



**MEDI-CAL DRUG USE REVIEW BOARD
MEETING MINUTES
Tuesday, September 11, 2012
10:30 a.m. – 1 p.m.**

Location: Department of Health Care Services
1500 Capitol Avenue
Training Rooms B+C
Sacramento, CA 95814

Topic	Discussion
<p>1) WELCOME/ INTRODUCTION</p> <p>2) CALL TO ORDER/ REVIEW AND APPROVAL OF FEBRUARY 14, 2012, MINUTES</p>	<ul style="list-style-type: none"> • Dr. Frank Apgar with Xerox, was introduced as the stand-in for Dr. Gerald Rogan, until his return • The meeting was called to order by the Chair of the Board, Dr. Marilyn Stebbins • Board members present: Drs. Patrick Finley, Janeen McBride, Robert Mowers, Marilyn Stebbins, and Andrew Wong • Board members absent: Drs. Timothy Albertson and Stephen Stahl • Introduction of board members and attendees • Pauline Chan, RPh reviewed agenda items to be covered • The minutes from the May 22, 2012, meeting were motioned to be approved as amended with edits by Dr. Andrew Wong • The DUR Board approved the May 22, 2012, minutes with edits
<p>3) OLD BUSINESS</p>	<p>a. Review of Action Items From Previous Board Meeting:</p> <ul style="list-style-type: none"> • Send section of Provider Manual with list of non-capitated medications • List included in the board packet. Dr. Ron Sanui elaborated that these apply to major plans. DUR for carve out drugs is through the Medi-Cal FFS program. It was asked how the Medi-Cal FFS to Managed Care migration was going. Ron provided a broad overview of the status of the SPD Transition and Dual Demonstration Project. <p>ACTION ITEM: Add item to discuss DUR board's role as FFS continues to diminish and the role for the transition to Managed Care</p> <ul style="list-style-type: none"> • Intervention work group report • Second year for annual work group • For 2012, the intervention work group was held in June; currently, the DUR interventions are Medi-Cal educational bulletins and alerts • Working with the following organizations to distribute information: California State Board of Pharmacy, California Society of Health-System Pharmacists, and the California Pharmacist's Association • The board recommended sending links to physician associations and not be restricted to pharmacy providers only • Currently, there are no physician association distribution channels • Develop electronic mailing list for bulletin distribution channels • Xerox to present new tool at today's meeting that will soon be available to providers • Dr. Finley's data use agreement was renewed June 1, 2012 • Generic utilization data will be followed up at the next board meeting • Medi-Cal Incentive to Quit Smoking (MIQS) follow up <ul style="list-style-type: none"> a. Brief background: In April 2011, Pharmacy Benefits Division expanded benefits on smoking cessation medications prior to the initiation of the MIQS campaign kick-off in

	<p>October 2011.</p> <ul style="list-style-type: none"> b. The board recommended follow up studies at the May 22, 2012, DUR board meeting. Recommendations were reviewed by Pharmacy Benefits Division and MIQS, and it was concluded that the program is too new and not enough data is available for review. However, data is available to compare utilization pattern change of smoking cessation medications by comparing 12 months of utilization prior and post policy change. c. The utilization report covers 24 months utilization from April 2010 to March 2012, comparing 12 months pre and post policy change. Trend showed increase in number of beneficiaries using the benefits, increase in number of providers and increase in number of claims. The increase picked up around 3 months post implementation and another uptick in January the following year. <ul style="list-style-type: none"> • Handout with “Pharmacy Paid Claims” data was included in the board packet • Of the 12 months before the initiation of the benefit change and 12 months after, trend showing increase in use, more providers and beneficiaries utilizing • Starting in June, claims started to see increases as with Dec/Jan uptick (maybe New Year’s resolutions) • Restrictions on tramadol <ul style="list-style-type: none"> a. Code one restriction was implemented as of October 1, 2012 • Redesign of Quarterly Report <ul style="list-style-type: none"> a. Team would like to redesign future quarterly report to mirror annual report; specifically focusing on the CMS reporting requirements for retrospective and prospective DUR activities b. Because of the changes, DHCS/Xerox was not able to share the current quarterly report c. For the next quarterly report, where it was requested to break out Physician Administered Drugs (PADs) by class, specialty, has been deferred to November meeting d. From the quarterly report, for paliperidone injectable utilization, research growth vs. substitution (monthly dose vs. bi-monthly dose), has also been deferred to next meeting • Beta-blocker treatment after MI, 30-day and see the rate of beta-blocker utilization for the 1st 30-days post discharge from a MI. Potentially break down by county? <ul style="list-style-type: none"> a. Follow-up analysis to earlier bulletin reviewed claims data for the 285 patients who had a beta-blocker prescription filled after MI but were non-compliant during the entire 135-day follow-up period found 58.2% of these patients had a prescription filled within 30 days post-discharge b. The higher percentage of beta-blocker prescriptions filled within the first 30 days after discharge leads us to conclude that prescription fills tapered after the first 30 days post-discharge c. We were not able to develop any meaningful conclusions stratifying the data by county, as we only had 800 patients spread across the state and the power of this analysis was very low as a result
	<ul style="list-style-type: none"> b. Board Member Projects <ul style="list-style-type: none"> i. Anti-depressants <ul style="list-style-type: none"> • Dr. Patrick Finley’s project was tabled until the next meeting ii. Intervention Work Group <ul style="list-style-type: none"> • Workgroup is held annually (see a. ii. Above) iii. Target Drug List Work Group – Approach to Prospective DUR for implementation of new claims processing system
<p>4) NEW BUSINESS</p>	<ul style="list-style-type: none"> a. Medi-Cal Subscription Service (MCSS) <ul style="list-style-type: none"> • Jerry Lawson, Publications Manager (Xerox), presented MCSS, a web-based application making it possible for those who sign up as a MCSS subscriber to receive news flash items, bulletins, and other notifications from Medi-Cal • The service allows Xerox to track participation and produce reports to DHCS

	<ul style="list-style-type: none"> • The service would make available bulletins (monthly), news flashes (immediate), and looking to post to Twitter • Xerox will market the MCSS through the Medi-Cal website, Medi-Cal's call center, and directly to provider associations • Xerox is aiming for the MCSS to launch in January 2013; Bill Otterbeck is the lead for the project • Providers can subscribe via a two-column form that you can access through your mobile device • The MCSS initiative is aligned with the DUR Board's desire to involve providers
	<p>b. Xerox/UCSF Update</p> <p>i. August 2012 Medi-Cal Educational Alert: Hepatitis C</p> <ul style="list-style-type: none"> • PowerPoint entitled, "Updated Practice Guidelines for the Treatment of Hepatitis C, Genotype 1" was presented by Amanda Smith of UCSF • Recent reports show that hepatitis C is now responsible for more deaths in the US than HIV • Two new direct acting antiviral (DAA) drugs were FDA-approved in May of 2011 to treat hepatitis C, genotype 1: boceprevir (Victrelis®) and telaprevir (Incivek®) • Optimal regimen for hepatitis C, genotype 1 is now a triple therapy combination consisting of peginterferon alpha, ribavirin and one of the two DAA drugs. • Through June 30, 2012, a total of 298 Medi-Cal FFS beneficiaries have started triple therapy • In the month of June 2012, there were 17 beneficiaries on telaprevir and 31 on boceprevir; of the 48 beneficiaries, 8 were new starts. • The August 2012 bulletin describes effective use of the DAA drugs, including guidance for patients and providers to promote appropriate use and adherence, including: <ul style="list-style-type: none"> ○ How to determine if initiating triple therapy is appropriate for patients. ○ A summary of clinical monitoring guidelines; and when to discontinue treatment ○ Instructions to use telaprevir and boceprevir in combination with interferon and ribavirin; all three drugs are required in order to be effective ○ Ways to help patients manage side effects of the triple therapy regimen • More details are on the Medi-Cal website bulletin for August 2012 <p>ii. August 2012 Medi-Cal Educational Bulletin: Retro DUR Evaluation of Low-Dose Quetiapine</p> <ul style="list-style-type: none"> • PowerPoint presentation entitled, "Use of Low-Dose Quetiapine in the Medi-Cal Population" presented by Shal Lynch of UCSF (education bulletin is now posted on the provider website) • Reviewed quetiapine claims data for adults between 18 and 64 years of age, excluding residents in a long term care (LTC) facility and those presumed to be taking low-dose quetiapine during a wash-in or wash-out period. <ul style="list-style-type: none"> ○ One-year measurement period (4/1/11 to 3/31/12) ○ Study population = 5,601 ○ Subgroup of patients (n=2751) had complete medical claims for 3 years • Summary of findings: <ul style="list-style-type: none"> ○ 22% of Medi-Cal beneficiaries taking quetiapine were on an average dose of less than 150 mg daily ○ 42% of these beneficiaries had no recorded diagnosis of an FDA-approved indication for quetiapine ○ 20% of these beneficiaries took no medications for which quetiapine could be considered adjunctive therapy • Conclusions: <ul style="list-style-type: none"> ○ Inadequate evidence to support a minimum dose for off label indications ○ Doses < 150mg daily are associated with adverse side effects ○ Only prescribe quetiapine for FDA-approved indications and only prescribe quetiapine at therapeutic doses at 150 mg or higher • Key findings fully outlined in the bulletin which is posted on the DHCS website • It was commented that low dose may be appropriate for acute symptoms in the hospital. • Board commented on the excellent quality of the bulletins with data and actionable

	<p>topics</p> <ul style="list-style-type: none"> • Directions on when tablet was taken (example: QHS, every bedtime) was not available for study
	<p>c. DHCS Update</p> <p>i. CalMEND/UCSD Mental Health MTMS Pilot</p> <ul style="list-style-type: none"> • Kelly Lee (UCSD School of Pharmacy) and Kim Tallian (now currently with Scripps) were introduced to present PowerPoint presentation “CalMEND/UCSD Mental Health MTMS Pilot” • MTMS = Medication Therapy Management Services • UCSD outpatient psychiatric services – clinical setting where services are provided • Targeted population: Antipsychotic polypharmacy = 23% of beneficiaries receiving antipsychotics • MTMS Pilot Study – Overview <ul style="list-style-type: none"> ○ Intervention: Collaborative pharmacist-led MTMS model at the UCSD Outpatient Psychiatric Services (OPS) ○ Design: Cohort study of patients who received mental health care at the UCSD OPS MTMS ○ Sample size: 29 patients • Pharmacists are board certified clinical psychiatry pharmacists (BCPP) • Pilot pharmacists can prescribe; have DEA, NPI • UCSD was commended for the value of the multi-disciplinary model of care • Model might work well in ACO, the psychiatrists did not want to deal with the patients who had a lot of medical issues, RPHs would work closely with the physicians to control other conditions like diabetes • Important that the state would like to be informed of the innovative practices • Improvement of medication use is important to DUR • Many hurdles in behavioral health including physician buy-in and cost effectiveness <p>ii. CMS Annual Report</p> <ol style="list-style-type: none"> 1. Prospective DUR Alert Reviews <ul style="list-style-type: none"> • Point out that we will need improvement • Highest alert are ER (early refill), TD (therapy duplication), LR (late refill), ID (ingredient duplication) but others are also important • DHCS proposed to include all 12 alerts in the next quarterly report 2. Retrospective DUR Criteria <ul style="list-style-type: none"> • DHCS proposed that the Board be presented with DUR criteria at future meetings. 3. Board motioned for DHCS’s recommendations and approved <p>iii. Improving Psychotropic Medication Use in Foster Care Children and Youth: QI project (baseline data)</p> <ul style="list-style-type: none"> • Pauline presented Table H1 (Core): Medi-Cal FFS Mental Health Drug Exposure by Client Demographics (baseline data) • Data looked at all the children in the FFS and their eligibility, male or female, age, race, and foster care/non-foster care • Part of the initiative is to look at issues involved and the psychosocial aspect of children • Board commented that while foster care utilization may be the focus, looks like non-foster care children also show potential poly pharmacy and could benefit from analysis as well • Preliminary data of all psychotropic drugs, very general
5) BOARD MEMBERS & PUBLIC COMMENT	<ul style="list-style-type: none"> • Reminder to board members to submit meeting feedback
6) CONSENT AGENDA	
7) CLOSING REMARKS ADJOURNMENT	<ul style="list-style-type: none"> • The next Board meeting will be on November 13, 2012 • The meeting was adjourned at 1:30PM

Action Items	Ownership
Changes to Meeting Minutes	Jannice
Add agenda item to discuss DUR's role as FFS continues to diminish and the role for the transition to managed care.	Pauline