



**MEDI-CAL DRUG USE REVIEW BOARD
MEETING MINUTES
Tuesday, February 12, 2013
10:30 a.m. – 1:00 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 NOVEMBER 13, 2012 MINUTES</p>	<ul style="list-style-type: none"> • The meeting was called to order by the Chair of the Board, Dr. Marilyn Stebbins • Board members present: Drs. Timothy Albertson, Patrick Finley, Janeen McBride, Marilyn Stebbins, Stephen Stahl, Robert Mowers and Andrew Wong • Board members absent: none • Board members and attendees introduced themselves • Pauline Chan, RPh reviewed agenda items to be covered • The Medi-Cal DUR Board (the "Board") approved the November 13, 2012 minutes as submitted
<p>3) OLD BUSINESS</p>	<p>a. Review of Action Items From Previous Board Meeting:</p> <p>i. DUR's role in Medi-Cal fee for service (FFS) and the transition of FFS beneficiaries to Medi-Cal Managed Care Programs</p> <ul style="list-style-type: none"> • A federal waiver granted under section 1115(a) of the Social Security Act permits mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities into Medi-Cal managed care. • The waiver allows the Department of Health Care Services to achieve care coordination, better manage chronic conditions and improve health outcomes. • Mandatory enrollment began June 2011. • In summary, there will always be a FFS population which includes dual eligibles (or those with Medicare), foster children, long term care (LTC), share of cost (SOC) Medi-Cal, and California Children's Services (CCS) – in Alameda, Los Angeles, and San Diego counties. • FFS will remain, and the role of the DUR board will remain equally important. • Medications for those people moving to managed care will be handled by managed care, except medication for antipsychotic, HIV, some opioid dependence which will be handled by FFS. • FFS population around 1/3, or about 2M covered lives. • Dual eligibles antipsychotics are covered by Medicare Part D. • Most CCS go to managed care except for Alameda, LA and San Diego counties which remain in FFS. • Medi-Cal is moving into the rural counties during the year. • Because of the Healthcare Reform, Medi-Cal is expecting to have an additional 2 million

people enrolled.

ACTION ITEM: Pauline to follow up regarding the 2 million uninsured coming to Medi-Cal as a result of Healthcare reform. Will this group be FFS/Managed Care?

ACTION ITEM: Pauline will get back regarding Dr. Apgar's question. How many foster children are there and what is the state/volume of lives currently covering? Snapshot of FFS lives.

ii. MIS/DSS Update

- Existing data warehouse used by Xerox does not include some data available in MIS/DSS.
- This request is still pending with DHCS.
- Board expressed their concern about an estimated time MIS/DSS will be available for the DUR program.

iii. Video meeting capabilities for future board meetings

- Bagley-Keen Open Meeting Act 2004, Teleconference Meetings
- The act provides for audio or audio and visual teleconference meeting for the benefit of the public and the body.
- When a teleconference meeting is held, each site from which a member of the body participates must be accessible to the public.
- Hence, a member cannot participate from his or her car, using a car phone, or from his or her home, unless the home is open to the public for the duration of the meeting.
- Board member workplaces/offices that allow the public to go in it with wheelchair access.
- If other sites are used (i.e. board, member's office) they must be included in the agenda which is published 10 days before meeting.
- Xerox has the capabilities to do the meeting via WebEx.
- Department of Health Care Services will be our main site, but for the convenience of those traveling, the Board proposes a trial run for next meeting in May.
- The Board is in favor of trying a tele/video conference for the next quarterly meeting.

ACTION ITEM: Schedule meeting with Board members to discuss the details to host a video meeting teleconference remotely for the next board meeting

iv. What is feasible to report on related to drug costs

- Current DUR Quarterly report uses "Reimbursement Paid to Pharmacies"
- Pharmacy Benefits Division (PBD) continually evaluates each drug by applying the five criteria (Welfare and Institution Code section 14105.39):
 - Safety
 - Effectiveness
 - Essential need
 - Potential for misuse
 - Cost
- While net cost, including rebates is confidential, PBD continuously evaluates all drugs used in the Medi-Cal program.

	<ul style="list-style-type: none"> • Medi-Cal is able to realize significant savings with contracts. • In the prospective and retrospective DUR reviews, the status of whether or not drugs appear on the Contract Drug List are now noted. The DUR board can make a request to Pharmacy Policy Branch to ask for a review of a specific category of non-contract drugs, and ask if this category of drugs should be considered for contract. The board found this to be acceptable, for the time being. <p>v. When/where Medi-Cal population got flu vaccination</p> <ul style="list-style-type: none"> • The CDC published state level data and we are usually at about 40% vaccination rate. • California Immunization Registry (CAIR) ensures the secure, electronic exchange of immunization records to support the elimination of vaccine preventable diseases (mission). • CAIR's goal is to improve immunization rates for all California children through an innovative public-private partnership. • CAIR provides vaccines for children and adolescents for free through Vaccines for Children (VFC) or Section 317 funding. • CAIR tracks eligibility.
<p>4) NEW BUSINESS</p>	<p>a. Board Activities</p> <p>i. Strategic planning conference call</p> <ul style="list-style-type: none"> • Board has met twice since the last board meeting for strategic planning calls to discuss topics that were taking up a lot of time during the meetings. • Two main areas of weakness were incomplete data (MIS/DSS could strengthen this) and the issue of cost. • The issue of cost got really complicated and Dr. Wong brought up how LA County has a block cost system that shows cost as each relates to each other. • Mike Wofford took this back to PBD. • If the block cost suggested were concluded it could violate the drug rebate contracts however, Mike agreed that the Board could look at a block of drugs within a class without a rebate. • In the works is potential involvement to assist TAR office to help educate on treatment guidelines. • Drugs on the Contract Drug List are the least expensive. • The Board requested a high level explanation of the differences of MIS/DSS vs SURS. • Patrick Robinson has written letter requesting MIS/DSS and can share it with the Board if given permission from DHCS. <p>ACTION ITEM: Present the advantages/disadvantages of MIS/DSS vs. SURS</p> <ul style="list-style-type: none"> • If a drug is on the CDL, they are the most cost effective and get the federal rebate. • All drugs on the CDL get a supplemental rebate (CDL is on the internet and Epocrates) • All atypical antipsychotics and HIV drugs (by law) are on the CDL. • Example, there aren't any drugs on the CDL for multiple sclerosis. None of the drugs to treat multiple sclerosis have supplemental rebates. If the diagnosis is right, the TAR will be approved with proper documentation. Does that mean there is price parity for these drugs? Probably not. • Board would like to be able to provide guidance for the most cost effective medications for practitioners who do not have a particular first line treatment for these conditions.

ii. Depression and treatment patterns during pregnancy and postpartum

- Presented by Dr. Patrick Finley.
- During antepartum and postpartum periods, there is an increased risk of depression compared to the rest of the life cycle.
- There isn't a whole lot of data for treatment rates, so the study looks at a continuum of treatment and detection rates before pregnancy, during pregnancy, and postpartum and also compares them to a population that was not pregnant.
- The methodology included a retrospective longitudinal cohort of women between ages of 18 and 39 who were continuously enrolled in Medi-Cal fee-for-service program between January 2006 and December 2009.
- Results show that demographically, ethnicity was primarily Hispanic
- Results show that during pregnancy only 1.6% of women received a diagnosis of depression.
- Same with postpartum, which does not make sense.
- A study was done with a subgroup analysis of patients diagnosed with depression.
- Psychotherapy treatment was rare.
- SSRI use increased, 25% for Zoloft, think safest for pregnant and post partum
- Non-hispanic white population was 6 times more likely to get a diagnosis of depression than the Hispanic population, this disparity is much greater than other studies.
- Key findings showed detection and treatment rates for depression were significantly lower in perinatal population vs nonpregnant cohort and lower during perinatal period vs preconception period.
- Also, only 48 percent of pregnant women diagnosed with depression received any treatment (vs 72 percent of controls)
- Only 57 percent of postpartum women diagnosed with depression received any treatment (vs 73 percent of controls)
- Limitations included things like a unique population (results not generalizable), reliance upon billing codes for diagnosis, or limited number of demographic variables.
- Potential explanations for this include lack of routine screening by Ob/Gyn, reluctance of perinatal population to seek treatment, limited access to psychotherapy, cultural barriers to care, or incomplete coordination of care.
- A system of care needs to be in place, to follow these people and ensure a continuity of care.

ACTION ITEM: From depression and treatment patterns during pregnancy and postpartum presented by Dr. Patrick Finley, get more background information to take the next steps to potentially target a specific population in a particular region for an intervention.

b. DHCS Quality Strategy

- Desiree Backman with DHCS presented Strategy for Quality Improvement in Health Care
- The National Quality Strategy at the national level has 3 aims – better care, healthy people/healthy communities, and affordable care.
- The six priorities:
 1. Making care safer by reducing harm caused in the delivery of care.
 2. Ensuring that each person and family are engaged as partners in their care.

	<ol style="list-style-type: none"> 3. Promoting effective communication and coordination of care. 4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease. 5. Working with communities to promote wide use of best practices to enable healthy living. 6. Making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models. <ul style="list-style-type: none"> • Seven Priorities of the Quality Strategy <ul style="list-style-type: none"> ○ Improve patient safety ○ Deliver, effective, efficient, affordable care ○ Engage persons and families in their health ○ Enhance communication and coordination of care ○ Advance prevention (example is an incentivized quit smoking program) ○ Foster healthy communities ○ Eliminate health disparities • Guiding Principles <ul style="list-style-type: none"> ○ Person-centeredness and family engagement are central to high-quality care ○ Science provides the foundation for policy ○ Integration and coordination of services and systems within the Department and among its partners ○ Policy, interventions, and new innovations are designed and implemented with substantive stakeholder engagement and collaboration ○ Ongoing evaluation and updates of the Quality Strategy represent a commitment to strive for the highest quality and best possible outcomes • Desiree would be the one to talk to about the connection to providers via Facebook, etc social media. • DUR Board member have several studies that can be integrated into these quality efforts. <p>ACTION ITEM: Discuss potential for the DUR Board and the DHCS Quality Improvement strategy to find synergies in improving health care for Medi-Cal FFS beneficiaries.</p>
	<p>c. Quarterly Report – 3Q2012 (July –September 2012)</p> <ul style="list-style-type: none"> • Presented by Amanda Smith with UCSF. • One caveat, the report was written in October so it is still in the old format. • On page 11 you will see a huge drop in proton pump inhibitors (PPI) and statin utilization. • PPI’s have drugs in the OTC category and if they had a paid claim, they are included. • If you look at who is migrating to managed care, these are not big categories for the utilizing individuals. • You can explain the PPIs somewhat in that way, and PPIs are one of the highly overused drug categories. • Statins are the reverse; however the clinicians are more cautious.
	<p>d. Research Topics and Action Item from Previous Meeting</p>

	<p>i. Compare utilization for all atypical antipsychotic injections</p> <ul style="list-style-type: none"> • Amanda presented quarterly utilization from 1Q2009 to 3Q2011 for these medications. • Conclusion: paliperidone is growing with new starts and members switching from the other products.
	<p>e. Prospective DUR</p> <p>i. Review of DUR Alert: Drug/Allergy (DA)</p> <ul style="list-style-type: none"> • Definition can be found two places in the CDL • Generic Code Number Sequence Numbers (GCNs) on the CDL were identified but do not have the drug-allergy alert turned on. • A review of these GCNs showed they were either recently added or only available in bulk form. • Recommendation to turn on alert for certain GCNs was presented. • The Board discussion resulted in a recommendation to turn off the drug allergy alert, and was seconded. The reason is because they are mostly overridden and the system does not have a mechanism to correct wrong patient allergy information. The allergy information is coming from paid medical Medi-Cal claims. Pharmacy will have their own allergy check system. • DHCS will discuss the recommendation internally since the Board is advisory. <p>ACTION ITEM: DUR Board recommends turning off the drug allergy alert for all drugs. Will wait for direction from DHCS.</p> <p>ii. Review of Prospective DUR Criteria</p> <p>1. Maximum quantity restrictions: triptans</p> <ul style="list-style-type: none"> • Moved and seconded that policy committee look at their quantity limit because it may be excessive for triptan tablets and nasal preparations <p>ACTION ITEM: Policy committee to look at the quantity limits for triptan tablets and nasal preparations because they may be excessive.</p>
	<p>f. Retrospective DUR</p> <p>i. Review of Retrospective DUR Criteria</p> <p>1. Migraine quality of care: triptans</p> <ul style="list-style-type: none"> • This bulletin is under review right now. It has been written and you will be seeing it published next month. <p>2. Annual monitoring of persistent use medications: anticonvulsants, ACE inhibitors/ARBs, diuretics, and digoxin</p> <ul style="list-style-type: none"> • Proposed bulletin topics for 2013 • What we have now is paid claims for these potential bulletins. • ACE/ARB, example has over 150K paid claims for lisinopril from 10-1-2011 to 9-30-2012. • Digoxin had 15K identified paid claims with ~4,100 utilizing beneficiaries with a paid claim. This bulletin will assess the percentage of Medi-Cal FFS beneficiaries between 18 and 64 years of age who received at least 180 treatment days of digoxin during the measurement year (10/01/2011 – 9/30/2012) and had at least one serum potassium and either a serum creatinine or blood urea nitrogen monitoring test in the

	<p>measurement year.</p> <ul style="list-style-type: none"> • Xerox will try to present at least 6 topics each board meeting. • It was suggested to research opiates; if they do, do county by county, and maybe adolescent use of opioids • Board would like to see opioids and not wait until next board meeting. <p>ACTION ITEM: Retro DUR review of narcotic drug therapeutic class.</p> <p>3. Comprehensive diabetic care: insulin or oral hypoglycemic/anti-hyperglycemics</p> <ul style="list-style-type: none"> • This bulletin will assess the percentage of Medi-Cal FFS beneficiaries identified with diabetes (through pharmacy and medical claims) between 18 and 64 years of age who had hemoglobin A1c (HbA1c), low-density lipoprotein cholesterol (LDL-C) test, and eye screening during the measurement year. <p>ACTION ITEM: Retro DUR review of < 18 years population and comprehensive diabetes care</p> <p>4. Drug/drug interactions: Beta blockers and CYP 2D6 inhibitors</p> <ul style="list-style-type: none"> • This is a bulletin topic from Dr. Finley's recommendation. • PROPOSED INTERVENTION RECOMMENDATION TO THE DUR BOARD: Evaluate health outcomes in this population at 30-, 60-, and 90-days after starting one of the selected anti-depressants. Outcomes of interest are emergency department visits, hospital admissions, and continued use of anti-depressants and β-blockers. Present outcomes data to DUR Board and solicit recommendations and suggestions for future research on this drug-drug interaction. To avoid the study being under-powered, delaying this project until MIS/DSS access has been approved might be useful. Using the SURS database to pull preliminary data would limit the study population (SURS only has 15 months of continuous eligibility information, limiting the measurement period to one year). <p>ACTION ITEM: CYP 2D6 drug interactions with b-blockers and anti-depressants</p> <p>ii. Discussions/Recommendations for Future Educational Bulletins</p> <ul style="list-style-type: none"> • Presented by Shal Lynch • Migraine Quality of Care in the Medi-Cal Population • Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults: Comprehensive Diabetes Care and Annual Monitoring for patients on persistent medications • Safety alerts: telaprevir and zolpidem
	<p>g. Electronic Prescribing Update – Partners in E Program</p> <ul style="list-style-type: none"> • Deferred to next meeting
	<p>h. DHCS Update</p> <ul style="list-style-type: none"> • Deferred to next meeting <ul style="list-style-type: none"> i. Contract Drug List Look Up Tool ii. Medi-Cal Subscription
<p>5. BOARD MEMBERS & PUBLIC COMMENT</p>	
<p>6. CONSENT AGENDA</p>	
<p>7. CLOSING</p>	<ul style="list-style-type: none"> • The next Board meeting will be on May 14, 2013 with the trial of a potential remote WebEx.

REMARKS ADJOURNMENT	<ul style="list-style-type: none"> The meeting was adjourned at 1:00 p.m.
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Action Items	Ownership
Post approved November 13, 2012 Board Meeting Minutes to DUR website	Jannice
MIS/DSS Update	Pauline
Schedule meeting with Board members to discuss the details to host a video meeting teleconference remotely for the next board meeting.	Pauline/Patrick
Report back to group a snapshot of FFS lives as it relates to foster children, how many and what is the state/volume of lives currently covered.	Pauline
Pauline to follow up regarding the 2 million uninsured coming to Medi-Cal as a result of Healthcare reform. Will this group be FFS/Managed Care?	Pauline
Present the advantages/disadvantages of MIS/DSS vs. SURS.	Patrick
From depression and treatment patterns during pregnancy and postpartum presented by Dr. Patrick Finley, get more background information to take the next steps to potentially target a specific population in a particular region.	Pauline/Patrick Finley
Retro DUR review of narcotic drug therapeutic class.	Amanda/Shalini
Discuss potential for the DUR Board and the DHCS Quality Improvement strategy to find synergies in improving health care for Medi-Cal FFS beneficiaries.	Pauline
DUR Board recommends turning off the drug allergy alert for all drugs.	DHCS
Policy committee to look at the quantity limits for triptan tablets and nasal preparations.	DHCS
Retro DUR review of < 18 years population and comprehensive diabetes care.	Amanda/Shalini
CYP 2D6 drug interactions with b-blockers and anti-depressants.	Pauline/Patrick Finley