GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD
MEETING MINUTES
Tuesday, September 17, 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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<th>Topic</th>
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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 present: Drs. Timothy Albertson, Michael Blatt, Chis Chan, Lakshmi Dhanvantari, Jose Dryjanski, Stan Leung, Johanna Liu, Janeen McBride, Yana Paulson, Randall Stafford, Marilyn Stebbins, Vic Walker, and Andrew Wong.  
• Board members absent: Drs. Robert Mowers and Ramiro Zuniga.  
• Joanne Peschko, MBA from the DHCS Office of the Medical Director (OMD) was in attendance. DHCS Pharmacy Benefits Division (PBD) staff present included Pauline Chan, RPh, David Do, PharmD, Harry Hendrix, Emily Schulz, PharmD, and Ivana Thompson, PharmD. Teri Miller, PharmD, Paul Pontrelli, PharmD, and Dorothy Uzoh, PharmD attended the meeting via webinar.  
• Representatives present from other Medi-Cal managed care plans (MCPs) attending in-person included Michael T. Gee, PharmD (Kaiser), Nicki Ghazanfarpour, PharmD (CalOptima), Lisa Ghotbi, PharmD (San Francisco Health Plan), Adam Horn, PharmD (CenCal Health), Amit Khurana, PharmD (Aetna Better Health of California), Anita Lee, PharmD (CalOptima), Navnett Sachdeva, PharmD (Central California Alliance for Health), Jessica Shost, PharmD (San Francisco Health Plan), and Michelle Williams (Central California Alliance for Health).  
• Representatives present from other Medi-Cal managed care plans (MCPs) attending via webinar included Danielle Biasotti (Partnership HealthPlan of California, Inc.), Barrie Cheung, PharmD (Health Plan of San Mateo), Anthony Dao (AIDS Healthcare Foundation), Biyan Feng, PharmD (Health Plan of San Mateo), Kim Fillette, PharmD (Partnership HealthPlan of California, Inc.), Kris Gericke, PharmD (CalOptima), Dang Huynh (Santa Clara Family Health Plan), Helen Lee, PharmD, MBA (Alameda Alliance for Health), Charles Lino, PharmD (Community Health Group), Andrea Ocampo (Partnership Health Plan of California, Inc.), Lynette Rey, PharmD (Partnership HealthPlan of California, Inc.), Ankit Shah, PharmD (UnitedHealthcare Community Plan of California, Inc.), Flora Siao, PharmD (California Health & Wellness/Health Net Medi-Cal), Mimosa Tran, PharmD (Molina Healthcare of California Partner Plan, Inc.), and Bruce Wearda, RPh (Kern Family Heath Care). |
<p>| 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. Dr. Stafford then provided a brief overview of Robert’s Rules of Order. |</p>
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<th>3) REVIEW AND APPROVAL OF PREVIOUS MINUTES FROM MAY 21, 2019</th>
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<td>The Board reviewed the minutes from the Board meeting held on May 21, 2019. Dr. Wong stated he had two minor edits to the minutes. Dr. Dryjanski 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 included.</td>
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<td><strong>AYE:</strong> Blatt, Chan, Dryjanski, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, and Wong</td>
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<td><strong>NAY:</strong> None</td>
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<td><strong>ABSTAIN:</strong> None</td>
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<td><strong>ABSENT:</strong> Albertson, Dhanvanthari, Mowers, and Zuniga</td>
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<td><strong>ACTION ITEM:</strong> Incorporate edits from Dr. Wong into the May 21, 2019, minutes and post to the DUR website.</td>
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<th>4) OLD BUSINESS</th>
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<td><strong>a.</strong> Review of Board Action Items from May 21, 2019:</td>
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<td>i. Investigate options to remove the TAR requirement for &gt; 6 prescriptions – Ms. Chan stated that DHCS is supportive of this and is meeting internally to determine the best course of action. Dr. Paulson asked if this required a legislative change. Ms. Chan affirmed that it did and that DHCS was prepared to follow the timeline and process necessary for this legislative change.</td>
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<td>ii. Analyze claims denied because of the &gt; 6 prescriptions TAR requirement and review cases without a subsequent paid claim within the same therapeutic class – Ms. Chan reported that these data are not available due to limitations within the TAR database and reiterated that DHCS prefers to move forward on working to remove the TAR requirement.</td>
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<td>iii. Review best practices and assess if already implemented, could be implemented, or why could not be implemented. – Ms. Chan stated that Dr. Stafford would report on this in more detail later in the meeting.</td>
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<td>iv. 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 clusters. – Ms. Fingado reported that these suggested updates were approved by DHCS and have been incorporated into the global quarterly report presented today.</td>
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<td>v. Update the anticholinergic and antipsychotic bulletin, including extrapyramidal symptom (EPS) propensity for asenapine, iloperidone, and lurasidone. – Ms. Fingado stated that this bulletin has been updated and was published to the DUR educational bulletin web page in August 2019.</td>
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<td>vi. 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. – Ms. Fingado stated that this suggestion had been approved by DHCS and that these data will be presented at either the November 2019 or February 2020 DUR Board meeting.</td>
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<td>vii. Develop an educational bulletin focused on gabapentin (with reference to pregabalin). Ms. Fingado thanked Dr. Liu for agreeing to review this article and stated that it is on schedule to be published to the DUR educational bulletin web page in October 2019.</td>
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<td>viii. Send an educational letter to prescribers of zolpidem and include all Medi-Cal claims when calculating prescriber-specific data. – Ms. Fingado stated this letter was approved by DHCS and sent out in August 2019.</td>
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<td>ix. Send an educational letter to prescribers of codeine and tramadol in children between January 1, 2019 and June 30, 2019. – Ms. Fingado stated these letters were approved by DHCS and sent out in August 2019.</td>
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<td><strong>b.</strong> Recommended Action Items for MCPs from May 21, 2019: Ms. Chan presented the recommended action items for MCPs from the Board meeting held on May 21, 2019. Recommendations are separated into two categories: required action items and suggested action items.</td>
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Dr. Scott presented information about what is currently being done regarding the alignment of quality measures across programs within DHCS. She gave a brief overview of the Medicaid Core Set Measures, explaining that these measures are updated annually via a stakeholder process and drive alignment across all programs. Dr. Scott stated that measures are currently voluntary and there is inconsistent reporting by states. However, Dr. Scott explained that a subset of measures is included in the Medicaid Score Card, which can be used to compare data across states. Dr. Scott also shared that starting in Federal fiscal year (FFY) 2024 states would be required to report on the Child Core Set and behavioral health measures for the Adult Core Set.

Dr. Scott then discussed aligning programs with the Medicaid Core Set Measures. She stated that over the next year, MCPs will report on core set measures that apply to them. Dr. Scott added that at the county level was being explored and that granular reports can be generated for measures that are calculated with administrative data. Dr. Scott then reviewed the Value Based Payment (VBP) program, in which DHCS provides incentive payments to providers who meet specific measures aimed at improving care for certain high-cost or high-need populations. Dr. Scott explained that the target areas currently include behavioral health integration, chronic disease management, prenatal/postpartum care, and early childhood development, with increased incentives provided when beneficiaries are diagnosed with a substance use disorder, a serious mental illness, or who are homeless. She indicated the VBP program would be implemented in the managed care delivery system for at least three years, subject to funding. She stated that all measures were implemented on July 1, 2019, and that the Behavioral Health Integration Project Plan component is scheduled to begin on July 1, 2020.

Dr. Scott stated that the National Provider Identifier (NPI) listed in the rendering or ordering provider field must be an individual provider NPI (Type 1) in order to receive payment for the encounter. She explained that while administrative data is reported through MCP encounter data, supplementary data sources include the California Department of Public Health (CDPH) California Immunization Registry (CAIR) 2.0 for immunizations and the CDPH Blood Lead Registry for blood lead test results. Dr. Scott reiterated that an enhanced payment factor would be applied for services provided to beneficiaries with substance use disorder, serious mental illness, and/or homelessness (using the specific ICD-10 diagnosis codes Z59.0 or Z59.1).

Next, Dr. Scott discussed the Transformed Medicaid Statistical Information System (TMSIS), the process required under federal law in which data is returned to the Centers for Medicare & Medicaid Services (CMS). Dr. Scott stated that TMSIS is driving data quality and helping DHCS create a broad data quality program. Dr. Scott provided additional background information on TMSIS and noted that it has improved communication and cooperation within the various programs on DHCS.

Finally, Dr. Scott reported that the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was signed on February 17, 2009, is now 10 years old. She added that in April of 2018 the Promoting Interoperability Program was established, which gave both a new name and focus to the Medi-Cal Electronic Health Record (EHR) Incentive Program. She stated that this program improved patient access to health information, as well as promoting and prioritizing interoperability of health care data. Dr. Scott provided an overview of the transition from the Medicaid Management Information System (MMIS) to the modular Medicaid Enterprise Systems (MES). She stated that MES has matured through the Medicaid Information Technology Architecture (MITA) Framework and Initiative and that MES incorporates goals and requirements set in the Promoting Interoperability Program. Dr. Scott stated that this focus on interoperability includes the California Health Information Exchange Onboarding Program (CA-HOP), Health Information Technology for Emergency Medical Services (HITEMS), public health registries, and California’s prescription drug monitoring program (CURES). Dr. Scott concluded by touching on the future of Medicaid data, stating that the focus will remain on interoperability that provides data protection and rules on blocking information, agreements that support data integration, integration of
diverse data, alignment of measures and reporting, and a holistic approach for patients that ultimately provides data driven policies.

Dr. Stafford asked about the percentage of pharmacists that have their own NPI and about the utilization of the diagnosis codes available to code for homelessness. Dr. Scott said she did not have a number on pharmacists with individual NPIs, but that the two codes available for the homeless are underutilized. Dr. Albertson questioned if lead levels measured during hospitalization are being captured. Dr. Scott stated that they could only capture what is submitted from providers, but that their numbers are higher than anticipated. Dr. Liu commented that DHCS releases information via different channels and that it would be helpful if there were a way to synchronize messaging. Dr. Scott noted that DHCS gave a similar presentation for the medical directors as this and they are trying to share information in a consistent way across multiple avenues and on the public website. Dr. Liu also stated they have a lot of providers still without electronic medical records (EMR) and asked how to encourage providers to get EMR. Dr. Scott replied that while the EHR incentive program is finished, if providers are having trouble connecting there is additional funding to help these providers.

Dr. Khurana noted the push toward electronic prescribing and asked if there was a similar push toward electronic prior authorizations. Dr. Scott commented that she doesn't have a clear answer at this time, but the department has been working on eTARs. Dr. Scott stated that while she didn’t believe there were any measures around eTARs yet, this is evolving and that DHCS is willing to hear recommendations from those in the field. Dr. Ghotbi asked how to make the bridge for the type 1 NPI billing, as pharmacists are not allowed to bill under Medicaid except as part of a Federally Qualified Health Center (FQHC). Dr. Scott noted that FQHCs were excluded, so they look at the encounter to see where the service took place and it has nothing to do with type 1 or type 2 NPI. She added that in terms of providers, they do need to come through the managed care billing process because they look at encounters from managed care data and not from provider registration.

b. Health Plan Presentation by CalOptima:
   i. Promoting Pharmacist-Furnished Naloxone: A Tool Kit for Community Pharmacy – Nicki Ghazanfarpour, PharmD, [Manager, Pharmacy Clinical Programs, CalOptima] gave an overview of CalOptima’s pharmacist-furnished naloxone intervention. Dr. Ghazanfarpour stated they retrospectively identified 238 high-risk members for this intervention, which consisted of a pre-survey sent to the pharmacies, a naloxone toolkit that included a pharmacy-specific high-risk member list and a naloxone access handout, and pharmacist documentation whether a naloxone conversation was completed or a naloxone informational sticker was provided to the member.

   Dr. Ghazanfarpour then discussed the results of the intervention. She stated that a total of 89 members received an intervention and they saw a statistically significant increase in naloxone claims by 13 of the 15 pharmacies. She added that the results from the pre-surveys indicated that pharmacists felt comfortable with their knowledge and the time available to provide naloxone counseling; however, the post-surveys indicated that the pharmacists felt there was not an adequate amount of time for them to conduct their conversations around naloxone. Dr. Ghazanfarpour concluded there is a need to increase pharmacist-furnished naloxone and address barriers to naloxone conversations.

   Dr. Blatt asked if this intervention was for Medicare beneficiaries as well as Medi-Cal beneficiaries. Dr. Ghazanfarpour stated it included both populations. Dr. Paulson noted that one of the limitations for naloxone counseling is high store volume and wondered if the ability to bill for these services could be a factor in increasing naloxone conversations. Dr. Ghazanfarpour was hopeful, but stated that it depends on the message that retail chains deliver to their staff as conversations are time consuming. Dr. Stafford noted the high rate of accepting naloxone after the conversation and asked about some ways to improve the rate of furnishing naloxone. Dr. Ghazanfarpour shared that one pharmacy champion skewed results, and that more champions are needed to
drive furnishing. She reiterated that staff buy-in is critical and that while live training was
provided to all pharmacists, they often called back to discuss various scenarios and
received additional support from CalOptima.

ii. Pharmacist-Driven Deprescribing of Proton Pump Inhibitors (PPIs) in the Elderly – Anita
Lee, Pharm D, [Clinical Pharmacist, Pharmacy Clinical Programs, CalOptima] opened
by discussing the background of PPIs in the United States, including their associated
risks. Dr. Lee added that in 2015, the American Geriatrics Society added PPIs to the
Beers Criteria list, and that recommendations for use include avoiding scheduled use for
greater than eight weeks. Dr. Lee then described their intervention, which included
identifying 64 at-risk members, performing a PPI-focused medication review, and
evaluating the impact. She stated that an informational letter was sent to providers,
along with a medication review tool and a provider response sheet. Dr. Lee noted that
once the documents were sent to providers, a confirmation call was made to ensure the
documents were received, and then a follow-up phone call was made after two weeks.
Dr. Lee stated that a pharmacy claims review was conducted after 60 days, which was
followed by a repeat outreach if the results were inconsistent with the provider
response. She said that a pharmacy claim review was again conducted after 120 days.

Dr. Lee reported on the results of the intervention, stating that 36% of the members did
not have an appropriate indication documented for PPIs, 22% had a history of bone
disorder, and 16% had a history of cognitive impairment. She stated that they received
46 responses (from 63 letters sent), with 72% of providers responding that PPIs could
be discontinued or tapered down and 26% of providers responding PPIs must be
continued. For the 120-day review, Dr. Lee stated that there was a statistically
significant reduction in PPI use and no significant increase in alternative medication
use, including H2 receptor agonists (H2RAs).

c. Global DUR Board Activities
   i. DUR Board Vice Chair Elections – Dr. Stafford explained that a call was made by DHCS
for statements of interest for the DUR Board Vice Chair for 2020. He stated that a
statement of interest by Dr. Liu had been received and asked Dr. Liu to read that
statement. No additional statements of interest were noted. Dr. Dryjanski motioned to
elect Dr. Liu as DUR Board Vice Chair for 2020. The motion was seconded and there
was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dhanvantari, Dryjanski, Leung, Liu, McBride, Paulson, Stafford,
Stebbins, Walker, and Wong

NAY: None

ABSTAIN: None

ABSENT: Mowers and Zuniga

ACTION ITEM: The recommendation to elect Dr. Johanna Liu as the DUR Board Vice Chair for
2020 will be submitted to DHCS.

   ii. Summary of MCP Best Practices – Dr. Stafford suggested the Board revisit best
practices from each of the Board priority areas and discuss opportunities for the Board
to take additional action.

Dr. Stafford stated that at the May 2019 Board meeting the Board recommended that
each plan, including Medi-Cal fee-for-service (FFS), review the best practices in each
priority area and assess if these best practices have already been implemented, could
be implemented, or why they could not be implemented. Dr. Stafford presented the
summary of the Board priority areas for 2019, including:

- Optimizing drug prescribing and dispensing, including specialty drugs
- Optimizing pain management and opioid use
- Optimizing chronic disease management, including diabetes, hypertension, asthma,
and prevention (through immunization)
Dr. Blatt expressed concern about the upcoming carve-out of the pharmacy benefit across Medi-Cal. Dr. Blatt stated that managed care plans have staff designated for pharmacy and now their work will need to shift. He suggested this is an opportunity for DHCS to consider implementing medication therapy management (MTM). Dr. Blatt suggested the Board should make specific recommendations to DHCS on potential programs for plans to implement, especially since managed care plans are currently planning for future staffing needs. Dr. Stafford asked for specific priorities in this area that the Board should focus on and stated that managing pharmacy costs has implications for other costs and programs. Dr. Blatt suggested that with the carve-out of the pharmacy benefit there is an opportunity to identify gaps in care and have a more upstream approach developing and creating specific actions for managed health care.

Dr. Leung stated that pharmacy services encompasses a variety of activities and that by removing some of these pieces the overall strategy of what plans do as a whole is impacted. He provided an example of how pharmacy services align with quality measures, especially medication-related Healthcare Effectiveness Data and Information Set (HEDIS) measures, including identifying gap populations, communicating information to clinics, recommending activities for plans to partner with providers to improve HEDIS measures. Dr. Paulson shared concerns that the proposal would fracture the managed care model and pose huge risks toward the quality of care for members. She noted that specialty pharmacies have provided case management for high cost drugs and these services are now threatened by fracturing the medication piece away from plans.

Dr. Stafford asked if anyone on the Board had specific recommendations regarding the review of best practices from the past annual report. Dr. Liu suggested a medication review program that could be designed for the populations within each plan. She added that on the DHCS quality side, they could implement something similar to Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs), where plans would be allowed to choose the area of focus and the DUR Board could recommend a certain number of these projects each year. Dr. Stafford noted that the Managed Care Quality and Monitoring Division (MCQMD) has a structure in place for this type of work already. Dr. Blatt agreed that there is precedent for QIPs/PIPs and stated they are necessary for high quality care. Dr. Leung suggested the Board could advocate for managed care plans to retain the clinical management of patients, which is still needed for HEDIS measures despite pharmacy claims management being moved to fee-for-service. Michelle Williams (Central California Alliance for Health) shared an anecdote about the impact of interventions before chronic conditions develop, including how community pharmacists can improve continuous blood glucose monitoring among pre-diabetic patients.

Dr. Stafford asked Ms. Chan to clarify how these services will be addressed under the carve-out of pharmacy claims. Ms. Chan deferred these questions to the afternoon session when Harry Hendrix would be present to provide more information about Medi-Cal Rx. Adam Horn, PharmD (CenCal Health) noted the quality department at CenCal is looking for more flexibility to integrate priorities of other departments besides pharmacy, in order to address plan areas of interest. Dr. Blatt suggested that there could be a PIP requirement each quarter that could be open-ended for plans to choose the focus.

Dr. Stafford asked if there were any specific recommendations the Board would like to make to the Medical Director’s office. Dr. Blatt recommended an MTM program and a PIP program and stated that one or both of these programs should be a requirement so counties could offer equitable programs and levels of care. Dr. Albertson asked if each plan has had these programs within the last year and should this be the minimum standard to be expected for plans. Dr. Paulson stated she believes that that not every plan is engaged in PIPs or similar programs due to fluctuation of funding. Dr. Dhanvanthari stated from a Chief Medical Officer (CMO) perspective, the pharmacy team has been important to quality improvement and is an essential piece of managing the member. She reported that pharmacy is involved in improving the quality and control
the cost through formulary management and noted that another piece that has not yet been addressed is pharmacist management of physician-administered drugs. She stated that managed healthcare plans would need real-time data on the carved out piece to maintain quality of care. Dr. Dhanvantari also suggested that if the Board recommends certain activities as requirements, plans would need funding for pharmacy staffing to implement any requirements.

Dr. Ghotbi noted that what is being proposed in the slides is a series of activities, not necessarily widely accepted best practices. She stated that no rigor has been applied to determine if these are truly best practices for the entire Medi-Cal population. Dr. Ghotbi proposed establishing a process to determine what is a best practice. Dr. Stafford stated that the Board could use the current medical management process along with the PIP program. Dr. Paulson reported that these Medicare measures have been extremely effective at decreasing emergency room visits and hospitalizations and wondered if something similar be established for Medi-Cal. Dr. Stafford asked if someone wanted to make a motion to address medical management and PIPs.

Dr. Blatt motioned to develop a Medicare type program that is like a PIP for Medi-Cal managed healthcare plans. Dr. Stebbins suggested that any proposed recommendations should be comprehensive and include all beneficiaries, including fee-for-service. She motioned to amend the motion to address all Medi-Cal beneficiaries and not just managed care. The motion was seconded. Dr. Albertson noted that because of the different process for FFS and MCP he was not sure how this recommendation could be implemented on a statewide basis. Dr. Stebbins stated she would like to avoid disparity between groups or sending the message that MCP beneficiaries get more services over FFS, because not all beneficiaries get the choice of FFS or MCP. Dr. Liu noted that the Board is advisory, so the operational component of implementing any recommendations will be left to DHCS. Dr. Stebbins worried that MCPs will not have access to the data they were used to having. Dr. Albertson stated that there needs to be transparency in access to the data.

Dr. Stafford restated the motion was to recommend that both MCP and FFS disseminate and facilitate adoption of the MTM and PIP processes. He stated that the next step would be to identify best practices that each plan and FFS will be scrutinized as to whether these have been implemented, would be implemented, or a rationale documented for why they could not be implemented. Dr. Stebbins suggested making the recommendation more generic so that it is reasonably applicable to both MCP and FFS. Dr. Blatt clarified that the Board could recommend a specific Medi-Cal MTM program as well as a second set of QIP/PIP set of activities, with specific details to be determined later. Dr. Paulson noted that MCPs have infrastructure already in place to implement PIPs, while the FFS program does not. She suggested recommending that MCPs implement and adopt PIPs and FFS explore and develop the infrastructure for these programs. Dr. Stafford agreed and suggested splitting the current motion into two separate motions.

Dr. Blatt motioned for all Medi-Cal MCPs to facilitate and adopt a Medicare-like MTM program and a performance improvement project (PIP) model. The motion was seconded and there was no further discussion. The motion passed.

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

ACTION ITEM: The recommendation for all Medi-Cal MCPs to facilitate and adopt a Medicare-like MTM program and a performance improvement project (PIP) model will be submitted to DHCS.
Dr. Blatt motioned for the Medi-Cal FFS program to explore and develop the infrastructure for a Medicare-like MTM program and a performance improvement project (PIP) model. The motion was seconded and there was no further discussion. The motion passed.

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

Dr. Stafford asked if the Board had a recommendation regarding the maintenance of a pharmacy team and data flow between DHCS and MCP plans. Dr. Albertson motioned to ensure that appropriate funding be provided to MCPs to maintain appropriate pharmacy efforts to support important programs. He stated that the Board should be very direct about recommending that pharmacy staff supporting MTMs and PIPs be maintained and that adequate funding be included to maintain these programs. The motion was seconded. Dr. Ghotbi asked if there was a statutory requirement for Board participation. Dr. Stafford asked if MCPs would continue involvement in the Global DUR process with the same requirements. Ms. Chan affirmed there is a federal mandate for DUR that includes all MCPs. Dr. Ghotbi asked for clarification of the obligation for participation if plans will no longer manage the formulary or programs. Dr. Albertson asked how any of these programs could be executed without input from MCPs. He noted that if we ask that plans be given resources and implement specific programs they must be involved with the Board. Dr. McBride read slides from the Medi-Cal Rx informational session that stated MCPs would continue to be responsible for participation on the DUR Board and other committees as needed. There was no further discussion on the motion. The motion passed.

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

ACTION ITEM: The recommendation to allot funding for Medi-Cal MCP participation in MTM, QIP/PIP programs, and the DUR Board will be submitted to DHCS.

Dr. Stafford asked if the Board needed to make any motions regarding the flow of data. Dr. Blatt stated a need for access to real time data to the MCPs for care coordination. Dr. Liu asked if the proposal covered access to data. Ms. Fingado stated that the proposal did cover data access requirements. Dr. Paulson asked if the Board should get into specifics regarding data access, such as recommending access to the database via an interface. Dr. Leung suggested a need for a portal to access any claims data. Dr. Blatt motioned for real-time data to MCPs, a portal for health plan access to data, and regular transmission of encounter files in a standardized format, in order to ensure care coordination for members and providers. The motion was seconded and there was no further discussion. The motion passed.

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

ACTION ITEM: The recommendation to provide real-time data to MCPs, a portal for health plan access to data, and regular transmission of encounter files in a standardized format, in order to ensure care coordination for members and providers will be submitted to DHCS.
iii. Review OIG Report: ADHD – Due to time constraints, the OIG report on attention-deficit/hyperactivity disorder (ADHD) was not discussed at this meeting.

iv. Retrospective DUR Review: Antihyperglycemic Medications – Due to Dr. Mowers’ absence, the retrospective DUR review of antihyperglycemic medications was not discussed at this meeting.

d. Recap of morning action items – Dr. Orozco read the Board action items from the morning session. There was no discussion and no edits were made to the listed action items.

e. Health Plan Presentations by Central California Alliance for Health:

i. Academic Detailing: Improving Patient Outcomes Through Informed Medication Prescribing – Navneet Sachdeva, PharmD, BCPS, BCGP [Central California Alliance for Health] gave an overview of their academic detailing program, including their current process for selecting providers for academic detailing. Dr. Sachdeva stated that the process included internal referrals, referrals from other departments based on HEDIS scores and member experience, and requests from providers. She shared that the academic detailing topics for 2017 and 2018 included pain management and disease management for diabetes, asthma/COPD, and hypertension. Dr. Sachdeva reported that three clinics and 54 providers received academic detailing on diabetes in 2018, and the subject of each intervention determines which department leads the intervention. Dr. Stebbins asked if any of the clinics that received academic detailing had pharmacies. Dr. Sachdeva said they do not have pharmacies in those clinics. Dr. Ghotbi inquired if they developed any tools to use for academic detailing. Dr. Sachdeva stated that they did not develop any specific materials but they do have a link on the website for providers to email if there are formulary questions. She said there are representatives available who interact and build relationships with the providers. She also added that down the road, they might use incentives as a way to increase engagement.

ii. PAD and Retail Pharmacy Benefit Alignment Project – Michelle Williams [Central California Alliance for Health] described how their pharmacy department works to align pharmacy benefits across all billing pathways for both physician-administered drugs (PADs) and drugs dispensed within the retail pharmacy. She described the importance of clinical oversight, including how formulary and prior authorization criteria for all drugs are approved at quarterly Pharmacy & Therapeutic (P&T) meetings. Ms. Williams also mentioned the importance of ensuring all members receive safe and effective pharmacy benefits at any place of service, providing in-service training, and supporting providers who are seeking access to supplies that are billable through the pharmacy benefits manager (PBM) or medical claims. Dr. Ghotbi asked if the goal was to improve access or was there also expectation of a financial benefit. Dr. Sachdeva stated that there is a cost benefit and Dr. Blatt noted they prevented double dipping by providers for the same claim, which had an immediate financial impact. Dr. Ghotbi stated that there were 75 CPT codes that required prior authorization and questioned if each was set up to respond to both pharmacy and medical prior authorization requests. Dr. Sachdeva and Ms. Williams explained that while the codes could be set up for both, this is determined at the drug level. Dr. Paulson asked if they considered a formulary with rebating. Dr. Sachdeva and Ms. Williams stated that they have no say on rates and contracting and their cost containment department holds that information. Dr. Paulson asked about how they paid for PADs. Ms. Williams replied that payment for PADs comes out of the medical benefit budget.

f. Pharmacy Update

i. H.R. 6 – SUPPORT for Patients and Communities Act – Ivana Thompson, PharmD reported that a draft of an all-plan letter (APL) outlining the requirements of H.R. 6 was sent out to all MCPs on Friday, September 13, 2019 for comment. In regards to the safety edits for subsequent opioid fills and maximum daily morphine equivalent, she stated that this can be accomplished via either prospective edits or retrospective edits. Dr. Thompson stated at a minimum, each MCP would have to conduct a retrospective review of concurrent opioid and benzodiazepine or antipsychotic use, antipsychotic use
in children (when applicable), and have a process that identifies fraud and abuse by enrolled beneficiaries and pharmacies. In regards to claims, she stated that plans are required to implement edits on early refill, duplicate (same-day) prescriptions, and quantity limits. She added that refills must fill no earlier than the 75% threshold and that the minimum morphine milligram equivalent (MME) edit will be set at 500 MME, which means anything over 500 MME would require a prior authorization. Dr. Thompson noted exceptions to this requirement are outlined in the APL.

Dr. Leung confirmed that the 500 MME is a cumulative dose, and not specific for individual prescriptions. Dr. Orozco shared a question from the webinar asking if Medi-Cal would be providing plans with the paid claims for antipsychotic medications, and would this be provided on a daily basis or monthly. Dr. Thompson stated that plans are encouraged to send feedback to DHCS on the APL or any other issues that require clarification. Dr. Ghotbi asked if the annual reporting requirement was an additional report that would be required. Dr. Thompson shared that the current annual report required by MCPs would meet this requirement and there would not be an additional report needed.

**ii. Medi-Cal Rx – Harry Hendrix [Pharmacy Benefits Division Chief, DHCS], provided an overview of Medi-Cal Rx, which included the Executive Order N-01-19, issued by Governor Gavin Newsom on January 7, 2019. He stated that the intent of the Executive Order is to achieve cost-savings for drug purchasing made by the state and that this Order requires that all Medi-Cal pharmacy services be transitioned from managed care to fee-for-service by January 1, 2021. Mr. Hendrix added that this new delivery system would be identified as Medi-Cal Rx and that Medi-Cal Rx does not apply to pharmacy services billed on medical/institutional claims. He stated that other components of Medi-Cal Rx include standardizing Medi-Cal pharmacy benefits, improving access to pharmacy services to include the majority of California pharmacies, creating statewide utilization management protocols to all outpatient drugs, and to strengthen California’s ability to negotiate state supplemental drug rebates with drug manufacturers. Mr. Hendrix stated that DHCS released a request for proposals (RFP) on August 22, 2019 for the takeover, operation, and eventual turnover of administration of the Medi-Cal Rx program and proposals are due by 4:00 PM PDT on October 1, 2019. He encouraged anyone seeking more information to visit the [DHCS' procurement](#) and [FI$Cal/Cal eProcure](#) websites and to send any RFP specific questions to [CSBRFP1@dhcs.ca.gov](mailto:CSBRFP1@dhcs.ca.gov). Mr. Hendrix also noted that a question and answer phone call will be held on September 26, 2019 from 2:00 – 4:00 PM PDT. Mr. Hendrix assured that DHCS is seeking a smooth transition by working with MCPs, counties, providers, consumer advocates, and beneficiaries and that general Medi-Cal Rx questions not related to the RFP can be sent to [RxCarveOut@dhcs.ca.gov](mailto:RxCarveOut@dhcs.ca.gov).

Mr. Walker inquired if DHCS will be conducting a net savings analysis before and after Medi-Cal Rx is implemented. Mr. Hendrix assured that the fiscal impact would be looked at. Dr. Ghotbi sought clarity on how the formulary would be structured and how the DUR Board would be maintained. Mr. Hendrix stated that the FFS Medi-Cal List of Contract Drugs (CDL) will continue to be used and that DHCS looks at guidelines to establish Code 1 edits. He added that prior authorizations for anything not on the CDL would still be required. Mr. Hendrix noted that care coordination is still the responsibility of the health plans and that Medi-Cal Rx only covers payment and claims processing.

Mr. Hendrix stated that MCPs would have daily data feeds and real-time access into the vendor’s data environment via a portal. He noted the RFP states the vendor must provide care coordination liaisons to the MCPs, which was the result of DHCS responding to a comment received during the comment period. Dr. Dhanvanthari shared her concerns about losing staff pharmacists due to the unknown plans for clinical care, and asked how the clinical programs would be able to retain staff with pharmacy payment removed. Dr. Hendrix stated that not all of the pharmacy payment would be removed from MCPs but at this time he could provide specifics on what is being retained. He noted these concerns are being acknowledged in other areas as well. Dr.
Blatt questioned if plans will still get pharmacy administrative fees and if DHCS will provide more clear expectations so that plans can determine future staffing needs. Mr. Hendrix replied that there would be more information disseminated at pharmacy directors meetings and other additional meetings as information becomes available.

Dr. Liu noted the current DUR Board provides recommendations to DHCS and wondered if this will be the future plan. Mr. Hendrix clarified DUR activities would continue to be separate from drug contracting, which is handled internally. Dr. Paulson stated that the MCP models are well established and that removing pharmacy benefits is an extreme action. She questioned if there was room for a hybrid plan with drug negotiations. Mr. Hendrix stated the Medi-Cal Rx plan is already in motion. Dr. Ghotbi asked if plans could petition for an exception from Medi-Cal Rx. Mr. Hendrix stated that was not possible. Dr. Blatt inquired what the different phases of the RFP meant for MCPs. Mr. Hendrix replied that the phases are only applicable for the vendor, not the plans or beneficiaries. Mr. Hendrix concluded by stating the situation is evolving and he expected to return at the next Board meeting to continue the discussion with the Board. Dr. Stafford thanked him for coming and said the Board welcomes the opportunity to learn more at future meetings.

g. UCSF Update

i. Prospective DUR: Fee-for-Service

- Review of DUR Alerts for New GCNs in 2Q2019 (April – June 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 for the following drugs:
  - DICLOFENAC/LIDO/ME-SAL/CEPHOR – Drug-Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - DIPHENHYD/PHENYLEPHRINE/ACETAMINO – Ingredient Duplication (ID), High Dose (HD)
  - DOLUTEGRAVIR SODIUM/LAMVUDINE – Ingredient Duplication (ID)
  - LEVOTHYROXINE SODIUM – Therapeutic Duplication (TD), Late Refill (LR), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - METHYLPHENIDATE HCL – High Dose (HD), Low Dose (LD)
  - STIRIPENTOL – Additive Toxicity (AT)

There were no questions or objections to these alert profile recommendations. There was no further discussion.

- Website Updates – Ms. Fingado shared that all prospective DUR content from DUR manual has been transferred to DUR web pages. She reported that the DUR: Alert Criteria page has the full description of all DUR alerts and the Medi-Cal Fee-for-Service Prospective Drug Use Review (DUR) Target Drugs spreadsheet allows users to search and sort by alert or drug, as needed. Updates are expected to be no more than four times per year and a notification of an update will be sent through Medi-Cal Subscription Service (MCSS). Dr. Ghotbi asked about the new high dose methylphenidate update and how do we know what the dose is for the high dose (HD) alert. Dr. Orozco stated that the exact details of each specific alert are in a separate location but that the alerts usually default to FirstDatabank, Inc. recommendations. Dr. McBride asked if this has eliminated the need for all the paper copies such as the manual. Ms. Fingado stated this does replace all of the sections in the manual where each alert had its own specific list of drugs.

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

- Mailing Update: Tramadol/Codeine Letter – Ms. Fingado noted the original proposal to the Board suggested mailing letters to all providers who prescribed tramadol and/or codeine to Medi-Cal FFS beneficiaries younger than 18 years of age (with
dates of service from January 1, 2019, through June 30, 2019). However, only one provider prescribed both tramadol and codeine to beneficiaries younger than 18 years of age so the decision was made to reduce this intervention into two letters; one specific for tramadol prescribers and one specific for codeine prescribers.

- **Mailing Update: Tramadol Letter** – Ms. Fingado presented details from the tramadol mailing, which aimed to inform health care providers and patients of the serious risks attributed to prescribing tramadol to patients younger than 18 years of age. Ms. Fingado reported the study population included 40 Medi-Cal fee-for-service beneficiaries younger than 18 years of age (65% were 17 years of age) who had at least one paid claim for tramadol between January 1, 2019 and June 30, 2019. A total of 44 prescribers were identified for educational outreach letters, which were mailed on July 29, 2019. Each letter included patient profiles, the Medi-Cal DUR tramadol alert, and a provider response survey. Ms. Fingado reminded the Board that the primary outcome is the total beneficiaries younger than 18 years of age with a paid claim for tramadol in the 12-month period following the mailing. Final outcomes, as well as the response rate and returned mail rate will be presented at a future Board meeting.

- **Mailing Update: Codeine Letter** – Ms. Fingado presented details from the codeine mailing, which aimed to inform health care providers and patients of the serious risks attributed to prescribing codeine to patients younger than 18 years of age. Ms. Fingado reported the study population included 450 Medi-Cal fee-for-service beneficiaries younger than 18 years of age who had at least one paid claim for codeine-containing medication between January 1, 2019 and June 30, 2019. A total of 313 prescribers were identified for educational outreach letters, which were mailed on August 1, 2019. Each letter included patient profiles, both of the Medi-Cal DUR codeine alerts, and a provider response survey. Ms. Fingado noted that 36% (n=113) of the prescribers receiving a letter were dentists and 53% (n = 29) of prescribers with more than one patient profile were dentists. Ms. Fingado reminded the Board that the primary outcome is the total beneficiaries younger than 18 years of age with a paid claim for a codeine-containing medication in the 12-month period following the mailing. Final outcomes, as well as the response rate and returned mail rate will be presented at a future Board meeting.

- **Mailing Update: Zolpidem Letter** – Ms. Fingado presented details from the zolpidem mailing, which aimed to determine whether there was inappropriate use of zolpidem products based on FDA warnings that female patients have lower clearance rates than males. Ms. Fingado reported that educational outreach letters were mailed on August 20, 2019, to the top 100 prescribers of zolpidem in the FFS population. Each letter included the Medi-Cal DUR zolpidem alert, a provider response survey, and provider-specific data including the percentage of female Medi-Cal beneficiaries with an initial dose of zolpidem exceeding the recommended initial dosage limits, the percentage of female Medi-Cal beneficiaries with an initial dose of IR zolpidem > 5 mg, and the percentage of female Medi-Cal beneficiaries with an initial dose of ER zolpidem > 6.25 mg. Ms. Fingado reminded the Board that the primary outcomes include provider-specific percentages of initial zolpidem prescriptions exceeding the recommended initial dosage limits, stratified by female gender within 12 months following the mailing and the total initial zolpidem prescriptions exceeding the recommended initial dosage limits within 12 months following the mailing. Final outcomes, as well as the response rate and returned mail rate will be presented at a future Board meeting.

- **Proposal: Gabapentin** – Ms. Fingado presented a proposal to address potential inappropriate use of gabapentin based on retrospective DUR review findings presented to the Board. The top 100 prescribers of gabapentin (by volume) in the Medi-Cal fee-for-service population will receive a letter that will include a provider-specific percentage of patients with concomitant opioid prescriptions. Ms. Fingado stated that the primary outcome would be total paid claims for gabapentin within 12
months following the mailing and secondary outcomes would include the total number of initial paid claims for gabapentin within 12 months following the mailing and the provider-specific percentage of patients with concomitant opioid prescriptions. There was a motion to recommend approval of this proposal. The motion was seconded. There was no further discussion. The motion passed.

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

**ACTION ITEM:** The DUR Board recommendation to send an educational letter to the top prescribers of gabapentin will be submitted to DHCS.

Ms. Fingado reviewed the queue of educational outreach topics and asked if there were any additional topics of interest to the Board that were not included on this list. Dr. Leung motioned to add the 2019 updated asthma management and prevention guidelines published by the Global Initiative for Asthma (GINA) to the list of potential educational topics. The motion was seconded. There was no further discussion. The motion passed.

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

**ACTION ITEM:** The DUR Board recommendation to add the 2019 updated asthma management and prevention guidelines published by the Global Initiative for Asthma (GINA) to the list of topics for educational outreach will be submitted to DHCS.

iii. **Retrospective DUR**
- Global Quarterly: 1Q2019 (January – March 2019) – Ms. Fingado presented the Global Quarterly Medi-Cal DUR report for 1Q2019. This quarterly report 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 MCP enrollees only.

Ms. Fingado noted that per Board request, the report now includes mean days' supply per utilizing beneficiary and data are stratified by the following population aid code groups:

- Affordable Care Act (ACA)
- Optional Targeted Low Income Children (OTLIC)
- Seniors and Persons with Disabilities (SPD)
- All other aid codes not categorized as ACA, OTLIC, or SPD (OTHER)

Ms. Fingado stated that she was informed right before the Board meeting that the aid codes used in the population aid code groups change over time, and asked if the Board had any objections to following the same population aid code groups as they are updated. The Board had no concerns with this approach.

Dr. Leung asked about the wide discrepancy between the days supply between FFS and MCP. Ms. Fingado stated that the transitive nature of enrollees moving from FFS to MCP might explain some of that difference. Dr. Leung asked if it would be possible to include continuous eligibility requirements. Ms. Fingado stated that would be possible and could be included in the next quarterly report. She noted that establishing a continuous eligibility requirement would result in a loss of beneficiaries included, but that the days supply would be more accurate reflection of
prescribing without the impact of plan eligibility. Dr. Leung motioned to use only continuously eligible beneficiaries with the same plan for the duration of the quarter for the Global Quarterly DUR Report. The motion was seconded. There was no further discussion. The motion passed.

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

ACTION ITEM: The DUR Board recommendation to use only continuously eligible beneficiaries with the same plan for the duration of the quarter for the Global Quarterly DUR Report will be submitted to DHCS.

- FFS Quarterly Report: 2Q2019 (April – June 2019) – Ms. Fingado presented the Medi-Cal fee-for-service quarterly DUR report for the 2nd 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 1%) and prior-year quarter (decreased by 3%). She also reported significant across-the-board increases in the MCP population during 2019 Q2 for naloxone, which was the subject of California legislation that became effective the first day of 2019 Q1 and bictegravir/emtricitabine/tenofovir alafenamide, which was approved by the FDA during 2018 Q1.

iv. Review of DUR Publications presented by Dr. Lynch
   - Alert (June 2019): Sleep Aids – Dr. Lynch let the Board know that the DUR educational alert entitled, “Drug Safety Communication: Sleep Behavior Risks with Select Sleep Aids,” published in June 2019. This alert was in response to the U.S. Food and Drug Administration (FDA) announcing the requirement of safety label changes for eszopiclone, zaleplon, and zolpidem because of the risk of complex sleep behaviors, including sleepwalking, sleep driving, and engaging in other activities while not fully awake.
   - Bulletin (August 2019): Anticholinergic Update – Dr. Lynch let the Board know that the DUR educational bulletin entitled, “Clinical Review Update: Concomitant Anticholinergic and Antipsychotic Use,” published in August 2019. This was an update to a previous bulletin on concomitant anticholinergic and antipsychotic use, which was published in 2015. Updates to the evaluation data and the table outlining the extrapyramidal symptom propensity of antipsychotic medications were included.
   - 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.

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

i. Looking ahead: Call for future meeting agenda – Ms. Chan stated that she welcomes recommendations from the Board for speakers. Two possible presentations for November include one by Partnership Health Plan of California, Inc. on insulin best practices and one by L.A. Care Health Plan on opioids.

6) PUBLIC COMMENTS
   • There were no public comments.
7) CONSENT AGENDA

- The next Board meeting will be held from 9:30 a.m. to 3:00 p.m. on November 19, 2019, in the DHCS 1st Floor Conference Room located at 1700 K Street, Sacramento, CA 95814.

8) ADJOURNMENT

- The meeting was adjourned at 2:57 p.m.

<table>
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<tr>
<th>Action Items</th>
<th>Ownership</th>
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<tr>
<td>Incorporate edits from Dr. Wong into the May 21, 2019, minutes and post to the DUR website.</td>
<td>Amanda</td>
</tr>
<tr>
<td>The recommendation to elect Dr. Johanna Liu as the DUR Board Vice Chair for 2020 will be submitted to DHCS.</td>
<td>DHCS</td>
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<tr>
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<tr>
<td>The recommendation to allot funding for Medi-Cal MCP participation in MTM, QIP/PIP programs, and the DUR Board will be submitted to DHCS.</td>
<td>DHCS</td>
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<tr>
<td>The recommendation to provide real-time data to MCPs, a portal for health plan access to data, and regular transmission of encounter files in a standardized format, in order to ensure care coordination for members and providers will be submitted to DHCS.</td>
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