# GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD MEETING MINUTES

Tuesday, May 21, 2019
9:30 a.m. – 3:00 p.m.

**Location:** Department of Health Care Services (DHCS)
1700 K Street, 1st Floor Conference Room
Sacramento, CA 95814

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| **1) WELCOME/INTRODUCTIONS** | The Global Medi-Cal Drug Use Review Board (the “Board”) members and meeting attendees introduced themselves.  
- Board members absent: Drs. Timothy Albertson, Chis Chan (attended via webinar), and Vic Walker (attended via webinar).  
- DHCS staff present included Pauline Chan, RPh, David Do, PharmD, Robert Garlick, RPh, Paul Nguyen, PharmD, Emily Schulz, PharmD, Jose Villalobos, MPA, and Dorothy Uzoh, PharmD.  
- Representatives present from other Medi-Cal managed care plans (MCPs) attending in-person included Matthew Garrett, PharmD (Health Plan of San Joaquin), Michael T. Gee, PharmD (Kaiser), Lisa Ghotbi, PharmD (San Francisco Health Plan), Adam Horn, PharmD (CenCal Health), Amit Khurana, PharmD (Aetna Better Health of California), Susan Nakahiro, PharmD (Care 1st Partner Plan), Flora Siao, PharmD (California Health & Wellness), and Bruce Wearda, RPh (Kern Family Health Care).  
- Representatives present from other Medi-Cal managed care plans (MCPs) attending via webinar included Barrie Cheung, PharmD (Health Plan of San Mateo), Anthony Dao (AIDS Healthcare Foundation), Riona Fujinaga (Inland Empire Health Plan), Kris Gericke, PharmD (CalOptima), Jeff Januska, PharmD (CenCal Health), Helen Lee, PharmD, MBA (Alameda Alliance for Health), Stephanie Lem, PharmD (CenCal Health), Luke Lim, PharmD (Anthem Blue Cross), Charles Lino, PharmD (Community Health Group), Andrea Ocampo (Partnership Health Plan of California, Inc.), Ankit Shah, PharmD (UnitedHealthcare Community Plan of California, Inc.), Jessica Shost, PharmD (San Francisco Health Plan), Kristen Tokunaga, PharmD (Health Plan of San Joaquin), and Mimosa Tran, PharmD (Molina Healthcare of California Partner Plan, Inc.). |

| **2) CALL TO ORDER/GUIDELINES** | The Chair of the Board, Dr. Randall Stafford, called the meeting to order. Dr. Stafford reviewed the general meeting guidelines and stated that everyone should have the mindset to be courteous, respectful, and open-minded. Dr. Stafford stated that he is viewing an electronic copy of the agenda and packet in order to follow the agenda and attachments being presented. He explained that any Board members using personal computing devices during the meeting are viewing the same materials provided to the public. This statement is required by Open Meeting rules. Finally, Dr. Stafford asked Dr. Orozco to share questions from webinar participants as they arise.  
Ms. Chan provided a brief overview of Robert’s Rules of Order and introduced Emily Schulz, PharmD, a new pharmacist with the Pharmacy Operations Branch. |
The Board reviewed the minutes from the Board meeting held on February 26, 2019. Dr. Wong and Dr. Mowers stated they had minor edits to the minutes. Dr. Stebbins motioned that the minutes be approved with these edits. The motion was seconded. There was no discussion. The Board voted to approve the minutes with the edits suggested by Dr. Wong and Dr. Mowers included.

**AYE:** Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** Albertson, Chan, Walker

**ACTION ITEM:** Incorporate edits from Dr. Wong and Dr. Mowers into the February 26, 2019 minutes and post to the DUR website.

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**4) OLD BUSINESS**

**a.** Review of Board Action Items from February 26, 2019:

i. Complete an additional review of the Treatment Authorization Request (TAR) data to determine the percentage of TARs for each drug that are due to the statutory prescription limit and the top three reasons for denials among antipsychotic medications – Ms. Chan stated that due to system limitations it is not possible to retrieve a report listing the top three reasons for denials among antipsychotic medications. Ms. Chan provided a list of the top 30 TAR drugs for Q12019, which included the percentage of TARs for each drug due to the statutory prescription limit. Ms. Chan then introduced Robert Garlick, RPh, who is a supervisor from the Northern Pharmacy Section TAR field office.

Mr. Garlick acknowledged that the Pharmacy Benefits Division prepared the Q12019 report and he was here to talk more about the report and would try to answer any questions. He provided historical context about the TAR system and said that the column on the report regarding the percentage of TAR submissions due to the statutory prescription limit are not related to the actual prescription count by the claims processing system and are instead based on provider self-report. Dr. Stebbins asked if provider in this context meant a prescriber or a pharmacist. Mr. Garlick confirmed it is the pharmacist. Mr. Garlick also noted that any drug not on the Medi-Cal fee-for-service List of Contract Drugs (CDL) requires a TAR, regardless.

Dr. McBride asked what percentage of all TARs is due to the statutory limit. Mr. Garlick stated approximately 20% of TARs are due to the six prescription limit. Mr. Garlick took additional questions from the board on the average turnaround time (24 hours, if during business hours), why the statutory limit was imposed (thought to be due to state budgetary reasons, but was implemented before he started working at the TAR office), and whether vitamins are included in the limit (depends on whether it is on the CDL, with some exceptions). Dr. Leung asked if the pharmacist knows at the point-of-sale if a drug is not on the CDL and does not count toward the statutory limit. Mr. Garlick stated that reject codes might not be accurate. Dr. Leung stated in his experience, pharmacists might pick out the most important six medications and put those through first to ensure there are no access issues, but that beyond those six there could be issues. Mr. Garlick reminded everyone of the emergency access provisions available to pharmacists.

Dr. Stafford asked if any of the MCPs have similar TAR requirements based on the total number of prescriptions and the consensus at the meeting was that no MCPs have similar restrictions. Mr. Walker stated he would support efforts to remove this restriction in the fee-for-service population. Dr. Wong asked what could be done to update the law, especially since many times pairs of medications are needed and should be considered as one medication instead of two. He gave the example of methotrexate and folic acid and said there are similar cases for other medications and diseases such as diabetes.
Mr. Garlick noted that sometimes because of the prescription limit, the TAR office has been able to identify other issues, including potential drug interactions, incorrect dosage, and duplicate therapies. Dr. Stebbins commented she was surprised that if none of the managed care plans have a similar limitation, that this isn’t considered discrimination or a barrier to access for fee-for-service beneficiaries. Dr. Stafford then noted the time and asked the Board if they felt there should be a motion for a policy change or whether there should be a more thorough review of the statute and options for how the Board could move forward.

Dr. Ghotbi suggested changing a law might be difficult, but perhaps there could be action taken at a policy level. Dr. Mowers confirmed the TAR is approved at the National Drug Code (NDC) level, so if a dose change occurred, a new TAR would be needed based on the specific NDC on the CDL. Dr. Stafford stated that the number of steps a patient needs to go through to get access is a large source of dissatisfaction for Medi-Cal providers and noted that in the absence of evidence that there is a direct benefit to limiting the number of prescriptions, the Board should go beyond asking DHCS staff to investigate this issue. Dr. Garrett reported that South Carolina had a similar policy, and a subsequent investigation convinced the legislature that the negative outcomes and barriers to care as a result of the prescription limit outweighed any financial benefit to the state.

Dr. Zuniga motioned that staff to collect more information regarding the details of the statute, look at the intended consequences, and prepare a list of possible options available. The motion was seconded. The motion passed.

| AYE: | Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga |
| NAY: | None |
| ABSTAIN: | None |
| ABSENT: | Albertson, Chan, Walker |

**ACTION ITEM:** The DUR Board recommendation to investigate options to remove the TAR requirement for > 6 prescriptions, including policy workarounds will be submitted to DHCS.

Dr. Blatt stated it would be interesting to look at denied claims due to the statute and see if there was a paid claim at a later time. Dr. Blatt suggested this might vary by pharmacy and the level of training and experience that pharmacy staff has navigating the TAR process. Dr. Stebbins clarified that the reasons for denied claims are not as important as whether or not there is an eventual paid claim within the same therapeutic class. Dr. Blatt motioned for the analysis of claims denied because of the > 6 prescriptions TAR requirement to include a review for cases without a subsequent paid claim within the same therapeutic class. The motion was seconded. There was no further discussion. The motion passed.

| AYE: | Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga |
| NAY: | None |
| ABSTAIN: | None |
| ABSENT: | Albertson, Chan, Walker |

**ACTION ITEM:** The DUR Board recommendation to analyze claims denied because of the > 6 prescriptions TAR requirement and review for cases without a subsequent paid claim within the same therapeutic class will be submitted to DHCS.

Dr. Blatt stated it would be interesting to look at denied claims due to the statute and see if there was a paid claim at a later time. Dr. Blatt suggested this might vary by pharmacy and the level of training and experience that pharmacy staff has navigating the TAR process. Dr. Stebbins clarified that the reasons for denied claims are not as important as whether or not there is an eventual paid claim within the same therapeutic class. Dr. Blatt motioned for the analysis of claims denied because of the > 6 prescriptions TAR requirement to include a review for cases without a subsequent paid claim within the same therapeutic class. The motion was seconded. There was no further discussion. The motion passed.

| AYE: | Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga |
| NAY: | None |
| ABSTAIN: | None |
| ABSENT: | Albertson, Chan, Walker |

**ACTION ITEM:** The DUR Board recommendation to analyze claims denied because of the > 6 prescriptions TAR requirement and review for cases without a subsequent paid claim within the same therapeutic class will be submitted to DHCS.

**ii. Review best practices for prior authorization process improvement and strategies to prevent filling prescriptions that are already cancelled – Ms. Chan stated that best practices collated from Annual Reports would be presented later today.**

| AYE: | Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga |
| NAY: | None |
| ABSTAIN: | None |
| ABSENT: | Albertson, Chan, Walker |


iii. Review the use and prescribing of opioids in the emergency department and surgical setting and review naloxone prescribing after the implementation of the new legislative requirements in California – Ms. Chan stated that this topic was approved and will be presented at the Board meeting on November 19, 2019.

iv. Review diabetes management, hypertension management, asthma management, and immunizations within populations with chronic disease, including a review of best practices among managed health care plans – Ms. Chan again stated that best practices collated from Annual Reports would be presented later today.

v. Approve the FFY2018 DUR Annual Report to CMS for the Medi-Cal Fee-for-Service (FFS) program – Ms. Chan stated this report has been submitted electronically to CMS and all that is needed is Dr. Stafford’s signature on the cover letter to present the report to Director Kent of DHCS.

vi. Present generic utilization and expenditure data exclusive of carved-out drugs for all FFS beneficiaries and MCPs (by plan) and also for all carved-out drugs – Ms. Chan noted that generic utilization in the FFS program exclusive of carved-out drugs for FFY 2018 was 82.5% (vs. 74.1% overall) and, similarly, generic expenditures was 15.7% of the total (vs. 7.3% overall). In addition, Ms. Chan shared MCP generic utilization for FFY 2018 ranged from 83.5% to 96.2% and the carved-out generic utilization for FFY 2018 was 56.2%, with a generic expenditure of 3.1%.

vii. Archive the varenicline alert – Ms. Chan stated this was completed.

viii. Conduct a retrospective DUR review of gabapentinoids – Ms. Chan stated this review would be presented later today.

ix. Use the DUR Vital Directions Framework to guide priority area topic clusters – Ms. Chan noted the framework has been incorporated into the discussion of priority areas that will take place later in the day.

b. Recommended Action Items for MCPs from February 26, 2019: Ms. Chan presented the recommended action items for MCPs from the Board meeting held on February 26, 2019. Recommendations are separated into two categories: required action items and suggested action items.

## 5) NEW BUSINESS

### a. Global DUR Board Activities

i. Summary of Best Practices – Dr. Stafford presented a summary of health plan best practices in the following four areas:

   - Prior authorization process improvement
   - Strategies to prevent fill of cancelled prescriptions
   - Diabetes, hypertension, and asthma management
   - Immunization

Ms. Chan explained that these best practices were identified through the managed care health plan DUR annual reports for Federal fiscal year (FFY) 2018. Dr. Stafford asked the group to consider whether having policies that direct plans to enact these best practices might be feasible. Dr. McBride suggested we could also look at what the health plans are doing and recommend these strategies for FFS. Dr. Stafford wondered to what extent these best practices are being implemented in FFS. Ms. Chan stated that FFS would review what is reported in the annual reports to see what can be done.

Dr. Dhanvanthari proposed that rather than direct plans to adopt everything, the Board should endorse adopting only what is possible, considering that each plan has a different set of priorities and schedule of implementation. Dr. Stebbins recommended that at the very least the Board could be accountable to give a status update or an explanation for why they do not choose to implement a particular best practice.

Dr. Stafford asked for comments from those attending via webinar and suggested there was room for additions to the list of best practices. Dr. Zuniga suggested the Board promote use of guidelines to manage chronic diseases and asked to include congestive heart failure along with diabetes, hypertension, and asthma management.

Ms. Chan reminded the group of the process used to compile the summary of best
practices and noted the differences between plans. Dr. Stafford stated that the existence of potential systemic barriers should not dissuade us from trying to implement these practices.

Dr. Ghotbi shared a concern with the slides seeming to endorse specific products and suggested changing the slide text for future discussions of best practices to more neutral wording. Dr. Mowers stated that best practices might be developed and modified to meet the needs of a specific site and agreed it would be helpful to be aware of what other groups are doing and consider if they might be a good fit. He suggested the Board review the best practices and encourage FFS and MCPs to see if any of these will work in their specific environment. Dr. Stafford recommended being more proactive in implementing best practices within the FFS population.

Dr. Dhanvanthari motioned that the Board recommend that the plans – including FFS – review the best practices and adopt those that have the easiest fit for their plan, with each plan to report back in six months what they have implemented or not implemented (and why not). Plans could also make a determination whether adoption is possible within a year. Dr. Dhanvanthari also recommended assigning a limited number of best practices to review.

Dr. Paulson agreed there are too many best practices and proposed grouping them into smaller numbers that would be more manageable. Dr. Ghotbi noted that a review of best practices is beyond the obligation of the all-plan letter (APL). She suggested any requirements for reporting be within the scope of the APL. Dr. Leung suggested it would be helpful to have clarification of the intent of this review of best practices. He asked if it was to report back to DHCS or to learn from each other. Dr. Leung recommended identifying three to five of the best practices that each plan doesn’t do and explain why they don’t. Dr. Zuniga stated that plans already submit an annual report, so there is already a mechanism to report what is being done and he hesitates to recommend any duplicative activity.

Dr. Stebbins asked if the summary presented on the slides include any best practices from the FFS program. Ms. Chan stated that the immunization practice is from FFS and is an award-winning program.

Dr. Stebbins suggested that perhaps MCPs have already fulfilled their contractual obligations to report and that it could now be incumbent upon FFS to review these best practices and respond about the feasibility of implementation.

Dr. Dhanvanthari amended her original motion to recommend that all plans, including FFS, review best practices and assess if already implemented, could be implemented, or why could not be implemented. The motion was seconded. There was no further discussion. The motion passed.

AYE: Blatt, Dhanvanthari, Dryjanski, Leung, Liu, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga
NAY: None
ABSTAIN: McBride
ABSENT: Albertson, Chan, Walker

ACTION ITEM: The DUR Board recommendation for all plans, including FFS, to review best practices and assess if already implemented, could be implemented, or why could not be implemented will be submitted to DHCS.

b. Health Plan Presentation: The Safe Choice Program: A Response to the Opiate Crisis – Heidi Solz, MD [Anthem Blue Cross] gave a brief overview of the Safe Choice Program and then introduced co-presenters Beth Stewart, MD [Medical Director, Anthem Blue Cross] and Nick Osterman, MA, LMFT [Director of Behavioral Health Services, West Region, Anthem Blue Cross]. Dr. Stewart stated that Safe Choice is a case management (CM) program that
utilizes pharmacy and/or provider lock-in as a tool for members. Dr. Stewart explained that Safe Choice was started in 2015 due to concerns with duplicate drug therapies, high-dose opioid prescriptions, multiple prescribers and pharmacies, drug-disease and drug-drug interactions, and medication misuse and abuse. Dr. Stewart stated the goals of Safe Choice were to design a member-centric program that was not punitive in order to enhance patient safety, improve provider awareness/education, improve coordination of care, including counseling, treatment for substance use disorder, and pain management.

Dr. Stewart then covered the structure and process of the Safe Choice committee, which includes physical and behavioral health medical directors, physical and behavioral health case managers, a pharmacy director, a data analyst, and a project manager. Dr. Stewart reviewed the program workflow steps, the inclusion/exclusion criteria for members, the launch strategy, identification of metrics, and program interventions. Dr. Stafford asked if prescribers are informed when members are locked-in. Dr. Stewart confirmed that prescribers are informed and that providers are asked before being designated as the lock-in provider.

Mr. Osterman then reviewed the outcomes from the Safe Choice pilot that started in July 2015 in both Tulare and Sacramento counties. He stated that in August 2015, there were eight members locked-in and that during the first year of the program a total of 155 referrals were reviewed, 25 members were locked-in and referred to CM, 85 members were referred to CM only, and three members were left in the program. After the first year, there was a decrease in both emergency room (ER) visits and opiate use among the first eight members locked-in, as well as a decrease in ER use among those who were only referred to CM. He then summarized the outcomes of the Safe Choice program from 2017 and 2018, noting that the program had been expanded to include members in Butte, Fresno, Alameda, and San Francisco counties.

Mr. Osterman explained that the Choice Plus program was developed as an alternative to the Safe Choice program for those members who were at high-risk, but did not qualify for the lock-in program. He stated that Choice Plus had the same algorithm as Safe Choice, has a referral requirement for CM and care coordination, involves two-way communication with members and providers, and that the program has demonstrated a reduction in ER visits, inpatient admissions, and overall opiate prescriptions. Mr. Osterman shared lessons learned, including recognizing the value of physical health and behavioral health team integration and the importance of communication among case managers, members, pharmacies, and providers. Mr. Osterman concluded by summarizing next steps, which include statewide expansion, provider intervention for top opiate prescribers, and provider communication upon controlled substance-related ER visit or admission. Dr. Stafford asked if sensitivity was established when determining initial eligibility criteria. Dr. Stewart and Mr. Osterman replied that all cases are identified via the algorithm and then are thoroughly reviewed to determine whether the case is appropriate for referral. They also stated that they would advise other plans implementing a similar program to begin with specific eligibility criteria, allowing for expansion and adjustments as needed. Dr. Stebbins questioned if a control group was examined that compared those members who met lock-in requirements that were locked-in to those who met the requirements that were not locked-in, in order to compare the effectiveness of CM alone, the lock-in program alone, or a combination of the two. Mr. Osterman stated that not everyone who was locked-in was willing to have CM. Dr. Wong asked why diseases such as AIDS, multiple sclerosis, and lupus were on the exclusion criteria. Dr. Stewart explained that the exclusion criteria were established based on what the various plans within Anthem recommended.

c. DUR Annual Report to CMS: FFY 2018 MCO Summary – Ms. Chan provided a question-by-question summary of the MCO answers on the FFY 2018 DUR annual report to CMS. Ms. Chan thanked all of the plans for their help in working through this process and stated she appreciated all plans meeting the deadline for submission to DHCS, with many plans even turning in their reports early. Ms. Chan noted that of the 26 Medi-Cal managed care plans, there were a total of 72 innovative practices described within the annual reports. She stated that the innovative practices focused on several different areas, including the following:
• Improving the DUR Program
• Improving appropriate drug prescribing and use
• Increasing access to care
• Improving coordination of care
• Aligning of benefits
• Collaborating across agencies
• Promoting cost-effective prescribing
• Implementing value-based purchasing

Ms. Chan proposed next steps for highlighting and disseminating these innovative practices across plans. She suggested inviting health plans to present at future Board meetings, either through a live presentation with time for questions and answers or as part of a lunchtime poster session. Ms. Chan also suggested presentations outside the Board meetings might be scheduled and could include webinars arranged by topics, panel discussions, or case studies. She asked the Board to brainstorm other opportunities for shared learning across plans. Ms. Chan then asked Bruce Wearda, RPh from Kern Family Heath Care to present a brief overview of some of the innovative practices from Kern Family Heath Care, including their approach to complex case rounds. Their interdisciplinary team has weekly meetings with a focus on mental health, transportation, and adherence. Kern Family Health Care uses a 2D profile that includes a provider scorecard and actionable measures.

d. Recap of morning action items – Dr. Orozco and Ms. Fingado read the Board action items from the morning session. There was no discussion and no edits were made to the listed action items. Dr. Orozco then reviewed the following two items: 1) the election for the Global Medi-Cal DUR Board Vice Chair will be held at the September 17, 2019, Board meeting and all candidates must submit a brief (no more than one page) statement to Pauline.Chan@dhcs.ca.gov by August 1, 2019 and 2) the proposed Board meeting dates for 2020 were provided. Dr. Wong suggested moving the March 3, 2020, Board meeting date to a date in February. Ms. Fingado stated that the timing of the data reports and completing the packet was easier if the meeting was pushed to the first Tuesday in March. Dr. Wong stated that he preferred a date in February. Dr. Stafford proposed that as long as the data reports were completed by the day of the meeting, it was not critical that they be included with the posted packet. Dr. Wong suggested a date of February 25, 2020. There were no objections to this date and there was no further discussion about proposed Board meeting dates.

e. Retrospective DUR
i. Global Annual Report FFY 2018 – Ms. Fingado presented the Global Medi-Cal DUR report for FFY 2018. This annual report was presented for the first time and contains all pharmacy utilization data for the Medi-Cal program. Utilization data are presented in aggregate, and then stratified by Medi-Cal FFS enrollees only and by Medi-Cal managed care plan (MCP) enrollees only. Ms. Fingado reported that she repeated the data pull for the previous global quarterly report three months after the initial data pull and found that 99.2% of the data were present at the time of the initial pull. As a result, Ms. Fingado reported that subsequent global quarterly reports will be presented at each Board meeting and will only be one quarter behind the FFS quarterly report (instead of two quarters behind).

Dr. Leung asked about the difference between the percentages when comparing total utilizing beneficiaries to total paid claims. Ms. Fingado stated that she could add mean days supply per beneficiary to Table 4 and Table 6, in order to provide more useful information about the utilization patterns of the top 20 drug therapeutic categories and drugs. Dr. Stafford noted that among the drugs that are taken as needed, the ratio of claims per person is higher for FFS than for MCP.

Dr. Zuniga requested more information about the demographics and complexity of the patients within each group. He stated that the reports the plans get are stratified by aid codes collapsed into categories. Ms. Fingado stated that she will provide more
information about the beneficiaries in future reports, including a summary of aid codes and age groups stratified by FFS and MCP enrollees. Dr. Leung motioned to update the global quarterly report to include both the mean days supply per beneficiary for the top 20 drug therapeutic categories and drugs and a description of beneficiaries in each population by age and aid code. The motion was seconded and passed without further discussion.

AYE: Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga
NAY: None
ABSTAIN: None
ABSENT: Albertson, Chan, Walker

ACTION ITEM: The DUR Board recommendations to update the global quarterly report template to include: 1) the mean days supply per beneficiary for the top 20 drug therapeutic categories and drugs and 2) a description of beneficiaries in each population by age and aid code will be submitted to DHCS.

ii. FFS Quarterly Report: 1Q2019 (January – March 2019) – Ms. Fingado presented the Medi-Cal fee-for-service quarterly DUR report for the 1st quarter of 2019, which includes both prospective and retrospective DUR data. This quarterly report contains fee-for-service pharmacy utilization data presented in aggregate, and then stratified by Medi-Cal FFS enrollees only and by Medi-Cal managed care plan (MCP) enrollees only. This report includes all carved-out drugs processed through the FFS program. Ms. Fingado noted that the total number of eligible beneficiaries decreased from both the prior quarter (decreased by 2%) and prior-year quarter (decreased by 3%). She also reported that naloxone posted a 249% increase in total paid claims from 2018 Q4, coinciding with California legislation effective January 1, 2019, which requires prescribers to offer a prescription for naloxone for patients meeting certain requirements.

iii. Biennial Report 2018: Part I – Ms. Fingado presented Part 2 (of 2) of the biennial report for 2018, which provides detailed evaluations of the following eight DUR educational articles, published between October 2014 and September 2016:

- Clinical Review: Morphine Equivalent Daily Dose to Prevent Opioid Overuse – September 2015
- Clinical Review: Concomitant Use of Anticholinergics and Antipsychotics – November 2015
- Alert: California Upgrades Prescription Drug Monitoring Program to CURES 2.0 – January 2016
- Clinical Review: Atypical Antipsychotics and Adverse Metabolic Effects – April 2016
- 2016 Immunization Updates: Influenza, Meningococcal, Tdap, Hib, Rotavirus – September 2016

Ms. Fingado stated that there were errors identified with the data presented in the biennial review of “Clinical Review: The Treatment of Opioid Addiction with Buprenorphine – August 2016,” and that a corrected review of this article would be presented at a future meeting. The Board agreed with all suggested recommendations in the biennial report. A motion was made to update the anticholinergic and antipsychotic bulletin, including adding extrapyramidal symptom (EPS) propensity for asenapine, iloperidone, and lurasidone. The motion was seconded. There was no further discussion. The motion passed.

AYE: Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins,
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**ACTION ITEM:** The DUR Board recommendation to update the anticholinergic and antipsychotic bulletin, including extrapyramidal symptom (EPS) propensity for asenapine, iloperidone, and lurasidone will be submitted to DHCS.

Dr. Ghotbi expressed concern with the increased percentage of beneficiaries 65 years of age or older with six paid claims for both anticholinergic and antipsychotic medications, which almost doubled since the original article was published (increased from 1.0% to 1.7%). Dr. Ghotbi recommended taking a look at the use of drugs listed in the American Geriatrics Society (AGS) Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults in the 65 years of age or older Medi-Cal population. There was discussion about how it would be important to know how many FFS and MCP beneficiaries are 65 years of age or older and are not also enrolled in Medicare, and then see how many of them are taking drugs appearing on the 2019 AGS Beers Criteria® lists. A motion was made to identify the total number of Medi-Cal beneficiaries age 65 years of age or older not eligible for Medicare (FFS and MCP), review literature for the typical cutoff age for Beers list interventions, and analyze paid claims for drugs appearing on the 2019 AGS Beers Criteria® lists. The motion was seconded. There was no further discussion. The motion passed.

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<td>ABSTAIN: None</td>
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**ACTION ITEM:** The DUR Board recommendation to identify the total number of Medi-Cal beneficiaries age 65 years of age or older not eligible for Medicare (FFS and MCP), review literature for the typical cutoff age for Beers list interventions, and analyze paid claims for these drugs accordingly will be submitted to DHCS.

iv. Review: Gabapentinoids – Dr. Lynch presented a retrospective DUR review on gabapentinoids (gabapentin and pregabalin), which are frequently prescribed with opioids for their opioid-sparing and adjuvant analgesic effects. Dr. Lynch stated that recent reports suggest concomitant use of gabapentinoids and opioids might be an indicator of high-risk opioid misuse and could increase the risk of serious adverse events and pointed to a 2018 CDC report of overdose deaths in 11 states that found gabapentin detected in 21.6% of prescription opioid-only deaths. She noted that pregabalin is a Schedule V controlled substance, however gabapentin is not scheduled under the Controlled Substances Act of 1970. Many US states have implemented regulatory approaches to mitigate diversion and abuse of gabapentin and during FFY 2018, more than half of state DUR programs completed educational interventions focused on gabapentinoids. Dr. Lynch stated that in the Medi-Cal fee-for-service program, pregabalin is available only with an approved Treatment Authorization Request and gabapentin is on the Medi-Cal List of Contract Drugs without any additional restrictions to use. Dr. Lynch reported that for this review, all paid pharmacy claims for gabapentinoids were included for calendar years 2010 – 2018, and were subsequently stratified by FFS and MCP enrollees. In addition, she reported that for calendar year 2018, an additional evaluation was conducted for all continuously-eligible FFS enrollees, including the following:

- Top concomitant medications by utilizing beneficiary
- Top primary/secondary diagnosis codes by utilizing beneficiary
- % of utilizing beneficiaries with FDA-approved indication

Dr. Lynch presented the results of the review, showing that a total of 393,514 Medi-Cal
enrollees had a paid claim for a gabapentinoid during calendar year 2018, including a total of 38,532 FFS enrollees (4,102 of these were continuously-eligible in the FFS program for all of calendar year 2018). Utilization trends showing increasing use of gabapentinoids over time. Dr. Lynch showed that only 12% of continuously eligible FFS beneficiaries had an FDA-approved indication for a gabapentinoid within the last five years. Dr. Lynch recommended writing a DUR educational bulletin focused on gabapentinoids, including a summary of use within the Medi-Cal population. The bulletin would include a review of the potential for adverse-events attributed to use within high-risk populations and the potential for abuse and misuse of gabapentinoids.

The Board agreed that gabapentinoids, specifically gabapentin, should be the topic of an educational bulletin. Dr. Stafford suggested keeping references to pregabalin as well, but to separate out the data for the two drugs, as he thought the results would likely be different for each drug. Dr. Stebbins motioned to develop an educational bulletin focused on gabapentin, with reference to pregabalin. The motioned was seconded. There was no further discussion. The motion passed.

AYE: Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga
NAY: None
ABSTAIN: None
ABSENT: Albertson, Chan, Walker

ACTION ITEM: The DUR Board recommendation to develop an educational bulletin focused on gabapentin (with reference to pregabalin) will be submitted to DHCS.

f. Review of DUR Publications presented by Dr. Lynch
i. Bulletin (February 2019): MEDD Updates – Dr. Lynch let the Board know that the DUR educational bulletin entitled, “Clinical Review Update: Morphine Equivalent Daily Dose” published in February 2019. This was an update to a previous bulletin on morphine equivalent daily dose, which was published in 2015. Major updates included a summary of the CDC pain guidelines and information about recent legislation in California related to prescription opioids.

ii. Alert (March 2019): Fluoroquinolones – Dr. Lynch let the Board know that the DUR educational alert entitled, “Drug Safety Communication: Updated Adverse Effects from Fluoroquinolones” published in March 2019. This alert was in response to the U.S. Food and Drug Administration (FDA) warning that fluoroquinolones administered orally or intravenously may increase the risk of ruptures of an aortic aneurysm or aortic dissections, which are rare but serious events that can lead to dangerous bleeding or even death.

iii. Alert (April 2019): Sudden Discontinuation of Opioids – Dr. Lynch let the Board know that the DUR educational alert entitled, “Drug Safety Communication: Risks with Sudden Discontinuation of Opioids” published in April 2019. This alert summarized the FDA warning that it has received reports of serious harm in patients who are physically dependent on opioid pain medicines when these medicines are suddenly discontinued or the dose is rapidly decreased.

iv. Discussion/Recommendations for Future Educational Bulletins – Due to time constraints, the calendar for future DUR educational bulletins was not reviewed in detail at this meeting.

g. Prospective DUR: Fee-for-Service
i. Review of DUR Alerts for New GCNs in 1Q2019 (January – March 2019): At each Board meeting, a list of new GCN additions with prospective DUR alerts turned on other than DD, ER, and PG are provided to the Board for review. At this meeting, the Board reviewed the alert profiles of the following GCNs:
   - GCNs #078222, #079488, and #079489: BENZHYDROCODONE/ACETAMINOPHEN – Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD)
   - GCN #074339: CHLORPHENIRAMINE/CODEINE PHOS – Additive Toxicity (AT), Drug-Age (PA)
There were no questions or objections to these alert profile recommendations. There was no further discussion.

ii. Update: AT Alert and Gabapentinoids – Ms. Fingado reported that effective April 15, 2019, both pregabalin and gabapentin have been added to the list of drugs for the AT alert based on side effect profile, literature review, and analysis of pharmacy claims data. Ms. Fingado stated there has been a 12% increase in AT alerts since that time, and alert burden would continue to be monitored over time.

h. DUR Educational Outreach to Providers: Fee-for-Service

i. Proposal: Zolpidem – Ms. Fingado presented a proposal to address potential inappropriate use of zolpidem products based on FDA warnings that female patients have lower clearance rates than males. The top 100 prescribers of zolpidem in the Medi-Cal fee-for-service population will receive a letter that will include reference data including the overall percentage of initial zolpidem prescriptions exceeding the recommended initial dosage limits, stratified by gender. Ms. Fingado stated that the primary outcome would be provider-specific percentages of initial zolpidem prescriptions exceeding the recommended initial dosage limits, stratified by gender within 12 months following the mailing and the secondary outcome would be the total number of initial zolpidem prescriptions within 12 months following the mailing. Dr. Stafford suggested including all Medi-Cal data in the prescriber-specific profiles, in order for providers to have a more comprehensive look at the data. Ms. Fingado stated this recommendation would be incorporated into the mailing. There was a motion to recommend approval of this proposal. The motion was seconded. There was no further discussion.
**AYE:** Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga

**NAY:** None

**ABSTAIN:** None

**ABSENT:** Albertson, Chan, Walker

**ACTION ITEM:** The DUR Board recommendation to send an educational letter to prescribers of zolpidem and include all Medi-Cal claims when calculating prescriber-specific data will be submitted to DHCS.

- **Proposal: Opioids in Children < 18** – Ms. Fingado presented a proposal to inform health care providers and patients of the serious risks attributed to prescribing medications containing codeine and tramadole to patients <18 years. Prescribers with at least one paid claim within a 90-day period for a selected opioid medication in a child or adolescent < 18 years of age in the Medi-Cal fee-for-service population will receive a letter and a copy of the DUR alert on this topic. Ms. Fingado stated that the primary outcome would be the total number of continuously eligible beneficiaries < 18 years of age with a paid claim for selected opioids within the 12 months following the mailing.

  Dr. Mowers suggested expanding the date range to include data from January 1, 2019, in order to include a timeframe that overlapped with peak use of cough and cold products containing codeine. There was a motion to recommend approval of this proposal with the date range modified to include paid claims with dates of service between January 1, 2019, and June 30, 2019. The motion was seconded. There was no further discussion.

- **AYE:** Blatt, Dhanvanthari, Dryjanski, Leung, Liu, McBride, Mowers, Paulson, Stafford, Stebbins, Wong, Zuniga

- **NAY:** None

- **ABSTAIN:** None

- **ABSENT:** Albertson, Chan, Walker

**ACTION ITEM:** The DUR Board recommendation to send an educational letter to all prescribers of codeine and tramadole in children between January 1, 2019, and June 30, 2019, will be submitted to DHCS.

- **Outcomes: MEDD 2019** – Ms. Fingado presented details from the most recent mailing aimed to educate providers about morphine equivalent daily dose thresholds and updated legislation regarding prescribing opioids in California. Ms. Fingado reported that the study population included 87 Medi-Cal fee-for-service beneficiaries with at least 1 paid claim > 120 mg MEDD since January 1, 2019. A total of 85 prescribers were identified for educational outreach letters, which were mailed on April 26, 2019. Each letter included patient profiles, the updated Medi-Cal DUR MEDD article, a naloxone handout, and provider response surveys. Ms. Fingado reminded the Board that the primary outcome is the percentage of the continuously eligible study population with a paid claim exceeding > 120 mg MEDD in the 6-month period following the mailing of the intervention letter. Final outcomes, as well as the response rate and returned mail rate will be presented at a future Board meeting.

- **Pharmacy Update** presented by Pauline Chan
  - **Policy: AB1114 Implementation** – Ms. Chan stated that AB1114 implementation would be on April 1, 2019, for FFS and by December 31, 2019, for MCPs. She added that a FAQ resource will be posted to the Medi-Cal website upon completion.
  - **DUR goals, priority areas, and related measures** – Ms. Chan suggested aligning DUR with Medicaid Health Care Quality Measures, including medication-related measures in both the 2019 Child Core Set and the 2019 Adult Core Set.
  - **Opioids Safety Toolkit for Health Plans** – Ms. Chan shared the link for the California Health Care Foundation’s Opioid Safety Toolkit, and noted that tools, tactics, best practices, and success stories can be found on that link.
iv. **CURES 2.0** – Ms. Chan reported that [CURES 2.0](#) is available for use and suggested providers refer to the [CURES Mandatory Use](#) reference sheet, [CURES Advisory Memo](#), and the [Medical Board of California’s FAQs](#) for further guidance, if needed.

v. **Academic Detailing** – Ms. Chan shared an [interview with a clinician](#) who had completed academic detailing training with the National Resource Center for Academic Detailing (NaRCAD). The interview focused on the barriers to and enablers of success when implementing an academic detailing program. Ms. Chan also provided a [registration link](#) for the NaRCAD training on Opioid Safety Academic Detailing, which will be held in July 2019.

i. **Addressing Complex Drug Regimens** – Ms. Chan stated that the Centers for Health Care Strategies provided access to their webinar entitled, “Addressing Medication Complexity Through Innovative Community-Based Strategies and Partnerships.”

ii. **SUPPORT Act** – Ms. Chan provided information about the [SUPPORT Act](#). Ms. Chan confirmed CMS would be providing additional guidance on the DUR minimum requirements outlined in the SUPPORT Act in the upcoming months.

iii. **FFY 2018 DUR Annual Report** – Ms. Chan reported that all annual reports for California (FFS and MCO) have been submitted to CMS, well in advance of the July 1 deadline.

j. Recap of today’s action items – Due to time constraints, the action items for the afternoon session were not discussed.

k. Looking ahead: Call for future meeting agenda – Ms. Chan stated that she welcomes recommendations from the Board for speakers. Two possible presentations for September include one by Linette Scott, MD, MPH on Core Set Measures and one by Sharon Cummins, PhD and Neal Kohatsu, MD, MPH entitled, “Tobacco Quitlines, Incentives and the Medicaid Population.”

### 6) PUBLIC COMMENTS
- There was a public comment from Thomas Jough, MBA, a senior strategic account manager at Walgreens. Mr. Jough updated the Board on several ongoing projects at Walgreens, including mental health initiatives, a collaboration with the U.S. Department of Veterans Affairs (VA), take-back kiosks located within pharmacies across California, refill- and adherence-based initiatives, and express pickup.

### 7) CONSENT AGENDA
- The next Board meeting will be held from 9:30 a.m. to 3:00 p.m. on September 17, 2019, in the DHCS 1st Floor Conference Room located at 1700 K Street, Sacramento, CA 95814.

### 8) ADJOURNMENT
- The meeting was adjourned at 3:04 p.m.

<table>
<thead>
<tr>
<th>Action Items</th>
<th>Ownership</th>
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<tbody>
<tr>
<td>Incorporated edits from Dr. Wong and Dr. Mowers into the February 26, 2019, minutes and post to the DUR website.</td>
<td>Amanda</td>
</tr>
<tr>
<td>The DUR Board recommendation to investigate options to remove the TAR requirement for &gt; 6 prescriptions, including policy workarounds will be submitted to DHCS.</td>
<td>Pauline</td>
</tr>
<tr>
<td>The DUR Board recommendation to analyze claims denied because of the &gt; 6 prescriptions TAR requirement and review for cases without a subsequent paid claim within the same therapeutic class will be submitted to DHCS.</td>
<td>Pauline</td>
</tr>
<tr>
<td>The DUR Board recommendation for all plans, including FFS, to review best practices and assess if already implemented, could be implemented, or why could not be implemented will be submitted to DHCS.</td>
<td>Pauline</td>
</tr>
<tr>
<td>The DUR Board recommendations to update the global quarterly report template to include: 1) the mean days supply per beneficiary for the top 20 drug therapeutic categories and drugs and 2) a description of beneficiaries in each population by age and aid code will be submitted to DHCS.</td>
<td>Amanda</td>
</tr>
<tr>
<td>The DUR Board recommendation to update the anticholinergic and antipsychotic bulletin,</td>
<td>Amanda/shal</td>
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including extrapyramidal symptom (EPS) propensity for asenapine, iloperidone, and lurasidone will be submitted to DHCS.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Signature</th>
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<tr>
<td>The DUR Board recommendation to identify the total number of Medi-Cal beneficiaries age 65 years of age or older not eligible for Medicare (FFS and MCP), review literature for the typical cutoff age for Beers list interventions, and analyze paid claims for these drugs accordingly will be submitted to DHCS.</td>
<td>Amanda</td>
</tr>
<tr>
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