-to-drug interactions. This savings is determined by an examination of the weekly ProDUR reject/override report that indicates the number of times the pharmacist chose to override the DUR rejection message and dispense the medication. The Health Department is then able to determine the number of times drugs were not provided and the approximate cost of the drugs that were not dispensed. The total of these transactions is the weekly cost avoidance. For 2007, there were 1,785,856 net on-line claim rejects resulting in annual savings of \$132,974,837.

VI. PROGRAM ENHANCEMENTS AND SUGGESTIONS FOR IMPROVEMENT

Several enhancements were made to both the ProDUR and RetroDUR Programs during 2007. These improvements, which were both programmatic and systemic, include the following:

A. Program Enhancements

- Approved new systems updates to RetroDUR database criteria, an ongoing activity for new drugs that are added to the Medicaid List of Reimbursable Drugs.
- Reviewed specificity of criteria, introduced new medications into the DUR system, and updated clinical information as needed to reduce false positive alerts in both ProDUR and RetroDUR systems.
- Updated criteria exceptions as needed to detect occurrences of drug misuse and to help ensure positive outcomes.
- Examined drug claims of special populations, including enrollees with HIV/AIDS, asthma, and patients using antipsychotics, to identify medication trends and develop interventions that support appropriate prescribing.

B. System Enhancements

- Initiated evolution discussions to modify ProDUR reporting to enable easier and more flexible user access.
- Increased volume of case reviews from 500 to 1,000 per month, an increase that will reach more providers and result in better pharmacy service for Medicaid beneficiaries.

C. Future Enhancements

- The Health Department will continue to investigate the ability to allow physicians to access a modified patient medical and drug history on-line prior to prescribing.
- The Health Department will increase RetroDUR case reviews from 1,000 to 2,000 cases per month.

VII. Conclusion

DUR programs have proven to be a valuable tool in New York State's efforts to protect and improve the health of Medicaid enrollees. An enhanced DUR initiative that commenced in 2007 raised the review of additional at-risk recipients from a pre-October 2007 level of 500 cases per month to the post-October 2007 level of 1,000 cases per month. This increase is aimed at maximizing the therapeutic benefits derived by the enrollees of the program as well as the potential to achieve greater cost savings through improved health outcomes.

ATTACHMENT A

DEFINITIONS

1. **Drug-to-Disease Interaction** – The potential for or the occurrence of an undesirable alteration of the therapeutic effect of a given prescription.
 - A. **Latrogenic Effect** – The potential of a drug causing an undesirable effect or disease state.
 - B. **Exacerbation Effect** – The potential of a drug making an existing disease state worsen.
2. **Drug Interaction** – The potential for or occurrence of an adverse effect as a result of using two or more drugs together.
3. **Over-utilization** – The use of a drug in quantities exceeding published standards that put the recipient at risk of an adverse medical result.
4. **Under-utilization** – The use of a drug in insufficient quantity to achieve a desired therapeutic goal.
5. **Duration** – The use of a drug for a period that exceeds published standards for achieving a desired therapeutic goal.
6. **Duplication** – The prescribing and dispensing of two or more drugs from the same therapeutic class such that the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program cost without additional therapeutic benefit.
7. **Clinical Appropriateness** – Patients who are taking certain medications that are considered national standard therapy for certain medical conditions or diseases.
8. **Criteria** – The expected levels of achievement of specifications against which performance can be assessed.
9. **Contraindication** – A specific situation in which a drug should NOT be used, because it may be harmful to the patient.

GLOSSARY OF TERMS

CMS	Centers for Medicare and Medicaid Services - The federal agency that administers the Medicare Program and works with the states to administer the Medicaid Program.
DOH	Department of Health
ECC	Electronic Claims Capture – In order to receive payment for service rendered, all pharmacies must submit their transactions through the on-line DUR program. This program can also capture claims electronically and transmit them to the fiscal agent for adjudication.
HID	Health Information Design
HIPPA	Health Insurance Portability and Accountability Act of 1996
JAR	Joint Application Review Sessions
NCPDP	National Council for Prescription Drug Programs
OMH	Office of Mental Health
PSYCKES	Psychiatric Services and Clinical Knowledge Enhancement System
SURS	Surveillance Utilization Review Subsystem

ATTACHMENT B
SECTION 369-bb OF THE NYS SOCIAL SERVICES LAW

§ 369-bb. Drug utilization review board. 1. A thirteen-member drug utilization review board is hereby created in the department. The board is responsible for the establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program.

2. The members of the DUR board shall be appointed by the commissioner and shall serve a three-year term. Members may be reappointed upon the completion of other terms. The membership shall be comprised of the following:

(a) Five persons licensed and actively engaged in the practice of medicine in the state, at least one of whom shall have expertise in the area of mental health, who shall be selected from a list of nominees provided by the medical society of the state of New York and other medical associations.

(b) Five persons licensed and actively practicing in community pharmacy in the state who shall be selected from a list of nominees provided by pharmaceutical societies/associations of New York state.

(c) Two persons with expertise in drug utilization review who are either health care professionals licensed under Title VIII of the education law or who are pharmacologists.

(d) One person from the department of social services (commissioner or designee).

3. The appointed members to the board, or its agents shall have no sanctions against them by medicare or medicaid.

4. The appointments to this board shall be made so that the length of the terms are staggered. In making the appointments, the commissioner shall consider geographic balance in the representation on the board.

5. The DUR board shall elect a chairperson from among its members who shall serve a one-year term as chairperson. The chairperson may serve consecutive terms.

6. Members of the DUR utilization review board and all its employees and agents shall be deemed to be an "employee" for purposes of section seventeen of the public officers law.

7. The department shall provide administrative support to the DUR board.

8. The duties of the DUR board are as follows:

(a) The development and application of the predetermined criteria and standards to be used in retrospective and prospective DUR that ensure that such criteria and standards are based on the compendia and that they are developed with professional input in a consensus fashion with provisions for timely revisions and assessments as necessary. Further, that the DUR standards shall reflect the appropriate practices of physicians in order to monitor:

- (i) Therapeutic appropriateness;
- (ii) Overutilization or underutilization;
- (iii) Therapeutic duplication;
- (iv) Drug-disease contraindications;
- (v) Drug-drug interactions;
- (vi) Incorrect drug dosage or duration of drug treatment; and
- (vii) Clinical abuse/misuse.

(b) The development, selection, application, and assessment of interventions or remedial strategies for physicians, pharmacists, and

recipients that are educational and not punitive in nature to improve the quality of care including:

(i) Information disseminated to physicians and pharmacists to ensure that physicians and pharmacists are aware of the board's duties and powers;

(ii) Written, oral, or electronic reminders of patient-specific or drug-specific information that are designed to ensure recipient, physician, and pharmacist confidentiality, and suggested changes in the prescribing or dispensing practices designed to improve the quality of care;

(iii) Use of face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;

(iv) Intensified reviews or monitoring of selected prescribers or pharmacists;

(v) The creation of an educational program using data provided through DUR to provide for active and ongoing educational outreach programs to improve prescribing and dispensing practices as provided in this subdivision. (This may be done directly or through contract with other entities);

(vi) The timely evaluation of interventions to determine if the interventions have improved the quality of care; and

(vii) The review of case profiles prior to the conducting of an intervention.

(c) The publication of an annual report which shall be subject to the department's comment prior to its issuance to the federal department of health and human services by December first of each year. The annual report also shall be submitted to the governor and the legislature before December first of each year. The report shall include the following information: (i) A description of the activities of the board, including the nature and scope of the prospective and retrospective drug use review programs;

(ii) A summary of the interventions used;

(iii) An assessment of the impact of these educational interventions in quality of care;

(iv) An estimate of the cost savings generated as a result of such program; and

(v) Recommendations for program improvement.

(d) The development of a working agreement for the DUR board with related boards or agencies, including, but not limited to: the board of pharmacy, the board of medicine, the SURS staff, and staff of the department of health and the office of mental health, in order to clarify the areas of responsibility for each where such areas may overlap.

(e) The establishment of a process where physicians or pharmacists will have the opportunity to submit responses to the DUR educational letters.

(f) The publication and dissemination of educational information to physicians and pharmacists on the DUR board and the DUR program to include information on:

(i) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients;

(ii) Potential or actual severe/adverse reactions to drugs;

(iii) Therapeutic appropriateness;

(iv) Overutilization or underutilization;

- (v) Appropriate use of generics;
- (vi) Therapeutic duplication;
- (vii) Drug-disease contraindications;
- (viii) Drug-drug interactions;
- (ix) Incorrect drug dosage/duration of drug treatments;
- (x) Drug allergy interactions; and
- (xi) Clinical abuse/misuse.

(f) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed or analyzed by the DUR board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but such identifying information may not be released to anyone other than a member of the DUR board or the department and its agents.

(h) The improper release of identifying information in violation of this article may subject that person to criminal or civil penalties.

(i) The board may release cumulative non-identifying information for purposes of legitimate research.

9. The relationship of the DUR board to the department is as follows:

(a) The department shall monitor the DUR board's compliance to federal and state statute and regulation.

(b) The DUR board shall serve at the discretion of the commissioner.

© The department shall have authority on all fiscal matters relating to the DUR program.

(d) The department shall have authority on all administrative matters relating to the administration of the medical assistance program within the DUR program.

(e) The DUR board shall have responsibility for all medical matters relating to the DUR program.

(f) The DUR board may utilize medical consultants and review committees as necessary, subject to department approval.

ATTACHMENT C

2007 NEW YORK STATE DRUG UTILIZATION REVIEW BOARD

PHYSICIANS

Richard S. Blum, MD

Ronald J. Dougherty, MD

David F. Lehmann, PharmD, MD

Jill Braverman-Panza, MD

Vacant

PHARMACISTS

Sidney Falow, RPh

Jon Gotowoko, RPh, MS, MBA

Marc L. Speert, RPh

Frank Barone, RPh

Marilyn C. Fortin, RPh

DUR EXPERTS

Elaena Quattrocchi, PharmD

Robert A. Hamilton, RPh, PharmD

DEPARTMENT DESIGNEE

Teofila L. Daley, RPh, MS

DUR PROGRAM MANAGER

Lydia J. Kosinski, RPh (January-July 2007)

John F. Naioti, Jr., RPh (July-December 2007)

ATTACHMENT D

SUMMARY OF 2007 DUR BOARD MEETINGS

Board Meeting of January 25, 2007:

Items for discussion included the Joint Application Review (JAR) sessions in preparation for the fiscal agent reprocurement, data extracts from the annual ProDUR report, the new official NYS forge-proof prescription blanks, and "Plan B", the emergency contraceptive drug, as an over-the-counter (OTC) item. The DUR Board considered a report on third generation cephalosporins and the utilization of Elidel and Protopric without a diagnosis of atopic dermatitis. HID introduced new reports for Year 2006. The DUR Board discussed a memorandum of Understanding with the University of Massachusetts Medical School (UMMS) and the DOH process of hiring new Department of Health staff dedicated to the DUR program, as well as an update on the proposed transition of DUR from the Office of the Medicaid Inspector General to the Office of Health Insurance Programs.

The DUR Board was advised of the Governor's Executive Order on public meetings access which requires that DUR Board meetings must be available as video/web casts effective commencing July 2007. The RetroDUR focus on the ACE/ARB drugs for diabetic Medicaid recipients was discussed and the Board requested a summary by HID of the provider response rate for alert letters for the March 2007 DUR Board Meeting.

A "Medicaid Update" article on the use of hydroxyurea in sickle cell disease written by the DUR Board was approved and published.

Board Meeting of March 22, 2007:

Items for discussion included the new edit scheduled for implementation for the newly issued serialized prescriptions and a presentation on "eClinical Works". Recommendations from the DOH Pharmacy and Therapeutics Committee (P&TC) were noted with additions to include ophthalmic quinolones, otic quinolones, ophthalmic antihistamines, immunomodulators (injectable), and cholesterol absorption inhibitors (CAIs). ProDUR overrides were discussed, as well as the need for documentation as part of ongoing program integrity activities. The DUR Board also reviewed the Center for Medicare and Medicaid Services Transformation Grant, materials related to intervention letter responses, physician responses by drug conflict, and institutional congestive heart failure (CHF) medication prescribing.

New matters for Board consideration included review of cases of abuse or misuse of Medicaid services identified via the DUR Board and external review referrals to the Recipient Surveillance and Utilization Review program for potential Recipient Restriction Program inclusion. Also considered was the integration of the P&T Committee and the DUR Board, and the rationale for transitioning the DUR Program to DOH.

The DUR Board discussed the cooperative agreement between OMH and DOH to share ambulatory outpatient data on Medicaid recipients' drug histories. The focus in particular would be the prescribing of antipsychotic and antidepressant drugs and identifying a Department of Health contact person.

New RetroDUR criteria were proposed by HID and unanimously approved by the DUR Board. The new criteria involved the medications paliperidone, rosiglitazone, Ketek, HIV/AIDS drug criteria, and erythropoieses-stimulating agents.

Board Meeting of May 24, 2007:

Changes in pharmacy reimbursement enacted as part of the 2007-08 Executive Budget were presented to the DUR Board as well as a new edit for dual eligible Medicare/Medicaid enrollees for claims for medical supplies. Project summaries prepared by Albany College of Pharmacy interns, including potassium-sparing diuretics, ACE/ARB, and HIV patients, were evaluated at the meeting. A target date for transition of DUR to OHIP was announced as mid-July. An overview of DUR operations from 1993 inception to the present, the need for a DUR program, and an outline of the ProDUR process were presented.

Duplicate therapy interventions for antipsychotic medications appeared successful as the number of identified physicians who met the original criteria decreased from 62 to 12, and the number of identified patients decreased from 290 to 55.

It was reported to the DUR Board that as a result of the January 2007 implementation of the Elidel/Protopic criteria, the daily average of prescriptions decreased from 180 to 114 in March 2007.

Board Meeting of July 26, 2007:

The transition of DUR activities from Office of Medicaid Inspector General (OMIG) to Office of Health Insurance Programs (OHIP) was accomplished on July 20, 2007.

The DUR meeting of July 26, 2007 was an opportunity to recognize the DUR Board members and Department of Health employees who had previously given service to the Drug Utilization Review Program. Discussion was limited to the transition to OHIP and future involvement of Drug Utilization Review in the activities of the Medicaid Program.