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

State of California
DEPARTMENT OF HEALTH CARE SERVICES

Notice is hereby given that the **Global Medi-Cal DUR Board** will conduct a public meeting on **Tuesday, February 25, 2020,** at the following location:

Department of Health Care Services
1700 K Street
1st Floor Conference Room
Sacramento, CA 95814
9:30 AM-3:00 PM
All times shown are approximate and are subject to change
Registration link to attend meeting via webinar

Report Type*	Agenda Item	Presenter	Time
C	**1.** Welcome/Announcements/Introductions/Roll Call	Pauline Chan, RPh, MBA	930-940
I/D	**2.** Call to Order/Guidelines/Robert's Rules	Timothy Albertson, MD, MPH, PhD	940-945
R/A/D	**3.** Review and Approval of Previous Minutes from November 19, 2019	Timothy Albertson, MD, MPH, PhD	945-950
	4. Old Business		
R/I/D	**a.** Review of Board Action Items from November 19, 2019 **b.** Recommended Action Items for MCPs from November 19, 2019 **c.** Pharmacy Update: Medi-Cal Rx and HR6	Pauline Chan, RPh, MBA Pharmacy Benefits Division	950-1045
Morning Break			1045-1055
	5. New Business		
	a. Health Plan Presentation by Alameda Alliance for Health: Opioid Stewardship	Ramon Tran Tang, PharmD and Helen Lee, PharmD, MBA	1055-1120
A/D	**b.** Global DUR Board Activities i. Annual Review/Accomplishments: 2019 ii. Board Goals/Priorities: 2020 iii. Update: Asthma Affinity Group iv. Retrospective DUR Proposal: Use of Antipsychotics among Children and Adolescents	 Randall Stafford, MD, PhD Timothy Albertson, MD, MPH, PhD Randall Stafford, MD, PhD	1120-1200

	Lunch Break		1200-100
	c. Recap of morning action items	Hannah Orozco, PharmD	100-105
	d. Health Plan Presentations by CenCal Health: i. Asthma Population Health Project ii. Opioid-Benzodiazepine Edit and Provider Outreach Campaign	Adam Horn, PharmD	105-130
R/A/D	**e.** DUR Annual Report to CMS i. FFY 2018: State Comparison Summary ii. FFY 2019: Fee-for-Service Draft Report iii. FFY 2019: Fee-for-Service Additional Data	Pauline Chan, RPh, MBA Amanda Fingado, MPH	130-200
	Afternoon Break		200-205
R/A/D	**f.** UCSF Update i. Prospective DUR: Fee-for-Service ii. DUR Educational Outreach to Providers iii. Retrospective DUR iv. Review of DUR Publications	Amanda Fingado, MPH and Shalini Lynch, PharmD	205-245
R/D	**g.** Recap of afternoon action items **h.** Looking ahead: Call for future meeting agenda topics i. Health Plan of San Joaquin – Opioid Initiative ii. Managed Care Plan Quality Improvement Projects – DHCS Managed Care Quality and Monitoring Division	Hannah Orozco, PharmD	245-250
C	**6.** Public Comments **		250-300
I	**7.** Consent Agenda		
	a. Meeting feedback **b.** Next meeting: Tuesday, May 19, 2020 1700 K Street 1st Floor Conference Room Sacramento, CA 95814 **c.** Proposed DUR Board Meeting Dates for 2020/2021: Tuesday, September 15, 2020 Tuesday, November 17, 2020 Tuesday, February 23, 2021 Tuesday, May 18, 2021 Tuesday, September 21, 2021 Tuesday, November 16, 2021		
	8. Adjournment		300

* REPORT TYPE LEGEND: **A: Action**; **C: Comment**; **D: Discussion**; **I: Information**; **R: Report**

** Comments from the public are always appreciated. However, comments will be limited to five minutes per individual.

Picture identification is required to gain access into the California Department of Health Services building. However, your security information will not be provided to the Global DUR Board.

You can obtain the Global DUR Board agenda from the Medi-Cal DUR Main Menu Web site (http://files.medi-cal.ca.gov/pubsdoco/dur/dur_home.asp).

GLOBAL MEDI-CAL DUR BOARD MEETING
PACKET SUMMARY
February 25, 2020

- **Suggested Sections to Review Prior to Meeting:**
  - Announcements **(Page 4)**
    - The following dates for 2021 DUR Board meetings have been proposed:
      - Tuesday, February 23, 2021
      - Tuesday, May 18, 2021
      - Tuesday, September 21, 2021
      - Tuesday, November 16, 2021

  - Review DUR Board Goals/Priorities: 2020 (**Pages 26 – 29**)
    - Board goals and priorities are presented on an annual basis. Please review in advance of the meeting and be ready with any suggested changes.

  - DUR Annual Report FFY2018 State Comparison Summary Highlights (**Pages 37 – 47**)
    - While the full documents are available on the CMS website (FFS and MCO), highlights are included here for your review.

  - DUR Annual Report to CMS (**Pages 53 – 95**)
    - Please review the first draft of the FFS report. The final version of the report survey is still subject to change.

  - The following dates for 2021 DUR Board meetings have been proposed:
    - Tuesday, February 23, 2021
    - Tuesday, May 18, 2021
    - Tuesday, September 21, 2021
    - Tuesday, November 16, 2021

Announcements

- Dr. Chris Chan has resigned from the Global Medi-Cal DUR Board effective November 25, 2019. We thank him for his service!
- CalAIM is now Medi-Cal Healthier California for All
- DUR resources and content available on the Drug Utilization Review web page of Medicaid.gov
- DHCS News Release: DHCS Tackles Opioid Crisis by Expanding Access to Treatment
- Proposed Board Meeting Dates for 2021:
  - Tuesday, February 23, 2021
  - Tuesday, May 18, 2021
  - Tuesday, September 21, 2021
  - Tuesday, November 16, 2021

Global Medi-Cal DUR Board General Meeting Guidelines

- Be familiar with the Bagley-Keene Open Meeting Act
- Be familiar with Robert's Rules of Order
- Be courteous, respectful, and open minded of other's comments
- Be prepared by reviewing materials and downloading documents on PC/tablet in advance

Robert's Rules of Order

Purpose:

- Supports an orderly and democratic decision process
- Facilitates group decisions

Motion:

- A member presents a formal proposal requesting the group to take a certain action or position
- A main motion is required to begin the decision making process
- A motion occurs prior to discussion

The Main Motion Process

1
- Member makes a **clearly worded motion to take action on a position.**
- "I moved…..". Motion recorded in minutes

2
- **Motion must be seconded**. A motion without a second does not move forward.
- "Second!" A second allows discussion to occur; it does not signify approval.

3
- **Chairperson restates the motion.** This provides clarity.
- "It is moved and seconded that….."

4
- **Discussion/debate occurs.**
- Maker of motion starts discussion.
- If amendments offered – return to step 1 to amend motion: "I move to amend the motion by….."

5
- Chairperson closes discussion and **states the question/asks for a vote.**
- "The question is on the adoption of the motion that…."(Repeat the motion word for word)

6
- **Chairperson provides voting directions:** "Those in favor of the motion, say aye", "those oppose, say no".

7
- **Chairperson announces the result of the vote**: The "ayes have it, and the motion is adopted" or "the nos have it, and the motion is lost". Recorded in minutes.

Medi-Cal DUR

What to Say….

Purpose	Motion	Say	Debate allowed	Vote Required
Introduce business	Main	"I move that…"	Yes	Majority
Second a Motion	Second	"Second"	No	No
Change the wording/ clarify a motion	Amend	"I move to amend the motion by…."	Yes	Majority
Postpone action until a specific time	Postpone	"I move the motion be postponed until…"	Yes	Purpose
Take break	Recess	I move to recess for (x) minutes	No	Majority
Close meeting	Adjourn	I move to adjourn	No	Majority

Medi-Cal DUR

GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD
MEETING MINUTES
Tuesday, November 19, 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

Topic	Discussion
1) WELCOME/ INTRODUCTIONS/ ROLL CALL/ ANNOUNCEMENTS	• The Global Medi-Cal Drug Use Review Board (the "Board") members and meeting attendees introduced themselves. • Board members present: Drs. Timothy Albertson, Chis Chan, Stan Leung, Johanna Liu, Janeen McBride, Robert Mowers, Yana Paulson, Randall Stafford, and Marilyn Stebbins. • Board members absent: Drs. Michael Blatt, Lakshmi Dhanvanthari, Jose Dryjanski (attended via webinar), Vic Walker, and Andrew Wong (attended via webinar). • 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, MBA, David Do, PharmD, Paul Nguyen, PharmD, Ivana Thompson, PharmD, and Jose Villalobos, MPA. • Representatives present from other Medi-Cal managed care plans (MCPs) attending in-person included Mary Anne Choi, PharmD (LA Care), Clarence Chung, PharmD, MBA (Kaiser), Riona Fujinaga, PharmD, (Inland Empire Health Plan), Matthew Garrett, PharmD (Health Plan of San Joaquin), Lisa Ghotbi, PharmD (San Francisco Health Plan), Adam Horn, PharmD (CenCal Health), Amit Khurana, PharmD (Aetna Better Health of California), Helen Lee, PharmD, MBA (Alameda Alliance for Health), and Rahel Negash, PharmD (Alameda Alliance for Health). • Representatives 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), Biyan Feng, PharmD (Health Plan of San Mateo), Kris Gericke, PharmD (CalOptima), Dang Huynh (Santa Clara Family Health Plan), Susan Nakahiro, PharmD (Blue Shield of California Promise Health Plan), Andrea Ocampo (Partnership Health Plan of California, Inc.), Lynette Rey, PharmD (Partnership HealthPlan of California, Inc.), Navnett Sachdeva, PharmD (Central California Alliance for Health), Ankit Shah, PharmD (UnitedHealthcare Community Plan of California, Inc.), Jessica Shost, PharmD (San Francisco Health Plan), Ashley Teijelo, PharmD (Community Health Group), Mimosa Tran, PharmD (Molina Healthcare of California Partner Plan, Inc.), Bruce Wearda, RPh (Kern Family Heath Care), Andrew Yau, PharmD (Health Plan of San Mateo) and Jonathan Yeh, PharmD (Health Plan of San Joaquin). • Ms. Chan introduced Lisa Kroon, PharmD (UCSF School of Pharmacy) and announced the California Society of Health-System Pharmacists had presented Dr. Kroon with their Pharmacist of the Year Award for 2019. Dr. Stebbins thanked Dr. Kroon for her leadership, guidance, and commitment to the State of California. Dr. Kroon commented on the importance of the DUR program to the UCSF School of Pharmacy and how it aligns with the department's mission to serve the citizens of the State of California. • Ms. Chan went through each of the meeting announcements. Ms. Chan reported that Dr. Ramiro Zuniga resigned from the Global Medi-Cal DUR Board effective October 15, 2019. DHCS and the Board thanked him for his service. Ms. Chan gave a brief status update on the California Advancing and Innovating Medi-Cal (CalAIM) Initiative. She also noted that the most recent National Prescription Drug Take-Back Day was

	Saturday, October 26th. The Drug Enforcement Administration (DEA) now allows for the collection of vape pens and e-cigarette devices on the drug take-back day, but only after the batteries are removed from the devices. Ms. Chan stated that the DEA provides additional guidance and alternatives for disposal on its website. Ms. Chan then reported that there has been a Centers for Disease Control and Prevention (CDC) update on lung injury associated with e-cigarette use, or vaping. Ms. Chan then reminded the Board that the MCP's Annual Drug Use Review Report for FFY 2019 submission is due to DHCS on April 1, 2020. The survey questionnaire for FFY 2019 has yet to be released by CMS. • Ms. Chan reported that Barry Handon, MD, MPH passed away last month (October, 2019). Ms. Chan noted that she used to work with Dr. Handon at DHCS and he was a leader in the CalMEND (the California Mental Health Care Management Program) quality improvement initiative. Lisa Ashton, PharmD (formerly with DHCS, now with Johnson & Johnson) spoke fondly of her work with Dr. Handon at DHCS. Ms. Chan stated a major achievement of CalMEND under his leadership was integrating behavioral health and primary care to improve use of psychotropic medications, and that the DUR Program is continuing his important work.

2) CALL TO ORDER/ GUIDELINES/ ROBERT'S RULES	The Chair of the Board, Dr. Randall Stafford, called the meeting to order. Ms. Chan reviewed the general meeting guidelines and stated that everyone should have the mindset to be courteous, respectful, and open-minded. Ms. Chan then provided a brief summary of Robert's Rules of Order. 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 reminded the Board to complete the Board meeting feedback survey.
3) REVIEW AND APPROVAL OF PREVIOUS MINUTES FROM SEPTEMBER 17, 2019	The Board reviewed the minutes from the Board meeting held on September 17, 2019. Dr. Albertson motioned that the minutes be approved. The motion was seconded. There was no discussion. The Board voted to approve the minutes. **AYE:** Albertson, Chan, Leung, Liu, McBride, Paulson, Stafford, and Stebbins **NAY:** None **ABSTAIN:** Mowers **ABSENT:** Blatt, Dhanvanthari, Dryjanski, Walker, and Wong **ACTION ITEM**: Post the September 17, 2019, minutes to the DUR website.
4) OLD BUSINESS	**a.** Review of Board Action Items from September 17, 2019: i. Ms. Chan noted that all board recommendations to DHCS regarding the Medi-Cal Rx program have been reviewed by DHCS, including the following: • All Medi-Cal MCPs to facilitate and adopt a Medicare-like MTM program and performance improvement project (PIP) models. • Medi-Cal FFS program to explore and develop the infrastructure of a Medicare-like MTM program and performance improvement project (PIP) models. • DHCS to allot funding for Medi-Cal MCP participation in MTM and QIP/PIP programs and in the DUR Board. • Provide real-time data to MCPs, a portal for health plan access to data, and regular transmission of encounter files in a standardized format to ensure care coordination for members and providers. ii. Ms. Fingado reported that the recommendation to send a DUR educational outreach letter to the top prescribers of gabapentin was approved by DHCS. She estimates the letter will be sent in December 2019. iii. Ms. Fingado stated that a DUR educational alert regarding the 2019 updated asthma management and prevention guidelines published by the Global Initiative for Asthma (GINA) to the list of topics for educational outreach was published in October 2019 and a related outreach proposal would be presented this afternoon.

	iv. Ms. Fingado noted that the recommendation to use only continuously eligible beneficiaries with the same plan for the duration of the quarter for the Global Quarterly DUR Report was approved and that this recommendation had been incorporated into the global quarterly report to be presented this afternoon. **b.** Recommended Action Items for MCPs from September 17, 2019: Ms. Chan presented the recommended action items for MCPs from the Board meeting held on September 17, 2019. Recommendations are separated into two categories: required action items and suggested action items.

5) NEW BUSINESS	**a.** Health Plan Presentation by Partnership Health Plan of California: Asthma Medication and Asthma Medication Ratio (AMR) – Dr. Leung began his presentation with an overview of asthma, including economic burden, general pharmacology, and currently available therapies. He then described how to calculate the AMR, one of the current Healthcare Effectiveness Data and Information Set (HEDIS) measures. Dr. Leung discussed the following three best practices related the AMR measure: • Identify patients with an AMR < 0.5 and schedule time for education and assessment of these patients • Focus on appropriate ICD-10 coding for asthma and asthma-like symptoms • Develop a close relationship with local hospitals and emergency departments to help clinicians identify patients who are in need for a follow-up with their primary care physician Dr. Leung described the AMR Eligible Population Report Card, which was created by Partnership Health Plan of California. This report card is a clinic-specific tool for providers to use to help understand the AMR measure and to highlight any potential gaps in care. Dr. Leung explained the different aspects of the report card and showed how the AMR population can change throughout the year due to factors such as cough and cold season. Dr. Stebbins asked if he noticed an impact from the 2018 fires in California on the data presented. Dr. Leung noted that while the overall impact still needs to be assessed, there was definitely an impact from the poor air quality and the inability of patients to get needed medications during displacement from the fires. Dr. Leung gave an overview of best practices relating to the prescribing and pharmacy component of asthma care, including placing refill limitations and avoiding auto-refill on albuterol prescriptions. Dr. Leung then summarized the 2019 GINA guidelines, noting new recommendations to prescribe daily or as-needed low-dose inhaled corticosteroid (ICS) for adults and adolescents with mild asthma and to avoid treatment with short-acting beta-agonists (SABAs) alone. He concluded by noting that Partnership Health Plan of California is working with chain pharmacies to help them better understand their role in asthma management. Dr. Stafford asked if AMR methodology included a hierarchy for the calculation of the population denominator when there is more than one qualifying event. Dr. Leung stated that while there is not a hierarchy in the calculation of AMR, the hope is to explore the group meeting more than one criteria in further detail and share any relevant findings through academic detailing. Dr. Albertson asked how nebulizers are handled in the AMR calculation and how have they handled biologics instead of classic medication options. Dr. Leung replied that he would have to provide a follow up as the medical director handles these details. Dr. Lee asked if they had developed any tools for medication therapy management and case management. Dr. Leung stated that they are exploring an outcome-based model that can help with interventions and that they tried to provide a gap list to pharmacies but had mixed results. Ms. Chan asked if Dr. Leung felt that long-acting beta-agonist (LABA)/SABA combination therapy improved adherence. Dr. Leung stated that most patients carry around only one inhaler and did not know if they would carry two over just albuterol alone. He also noted that GINA guidelines do not promote as-needed use of ICS.

b. Global DUR Board Activities

i. Retrospective DUR Review: Antihyperglycemic Medications – Dr. Mowers reported that UC Health is currently reviewing policies and best available evidence for the treatment of type 2 diabetes mellitus (T2DM). As their final recommendations are still in progress, Dr. Mowers stated that this presentation today represents his own thoughts only and not those of UC Health. Dr. Mowers gave a brief overview of pharmacologic approaches to glycemic treatment, noting treatment should be patient-centered and consider efficacy and patient factors when choosing pharmacologic treatment of blood glucose. Dr. Mowers then reported on recent literature showing sodium-glucose co-transporter 2 (SGLT-2) inhibitors and glucagon-like peptide-1 receptor agonists (GLP-1 RA) may decrease the risk of cardiovascular events, hospitalizations, and death, while decreasing the total cost of care.

Dr. Mowers then showed high-level data looking at antihyperglycemic medication use in the Medi-Cal population, stratified by both FFS and MCP enrollees. Dr. Mowers reported low adoption for SGLT-2 and GLP1-RA medications in the Medi-Cal population and proposed that non-endocrinologists don't feel comfortable prescribing SGLT-2 or GLP1-RA. He suggested we should encourage providers to prescribe these drugs that are better antihyperglycemic medications than what is currently being prescribed to Medi-Cal beneficiaries with T2DM. Dr. Mowers proposed writing a DUR educational bulletin discussing the current American Diabetes Association (ADA) and American College of Cardiology (ACC) policies on using SGLT2 inhibitors and GLP1-RA in the treatment of T2DM.

Dr. Stebbins noted sometimes there is slow uptake once guidelines are published and asked what UC endocrinologists are currently recommending for patients. Dr. Kroon stated that these guidelines have been out for three years and that data is emerging faster, especially this past year. Dr. Kroon reported they were not switching patients but now are switching patients to SGLT-2 and GLP1-RA medications. She noted that these brand-to-brand cost switches are easier than switching from sulfonylureas, which are still being used relatively frequently. Dr. Stafford asked if there was data on how many Medi-Cal patients are on combination therapy and of those, what percentage of patients was considered to be high-risk. Dr. Mowers stated that these data were not assessed at this stage but it could be included in the bulletin. Dr. Ghotbi shared that UCSF endocrinologists provided input at their pharmacy and therapeutics committee meeting and advocated keeping sulfonylureas on formulary as many people benefit from these drugs.

Dr. Khurana asked what the perceived barrier is for prescribing. Dr. Mowers stated that extra paper and documentation is a barrier and on the commercial side, uptake is slower than might be expected. Dr. Stafford asked to what extent there are prior authorization restrictions on these drugs. Dr. Mowers motioned that FFS and MCP plans should review barriers and assess if these are needed. The motion was seconded. Dr. Stafford stated he was skeptical we needed this motion if there was a requirement to have availability of these drugs without an approved *Treatment Authorization Request* (TAR). Dr. Mowers reported hearing about paperwork barriers so he thinks it might be relevant to have each plan review potential barriers and how they could be mitigated. Dr. Stebbins agreed and noted our data show that best practices are not being followed. Dr. Stafford noted that sulfonylureas are being prescribed and there may be beneficiaries on appropriate combination therapy. Dr. Stebbins stated that any time we have updated guidelines and national data it should be shared with our providers.

Dr. Mowers then motioned the following:

1) Write a DUR educational bulletin discussing the current ADA and ACC policies on using SGLT2 inhibitors and GLP1-RA in the treatment of T2DM.
2) Review the process for FFS patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers FFS patients may have in obtaining either of

these two classes of medication and determine if any identified barriers can be mitigated.

3) Review the process for MCP patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers MCP patients may have in obtaining either of these two classes of medication and determine if any identified barriers can be mitigated.

The motions were seconded. There was no further discussion. The motions passed.

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

ACTION ITEM: The DUR Board recommendations to 1) write a DUR educational bulletin discussing the current ADA and ACC policies on using SGLT2 inhibitors and GLP1-RA in the treatment of T2DM; 2) review the process for FFS patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers FFS patients may have in obtaining either of these two classes of medication and determine if any identified barriers can be mitigated; and 3) review the process for MCP patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers MCP patients may have in obtaining either of these two classes of medication and determine if any identified barriers can be mitigated will be submitted to DHCS.

ii. Review of DUR Board Bylaws – Dr. Stafford reviewed the recent history of the annual review of the bylaws. Dr. Paulson asked if there were any known recommendations by the Board to make specific changes to the bylaws. Dr. Stafford noted the suggested edits were minor and mostly included updating the bylaws to use the term "Global" in a more consistent manner. Dr. Ghotbi made a suggestion to the Board to recommend the bylaws stipulate length of term and more detailed qualifications for becoming a Board member. Dr. McBride noted that the qualifications are described in the regulations. Ms. Chan agreed and stated the qualifications in the bylaws were taken from the federal regulations outlined in the Omnibus Budget Reconciliation Act (OBRA) of 1990. Dr. Stafford motioned for an additional edit on page three of the bylaws in order to clarify that a simple majority of the Board members present may pass a motion, once a quorum has been established. The motion was seconded. Dr. Liu requested the proposed changes be put on the screen. Dr. Orozco and Ms. Fingado drafted the following revision for page three and projected it on the screen: "A simple majority of members shall constitute a quorum. **Once a quorum has been established,** a simple majority **of those members present** is needed for a motion to pass." There was no further discussion. The motion passed.

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

ACTION ITEM: The DUR Board recommendation to accept all edits to bylaws, including the addition of a clarification on Page 3 will be submitted to DHCS.

iii. Summary of MCO Best Practices – Due to time constraints, Dr. Stafford quickly went through the MCO best practices slides, which focused on pain management and opioid use best practices. He reported that data from Smart Care California show that plans are adopting recommended strategies for opioid use best practices and showing improvements over time. Dr. Stafford recommended continuing to use health plan presentations as a platform to disseminate best practices more broadly. Dr. Stebbins suggested that plans engage their pharmacies. She is observing difficulties with appropriate access to pain medications post-discharge, where

medications are being prescribed correctly but pharmacies are not stocking pain medications and patients are issued only a 72-hour supply. Dr. Stebbins stated that pharmacies are blaming distributors and that there are pockets around California where access is particularly problematic, such as in the Central Valley. Dr. Stebbins reported that geographically isolated patients having pain medications restricted by their pharmacies is currently the top problem identified through the transitions of care program at UCSF.

iv. Review OIG Report: ADHD – Ms. Chan provided a brief summary of the Office of Inspector General report, "Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Followup Care," which was published on August 13, 2019. Ms. Chan noted that a follow-up visit after ADHD medication will be a part of the DHCS Quality Improvement Strategy for 2020.

v. CMS Initiative: Improving Asthma Control Learning Collaborative – Dr. Albertson reported that CMS has launched a new initiative, "Improving Asthma Control Learning Collaborative." This initiative will support state Medicaid and CHIP beneficiaries and will focus on improving asthma control. Dr. Albertson noted there are two parts to the initiative: 1) a series of four webinars that began in October 2019 for discussing concepts and tools for asthma control and 2) an affinity workgroup to begin in March 2020 to take action.

Dr. Albertson motioned to recommend the DUR program and Medi-Cal MCPs participate in this action-oriented affinity group in designing and implementing QI projects related to improving asthma control in California. The motion was seconded.

Dr. Albertson noted that asthma is an amplifying disease with potential lifetime consequences and that this could be an opportunity for FFS and MCP to align and come up with a unified approach to asthma control. Dr. Leung asked if this program was in conjunction with the National Asthma Control Program, which is led by the Centers for Disease Control and Prevention (CDC). Dr. Albertson said this initiative is led by CMS and is focused on the Medicaid and CHIP populations. Ms. Chan described the past positive experience of the DUR program participating in a CMS-led affinity workgroup that focused on improving psychotropic medication use in children. There was no additional discussion. The motion passed.

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

ACTION ITEM: The DUR Board recommendation that the DUR program and MCPs participate in an action-oriented affinity group in designing and implementing QI projects related to improving asthma control in California will be submitted to DHCS.

c. 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.

d. Health Plan Presentation by LA Care Health Plan: The Role of Managed Care Pharmacists in Improving Outcomes of Patients with Type 2 Diabetes – Dr. Paulson, PharmD introduced Mary Anne Choi, PharmD, [Clinical Pharmacist, LA Care] to provide an overview of the role of managed care pharmacists and how they work to enhance member care and satisfaction, optimize appropriate use of resources, bridge gaps in patient care, and are a critical component in innovative care models.

Dr. Choi briefly described three programs at LA Care where managed care pharmacists play a key role in improving outcomes of patients with type 2 diabetes, including the

Community Pharmacy Value-Based Program, the Ambulatory Care program, and the High Touch Telephonic Outreach – Insulin Initiation.

Dr. Choi stated that the Community Pharmacy Value-Based Program was a pilot program that received grant funding from the CDC and the Los Angeles County Department of Health. Dr. Choi provided information on the program stakeholders and discussed the benefits of payer-pharmacy engagement, where pharmacies receive payment or incentives to provide comprehensive medication management (CMM) and payers are not expected to pay for CMM services that do not have a high probability of delivering results.

Dr. Choi then focused on the Ambulatory Care program, a pilot program that partnered pharmacists with primary care clinics with the goal of bridging the gap between healthcare payers and providers. Dr. Choi described how the plan for LA Care clinical pharmacists to assist clinics in the management of high-risk patients will help bridge the gap in care. She explained that data from this pilot would be analyzed and used to monitor the return on investment of the program.

Finally, Dr. Choi provided an overview of the High Touch Telephonic Outreach – Insulin Initiation, a completed program. Dr. Choi stated that a retrospective study was conducted to assess the impact of a pharmacist-led intervention on a high-risk diabetes patient population started on preferred basal insulin. Although the results of this program did not show a significant impact on the reduction of hemoglobin A1c, Dr. Choi explained that this might have been due recent changes in the American Diabetes Association guidelines but also conceded the telephone outreach did not appear to have high impact, which is why LA Care tried the other two pilot programs.

Dr. Stebbins noted that there are three pillars in care, the community, the payer, and the clinic. Dr. Stebbins asked if they envision collaboration between the managed care plans and the community pharmacies and how they plan to push value-based care. Dr. Paulson stated this is why they have proposed that the DUR Board support the recommendation that DHCS provide funding for community-based services. Dr. Paulson noted that leveraging different departments within the MCPs to support initiatives could help target patients who have a gap in care. Dr. Lee asked about details on the community pharmacies they worked with. Dr. Choi stated that they chose pharmacies with at least two pharmacists and who agreed to follow their training. Dr. Kroon stated that the results demonstrated about a 2% decrease in A1c and wondered if any outliers skewed the data. Dr. Choi replied that they did not assess outliers. Dr. Kroon then stated that AB1114 provides DHCS payment to pharmacists for level 1 and level 2 care and suggested asking for reimbursement based on level 4 care. Dr. Paulson replied that not many pharmacists are billing, but that they are working with pharmacies to educate them on this process.

e. Pharmacy Update: Medi-Cal Rx – Dr. Thompson provided a brief update on the status of Medi-Cal Rx. She stated that while a Notice of Intent to Award had gone out, DHCS received a Notice of Appeal last week so there is currently no update on vendor selection for Medi-Cal Rx. Dr. Thompson stated that there is no set timeline for the appeal process. Dr. Thompson reported that an updated version of the FAQ had been posted earlier in the month and may provide more answers. Dr. Thompson noted that over 100 applications were received for participation in the Medi-Cal Rx Advisory Workgroup and that there would be an announcement on December 13th regarding the Advisory Workgroup. She stated the Advisory Workgroup would have seven meetings and there would also be quarterly public forum meetings throughout the transition.

f. UCSF Update

i. Prospective DUR: Fee-for-Service

- Review of DUR Alerts for New GCNs in 3Q2019 (July – September 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:

- AMLODIPINE BENZOATE – Late Refill (LR), High Dose (HD), Low Dose (LD)
- CITALOPRAM HYDROBROMIDE – Therapeutic Duplication (TD), Late Refill (LR), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- CLIN-BEN-OTN-OCSL-OCT-OXY-TITN – High Dose (HD), Low Dose (LD)
- CLIND/OTN/OCSAL/O-CRL/OXB/TITN – High Dose (HD), Low Dose (LD)
- DEXTROMETHORPHN/ACETAMINOPH/CP – Ingredient Duplication (ID), High Dose (HD)
- DROSPIRENONE – Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- MIDAZOLAM – Additive Toxicity (AT)
- ROSUVASTATIN CALCIUM – Late Refill (LR), High Dose (HD), Low Dose (LD)

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

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

- Final Outcomes: Additive Toxicity Letter – Ms. Fingado reported on the final outcomes of the additive toxicity mailing, which was sent on January 18, 2019. The objectives for this mailing were the following:
  - To identify beneficiaries at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants
  - To help inform health care providers and patients of the serious risks attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics

The final undeliverable rate was 1% and the final response rate was 25%. The primary outcome showed 61% of continuously eligible beneficiaries did not have active paid claims for both opioids and benzodiazepines after 6 months following the mailing. Ms. Fingado noted that additional beneficiaries were only taking buprenorphine (no other opioids) after 6 months following the mailing. The secondary outcome showed 16% of total continuously eligible beneficiaries had a paid claim for naloxone within the 6 months following the mailing.

Dr. Ghotbi asked if letters are sent more than once. Ms. Fingado stated that each new mailing starts as a pilot and future actions could be taken depending on the outcomes shown from a mailing. Ms. Fingado noted that we have repeated a few of the mailings based on positive outcomes. Dr. Stafford suggested language in the letter to address the possibility there are tapers in progress. Ms. Fingado stated there is a line that states that we do not have access to the patient's comprehensive records or medication lists and that this letter is based on one moment in time. Ms. Fingado also noted that we sent this letter before gabapentin was added to the list of drugs generating an additive toxicity alert, so it would be worth doing again and seeing how many letters are generated. Dr. Stebbins motioned to repeat the additive toxicity alert educational outreach letter to providers. The motion was seconded. There was no further discussion. The motion passed.

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

ACTION ITEM: The DUR Board recommendation to repeat the additive toxicity alert educational outreach letter to providers will be submitted to DHCS.

- Final Outcomes: Nicotine Replacement Therapy (NRT) Letter to Pharmacies – Ms. Fingado Ms. Fingado reported on the final outcomes of the nicotine replacement therapy (NRT) letter to pharmacies, which was sent on August 23, 2018. The objectives for this mailing were the following:
  - To inform pharmacy directors of the protocol for pharmacist furnishing of NRT in California, including training requirements
  - To increase the number of pharmacists able to furnish NRT
  - To increase the number of Medi-Cal beneficiaries with a paid claim for NRT

  The final undeliverable rate was 1% and the final response rate was 11%. The primary outcome showed less than 20 paid claims in the 15 counties for pharmacist-furnished NRT within 12 months of the mailing. The secondary outcome showed less than 20 pharmacists in the 15 counties furnished NRT within 12 months of the mailing. However, Ms. Fingado reported that total NRT claims were up 18.6% in the 15 counties, compared with 9.0% among all other counties and 5% of utilizing beneficiaries in the 15 counties were prescribed combination NRT, compared with 2% among all other counties. Ms. Fingado stated that while these results were not either the primary or secondary outcome, they did show a trend in the right direction.

  Dr. Ghotbi noted that so much of NRT is one and done and that an intervention will take time as follow-up is needed over time for patients to follow through. She suggested letting pharmacists know how to register as an ordering, referring, or prescribing (ORP) provider. Ms. Fingado stated that the link for providers to register as an ORP was included in the letter. Dr. Kroon reported that registration is happening a lot quicker, with the time to register as an ORP dropping from about ten months down to about eight weeks. Dr. Stafford asked if there were any suggestions on how to help pharmacies register. Ms. Fingado mentioned academic detailing, reaching out to pharmacies. Dr. Stafford thought it might be useful to provide outreach to pharmacies to remind them they do have the ability to generate revenue by registering. Dr. Kroon stated that for chain pharmacies this usually requires approval from corporate office and for independents there is a new initiative for an integrated pharmacy network encouraging pharmacists to become ORP providers. Ms. Fingado noted we have other pharmacist furnishing topics in the queue and we could see if there is a difference in uptake for pharmacist furnishing of hormonal contraception or naloxone. Dr. Albertson noted that smoking cessation needs to be a more integrated process and by focusing on pharmacists alone in 15 counties is not enough. Dr. Albertson suggested targeting both pharmacists and physicians in the same county with a focus on the end results, not the process. He noted there is also a need to address psychological evaluation not just providing prescriptions for NRT. Ms. Fingado stated that although the primary and secondary outcomes focused on paid claims, the letter and DUR bulletin enclosure did contain other educational information about smoking cessation.

- Proposal: Asthma Guidelines – Ms. Fingado presented a proposal to inform health care providers of the updated the Global Initiative for Asthma (GINA) guidelines. Medi-Cal fee-for-service beneficiaries with paid claims for short-acting β2-agonists (SABAs) alone and a diagnosis of asthma will be included in the study population. The prescribers of the SABAs will receive a letter including the names and birthdates of the identified patient(s) in their practice, the Medi-Cal DUR alert on the GINA guidelines, and a provider survey. Ms. Fingado stated that the primary outcome would be the percentage of continuously eligible beneficiaries with paid claims for SABAs alone within 12 months following the mailing and the secondary outcome would be the percentage of continuously eligible beneficiaries with paid claims for inhaled corticosteroid (ICS) treatment within 12 months following the mailing. There was not a quorum so there was not a motion to recommend approval of this proposal. Ms. Fingado stated that the letter could be sent without a motion, if approved by DHCS. Dr.

Albertson suggested looking at use of SABAs alone for a one-year time period. Dr. Leung suggested three or more paid claims to show long-term use.

iii. Retrospective DUR

- Global Quarterly: 2Q2019 (April – June 2019) – Ms. Fingado presented the Global Quarterly Medi-Cal DUR report for 2Q2019. This quarterly report contains all pharmacy utilization data for the Medi-Cal program. Utilization data are presented in aggregate, and then stratified by FFS or MCP enrollment status and 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 noted that per Board request, the stratified tables of the report now include only beneficiaries who were continuously enrolled in the same plan for the entire duration of the quarter. She pointed out that by limiting the report to beneficiaries with continuous enrollment in the same plan for the duration of the quarter, the differences between mean days' supply between FFS and MCP enrollees were decreased. The Board recommended no changes to the report template for subsequent quarterly reports.

- FFS Quarterly Report: 3Q2019 (July – September 2019) – Ms. Fingado presented the Medi-Cal fee-for-service quarterly DUR report for the 3rd 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 14% of eligible Medi-Cal FFS enrollees had a paid claim through the Medi-Cal fee-for-service program, compared with only 2% of Medi-Cal MCP enrollees. Ms. Fingado also pointed out a utilization decrease among all beneficiaries in the 0 - 12 year age group and that the FFS utilization of proton-pump inhibitors showed a 28% increase in total paid claims from 2018 Q3, which may be attributed to the addition of omeprazole to the Medi-Cal fee-for-service List of Contract Drugs (CDL), effective May 1, 2019. Finally, Ms. Fingado reported a 379% in total paid claims from 2018 Q3 for naloxone, which was the subject of California legislation that became effective the first day of 2019 Q1.

- New Additions to the Medi-Cal List of Contract Drugs: FFY2018 – Dr. Shal Lynch (UCSF) reported that each month there are usually modifications made to the Medi-Cal List of Contract Drugs, including the addition of new drugs. A review of utilization patterns for these drugs is conducted each year in order to determine if there is a need for further evaluation of any of the drugs added to the Medi-Cal List of Contract Drugs during the 2018 Federal Fiscal Year. Dr. Lynch stated that during the Federal Fiscal Year 2018 (between 10/1/17 and 9/30/18), there were a total of 22 new prescription medications added to the Medi-Cal List of Contract Drugs. Utilization data (total number of paid claims and utilizing beneficiaries with at least one paid claim) were reviewed for each of these drugs during the period between 10/1/16 and 08/31/19 to allow at least 11 months of utilization data before and after the drug was added to the Medi-Cal List of Contract Drugs. Fourteen of the drugs had low utilization (< 20 utilizing beneficiaries during all of the months reviewed) and were not reported in detail. There were no comments or suggestions for additional evaluation.

iv. Review of DUR Publications presented by Dr. Lynch

- Bulletin (September 2019): Immunization Update – Dr. Lynch let the Board know that the DUR educational bulletin entitled, "2019 Immunization Updates: Flu, HepA, HPV, Measles, CA School Requirements," published in September 2019.

	• Alert (October 2019): Global Asthma Guidelines – Dr. Lynch let the Board know that the DUR educational alert entitled, "Alert: New Global Guidelines for the Treatment of Asthma," published in October 2019. • Discussion/Recommendations for Future Educational Bulletins – The calendar for future DUR educational bulletins was reviewed and it was noted that today's topic on anti-hyperglycemic medications had been added to the list. **g.** Recap of today's action items – The action item in the afternoon session to repeat the additive toxicity alert educational outreach letter to providers was noted. **h.** Looking ahead: Call for future meeting agenda – Ms. Chan stated that she welcomes recommendations from the Board for speakers. Possible presentations for February include CenCal Health describing both their asthma population health project and benzodiazepine provider outreach campaign and Alameda Alliance for Health sharing their opioid initiative.

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 February 25, 2020, 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.

Action Items	**Ownership**
Post the September 17, 2019, Board meeting minutes to the DUR website.	Amanda
The DUR Board recommendation to write a DUR educational bulletin discussing the current ADA and ACC policies on using SGLT2 inhibitors and GLP1-RA in the treatment of T2DM will be submitted to DHCS.	Amanda/Shal
The DUR Board recommendation for DHCS to 1) review the process for FFS patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers FFS patients may have in obtaining either of these two classes of medication; and 2) determine if any identified barriers can be mitigated will be submitted to DHCS.	DHCS
The DUR Board recommendation for MCPs to 1) review the process for MCP patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers MCP patients may have in obtaining either of these two classes of medication; and 2) determine if any identified barriers can be mitigated will be submitted to DHCS.	DHCS
The DUR Board recommendation to accept all edits to bylaws, including the addition of a clarification on Page 3 will be submitted to DHCS.	Amanda
The DUR Board recommendation that the DUR program and MCPs participate in an action-oriented affinity group in designing and implementing QI projects related to improving asthma control in California will be submitted to DHCS.	Pauline
The DUR Board recommendation to repeat the additive toxicity alert educational outreach letter to providers will be submitted to DHCS.	Amanda/Shal/Hannah

Board Action Items from November 19, 2019

- Write a DUR educational bulletin discussing the current ADA and ACC policies on using SGLT2 inhibitors and GLP1-RA in the treatment of T2DM
  - Approved. This topic has been added to the queue for educational bulletins as a high priority for publication in 2020.
- Recommend DHCS review of the process for FFS patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers FFS patients may have in obtaining either of these two classes of medication and determine if any identified barriers can be mitigated
  - DHCS received the recommendation. Review completed.
- Recommend MCPs review the process for MCP patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers MCP patients may have in obtaining either of these two classes of medication and determine if any identified barriers can be mitigated
  - DHCS has received the recommendation and added it to the MCP Action Items for the November 19, 2019 Board meeting.

Medi-Cal DUR

Board Action Items from November 19, 2019 (cont.)

- Accept edits to bylaws, with the addition of one clarification on Page 3: "A simple majority of members shall constitute a quorum. **Once a quorum has been established,** a simple majority **of those members present** is needed for a motion to pass."
  - Approved. DHCS annual review of bylaws is in-progress.
- Recommend California participate in an action-oriented affinity group in designing and implementing QI projects related to improving asthma control, including input from the DUR program and MCPs
  - Approved. DHCS plans to apply for participation in the affinity group and will include DUR program in affinity group communications.
- Repeat educational letter to prescribers with patients that are at high risk for adverse events and have an overridden additive toxicity alert
  - Approved. Letters were sent in January 2020. More information will be presented later today.

Medi-Cal DUR

GLOBAL MEDI-CAL DRUG USE REVIEW BOARD
November 19, 2019 BOARD MEETING MCP ACTIONS

MCP: _____

Name of DUR representative: _____Attended meeting? Yes ___ No ___

Reminders

- MCPs are required to ensure representation and participation at Global Medi-Cal DUR Board meetings, either in-person or via webinar. Refer to the Global Medi-Cal DUR Board bylaws for the attendance requirements for Global Medi-Cal DUR Board members
- MCPs are required to have a process for distribution of provider education programs and materials developed by Global Medi-Cal DUR Board to their providers

Summary of Required Actions

I. **Educational Bulletins:** MCP to have a process for distribution of provider education programs and materials developed by Global DUR Board to their providers via established mechanisms.

Required dissemination of DUR educational bulletins and alerts		
Description	**Mechanism of dissemination**	**Date of Dissemination**
September 2019 Bulletin: 2019 Immuniztion Updates: Flu, HepA, HPV, Measles, CA School Requirements October 2019 Alert: Alert: New Global Guidelines for the Treatment of Asthma		

Summary of Global Medi-Cal DUR Board Activities
(not required to document on the Annual Report to CMS)

1. **Review Board Goals and Priorities:**
   a. Optimizing Drug Prescribing and Dispensing, including specialty drugs
   b. Optimizing Pain Management and Opioids
   c. Optimizing Chronic Disease Management, including prevention

   Actions:
   a. Review board goals and priority areas at MCPs P&T/DUR Committee.
   b. Submit innovative practices on priority areas MCPs has worked on and share lessons learned
   c. Consider presenting best practices at future DUR board meetings

2. **Ongoing Review of MCP's Reported Best Practices and Innovative Practices as Documented in the Plan's CMS DUR Annual Report**

   Actions:
   a. Consider sharing "how we did it" and "lessons learned" with the rest of the MCPs by volunteering to present at future Global Medi-Cal DUR board meetings
   b. Include "emerging" and "promising" practices

3. **Review Health Plan Presentation by Partnership Health Plan of California: "Asthma Medication and Asthma Medication Ratio (AMR)"**

   Actions:
   a. Review measure description and understand how the ratio is calculated
   b. Assess whether your MCP can adopt any strategies to improve this measure performance.

4. **Review Health Plan Presentation by LA Care: "The Role of Managed Care Pharmacists in Improving Outcomes of Patients with Type 2 Diabetes"**

   Action:
   a. Review the programs presented by LA Care where managed care pharmacists play key roles.

5. **Review Board Actions and Recommendations from the November 19, 2019 DUR Board Meeting (see "Action Items" found in the last section of the meeting minutes)**

   Actions:
   a. Discuss the actions and recommendations at the MCP's P&T/DUR meeting.
   b. Review the process for MCP patients to obtain a SGLT2 inhibitor and a GLP1-RA to identify potential barriers, and ways to mitigate such barriers.
   c. Consider offering feedback at future DUR board meetings

Pharmacy Update Topics:

Medi-Cal Rx
H.R. 6 - SUPPORT for Patients and Communities Act

Pharmacy Benefits Division
February 25, 2020

Global Medi-Cal Drug Utilization Review Board 2019 Accomplishments

Randall Stafford, MD, PhD
Pauline Chan, R.Ph., MBA
February 25, 2020

2019 DUR Board Accomplishments - 1

- The Board completed revision of Drug Utilization Review reports to include drugs that are commonly used in both Medi-Cal Fee-For-Service (FFS) and Managed Care Plans (MCPs). Significant expansion of the number of reports with stratification by population type.
- The Board facilitated close MCPs and FFS collaborations
  - MCPs presented 9 practices to share innovative ideas and lessons learned
  - Medi-Cal DUR disseminated 9 educational bulletins to MCPs
  - Established quarterly MCP Action Plan to integrate/align FFS and MCOs DUR Actions

2019 DUR Board Accomplishments - 2

- Board actions aligned with DHCS Quality Strategy
  - Increased participation at the DHCS Managed Care Quality Conference
  - Increased poster presentations
- Conducted a comprehensive review of MCPs opioid and pain management best practices, to support the implementation of Medicaid Drug Utilization (DUR) Minimum Standards for the "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities" Act
  - SUPPORT ACT

2019 DUR Board Accomplishments - 3

- Finalized the selection of three priority areas of focus:
  - Optimizing drug prescribing and dispensing, including specialty drugs
  - Optimizing pain management and opioid use
  - Optimizing medication for chronic conditions, including prevention
- Summarized and reviewed best practices in each focus area:
  - MCP presentations throughout the year
  - DUR annual reports
  - Innovative practice documentation

2019 DUR Board Accomplishments - 4

- Adopted "DUR Vital Directions" framework as guide
  - Data: measuring what matters most
  - Evidence: referencing clinical practice guidelines
  - Education and Outreach: substantially expanded dissemination through MCPs

Optimizing Drug Prescribing and Dispensing, including specialty drugs

1. Appropriate Use of Medication in High Utilizers and Super Utilizers
2. Formulary Review: Prior Authorization Process Improvement
3. Medication Use Optimization: Reduce Polypharmacy and Eliminate Unnecessary Drugs
4. Strategies to Prevent Filling Prescriptions Already Cancelled
5. Fostering Closer Collaboration between Medical and Pharmacy Services for Optimal Care
6. Specialty Drugs and Biosimilar Drugs
7. Specialty Pharmacy: Cost Effectiveness and Quality of Care
8. Biologics in Immunotherapy: (e.g., CAR-T Cell Therapy)

Optimizing Pain Management and Opioid Use

1. Opioids and Benzodiazepines Combination Use
2. Pain Management Guidelines

Optimizing Chronic Disease Management

1. Diabetes management
2. Hypertension management
3. Asthma control
4. Quality integration in health plan
5. Preventive medicine (immunization)

Global Medi-Cal Drug Utilization Review Board 2020 Goals and Priorities

Timothy E. Albertson, MD, MPH, PhD, Board Chair
Pauline Chan, R.Ph., MBA
February 25, 2020

Global Medi-Cal DUR Board Goals 2020 - 1

- Support DHCS Medi-Cal Rx initiative
- Continue to promote dialogue and collaboration of FFS & MCPs
  - Present innovative practices and projects
  - Share approach and lessons learned
  - Disseminate DUR Educational Bulletins to MCPs
  - Integrate/align FFS and MCPs DUR Actions

Global Medi-Cal DUR Board Goals 2020 - 2

- Align goals with Medi-Cal Healthier California for All (formerly CalAIM)
- Align goals with DHCS Comprehensive Quality Strategy
  - Participate in Managed Care Quality Improvement Initiatives and Quality Conference
    - Poster presentations
    - Platform presentations

Global Medi-Cal DUR Board Goals 2020 - 3

- Join the CMS-led Affinity Workgroup to develop strategies and approaches to improve asthma control
  - Collaborate with MCPs and other relevant partners
  - Identify, implement, and scale asthma initiatives
  - Improve Asthma Medication Ratio (AMR-AD, AMR-CH)
- Revisit HEDIS measures
  - Medicaid Adult Core Set Adult Core Set 2020
  - Medicaid Child Core Set Child Core Set 2020

Global Medi-Cal DUR Board Goals 2020 - 4

- Implement DUR requirements in Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act
- Continue to use the Vital Directions Framework to focus on the three DUR priority areas established in 2018-2019

DUR Vital Directions Framework

Vision

- To work collaboratively to enable and to empower providers and beneficiaries to perform optimally, in drug prescribing and dispensing, with the goal of shifting and optimizing utilization towards safe, accessible, cost effective care.

Core Goals

- Better health and well-being
- High-value health care
- Strong science and technology

DUR Vital Directions Framework (cont.)

Action Priorities

- Optimizing drug prescribing and dispensing, including specialty drugs
- Optimizing pain management and opioid use
- Optimizing chronic disease management, including prevention

Essential Infrastructure Needs

- Measure what matters most
- Clinical practice guidelines
- Education and outreach

Questions ?

CMS Initiative: Improving Asthma Control Learning Collaborative

Timothy E. Albertson, MD, PhD, MPH, Board Vice Chair
Pauline Chan, R.Ph. MBA
February 25, 2020

CMS Asthma Affinity Group: Background

- The purpose of the Asthma Affinity Group is to drive **measurable improvement** on asthma control for Medicaid and CHIP beneficiaries
- For example, to improve performance on:
  - Asthma Medication Ratio (AMR) measures in the Core Sets
  - Reduce asthma-related hospitalizations
  - Reduce asthma-related emergency department (ED) visits

CMS Asthma Affinity Group: Objectives

- Expand state Medicaid and CHIP agencies' knowledge of evidence-based asthma interventions and best practices for implementation
- Learn from states' experiences implementing asthma interventions
- Use data-driven approaches to identify, test, implement, and evaluate an asthma-related QI project
- Improve states' QI skills
- Support state strategies to work with providers and communities to improve asthma control

CMS Asthma Affinity Group: Structure

- Nine-month learning series that will run from April 2020 to December 2020, with ongoing support available through 2021
- Monthly meetings that alternate between group workshops and one-on-one state calls
- Group workshops will be peer-driven and facilitator-led with an emphasis on improvement and sharing
  - QI advisors and asthma experts will guide and support discussions on specific topics, such as the selection, implementation, measurement, and assessment of evidence-based interventions to promote asthma control
  - Opportunities for peer-to-peer learning across teams

CMS Asthma Affinity Group: Next Step

- State teams must submit an Expression of Interest (EOI) form that briefly explains the state goals and resources by **8:00 PM EST on Wednesday, March 4, 2020**
- The EOI form includes five questions:
  - Question 1: Participation goals and outcomes of interest
  - Question 2: Asthma-related covered services and key challenges or opportunities related to asthma control
  - Question 3: Early project ideas
  - Question 4: Asthma Affinity Group state team
  - Question 5: Leadership sign-off
- All materials, including webinar slides, can be found on the Improving Asthma Control Learning Collaborative web page

CMS Asthma Affinity Group: Selection Criteria

- Well-articulated goals for participation in the affinity group
- An understanding of the state's challenges or opportunities
- related to asthma control in the target population
- Access to asthma-related data
- Identification of a well-rounded state team for participation
- Commitment to action with support from Medicaid and/or CHIP leadership

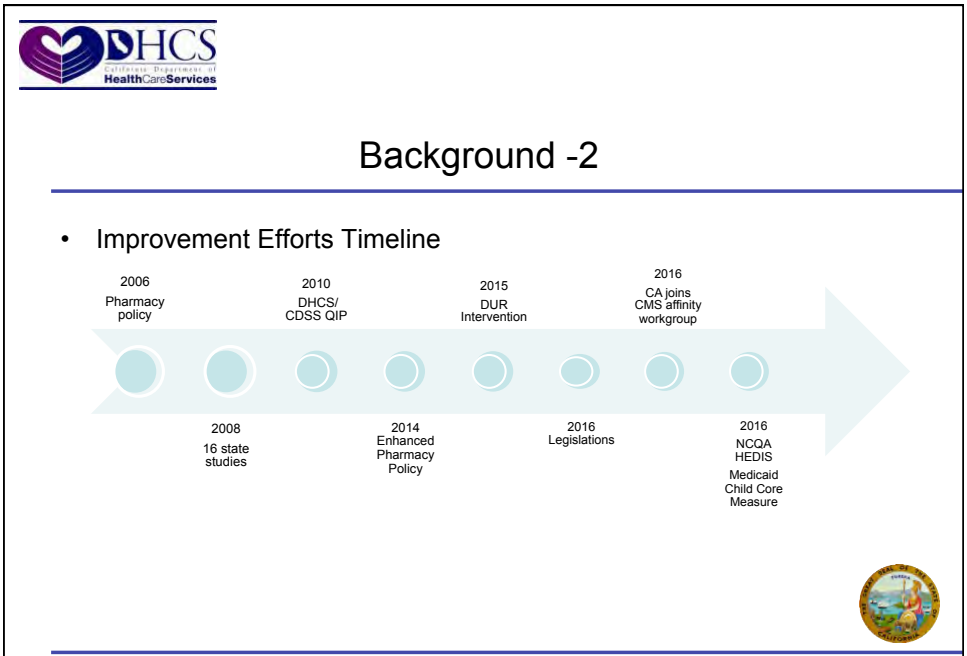
Antipsychotic Use in Children: A RetroDUR Proposal

Global Medi-Cal
Drug Utilization Review Board

Randall Stafford, MD, PhD
February 25, 2020

Background

- Concurrent use of more than one antipsychotic medication in children and adolescents has increased over time, raising concerns:
  - Appropriate use
  - Medication management
  - Side effects
- A Review of State Medicaid Approaches on Child Antipsychotic Monitoring Programs 2016 Antipsychotic Use in Children
  - Summary of California's approach and Medi-Cal's improvement efforts since 2006



Background -2

- Improvement Efforts Timeline

Background -3

- Two new measures were added to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) for 2015:
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM): the percentage of children and adolescents who have ongoing use of antipsychotic medications and metabolic testing during the measurement year
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC): the percentage of children and adolescents who were taking two or more concurrent antipsychotics for at least 90 days during the measurement year

Background -4

Medi-Cal fee-for-service population	Article data: 10/01/13 – 09/30/14	Policy impact data: 01/01/15 – 12/31/15	Biennial review data: 10/01/17 – 09/30/18	% change
Beneficiaries with two or more paid claims for antipsychotic medications	***6,013***	***3,717***	***2,442***	***-59.4%***
APM: % with at least one test for both blood glucose/HbA1C and LDL- C/cholesterol	37.4%	38.9%	53.6%	16.2%
Beneficiaries with at least 90 consecutive days of antipsychotic medication treatment	***5,375***	***3,445***	***2,017***	***-62.4%***
APC: % taking two or more concurrent antipsychotics for at least 90 days	5.7%	6.6%	6.0%	0.3%

Proposal

- Evaluate the same HEDIS measures (APC and APM) using data from calendar year 2019
  - Refer to Medicaid Child Core Set 2019, 2020
- Expand to include data from FFS, MCP, and FFS/MCP populations
- Update March 2015 bulletin
  - New data/results
  - Update Table 2: FDA Age Restrictions on Antipsychotics
- Consider additional provider outreach as needed

DUR Annual Report to CMS: FFY2018 State Comparison Reports

- National Medicaid Fee-For-Service (FFS) 2018 Drug Utilization Review (DUR)
- National Medicaid Managed Care Organization (MCO) 2018 Drug Utilization Review (DUR)

Medi-Cal DUR

National Medicaid Managed Care Organization (MCO) 2018 Drug Utilization Review (DUR) State Comparison Report Highlights

Pauline Chan, R.Ph., MBA

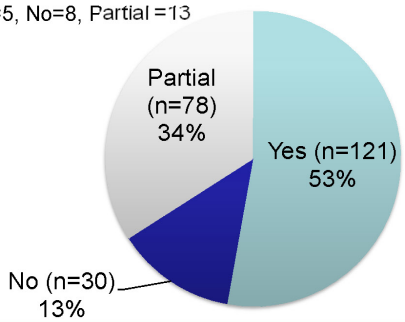
February 25, 2020

2018 National MCO DUR Report

- Report cove s MCO DUR activities within the Federal fiscal year 2018 (October 1, 2017 to September 30, 2018)
- Demographics and enrollees
  - 35 states, including the District of Columbia, have submitted 229 Medicaid MCO DUR Annual Reports
  - CA submitted 26 (11.3%) MCO DUR reports
  - 47,808,459 enrollees in state MCOs DUR Medicaid programs with pharmacy benefits
  - 10,783,187 (22.5%) enrollees in California
  - Does not include Arizona (waiver) or Missouri, Tennessee, Texas, West Virginia, Wisconsin (carved out pharmacy benefits)

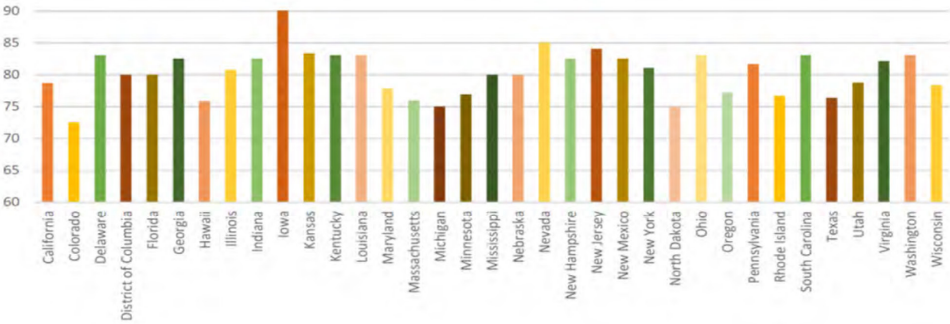
Prospective DUR (ProDUR)

- 200 MCOs (87 %) contract with an outside vendor to process their POS claims. CA=25
- 121 MCOs (53%) allow the pharmacist to override message, 30 (13%) do not allow override, 78 (34%) allow partial override with limits.
  - CA Yes=5, No=8, Partial =13



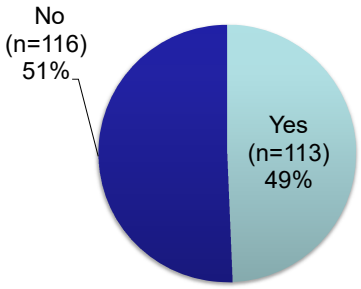
Early Refill Thresholds by State

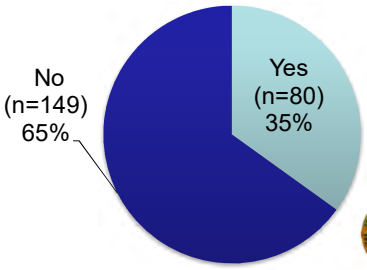
- All MCOs se tearly prescription refill thresholds as a way of preventing prescriptions from being refilled too soon (national range 73%-90%, average 80% non-controlled, 84% controlled)



Prescription Synchronization & Auto-Refill

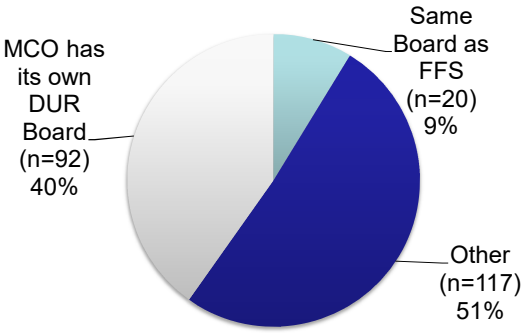
- Synchronization of prescription refills?
  CA Yes = 4, No =22
- Policy prohibiting the auto-refill process at the POS (i.e. must obtain beneficiary's consent prior to enrolling)
  CA Yes =10, No =16





Retrospective DUR (Retro DUR)

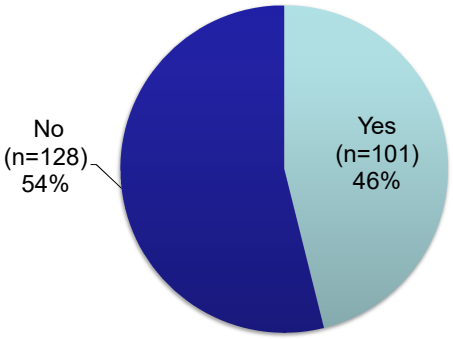
- State DUR Board and MCO's own DUR Board



DUR Board Activities

Medication Therapy Management Program

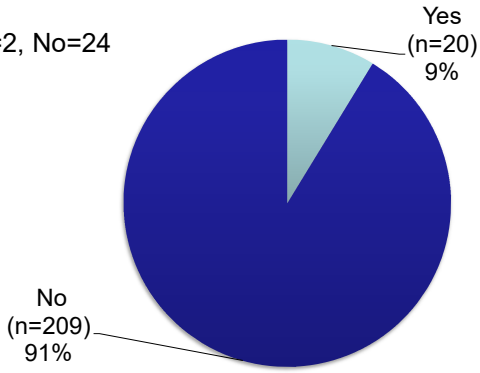
- CA Yes=6, No=20



Physician Administered Drugs (PADs)

Incorporation of NDCs for Covered Outpatient PADs into DUR criteria for ProDUR

- CA Yes=2, No=24

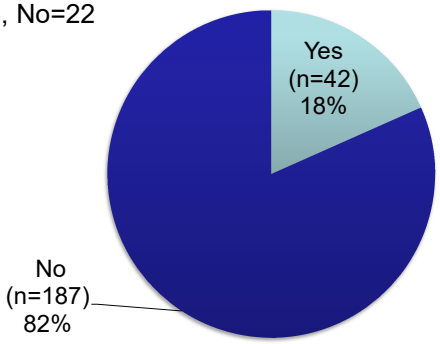


DHCS California Department of HealthCareServices

Physician Administered Drugs (cont.)

Incorporation of NDCs for Covered Outpatient PADs into DUR criteria for RetroDUR

- CA Yes=4, No=22



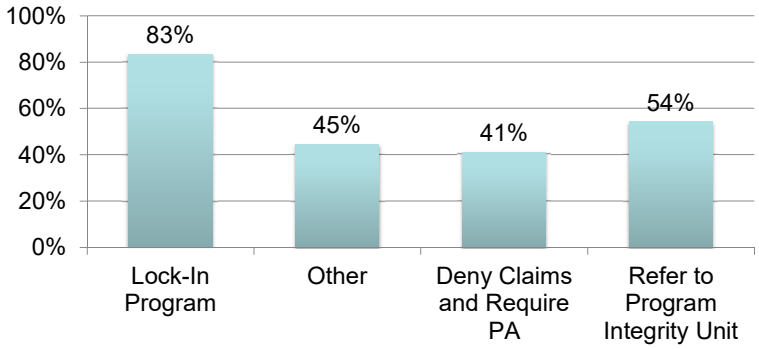
DHCS California Department of HealthCareServices

Average Generic Utilization Percentage Across all MCOs by State

State	Average %	State	Average %	State	Average %
California	87.05	Louisiana	88.85	North Dakota	84.81
Colorado	87.76	Maryland	85.01	Ohio	87.65
Delaware	85.00	Massachusetts	84.19	Oregon	76.42
D.C.	85.29	Michigan	87.51	Pennsylvania	86.06
Florida	83.62	Minnesota	88.21	Rhode Island	87.75
Georgia	90.16	Mississippi	85.57	South Carolina	88.97
Hawaii	89.64	Nebraska	89.31	Texas	79.93
Illinois	87.03	Nevada	87.38	Utah	87.11
Indiana	84.61	New Hampshire	84.37	Virginia	85.55
Iowa	84.95	New Jersey	88.70	Washington	85.83
Kansas	83.40	New Mexico	88.03	Wisconsin	86.13
Kentucky	89.70	New York	83.39		

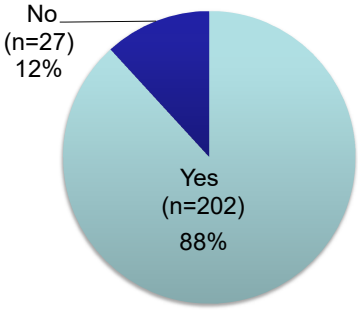
Fraud, Waste, and Abuse Detection – Beneficiaries

Action process initiates when potential fraud or abuse of controlled drugs by beneficiaries is detected

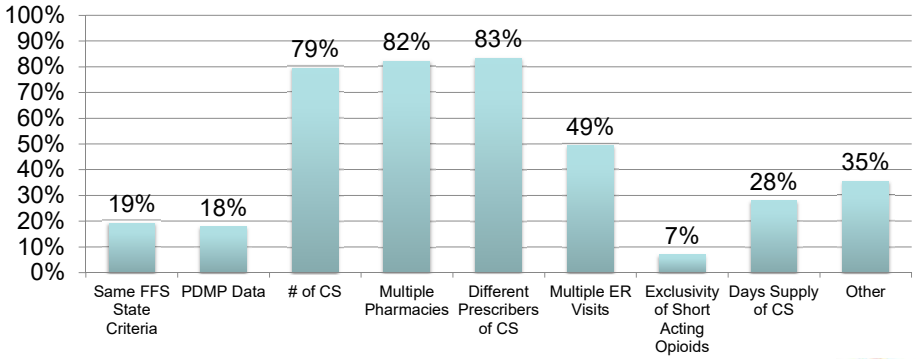


Lock-In Program

CA Yes=13, No =13

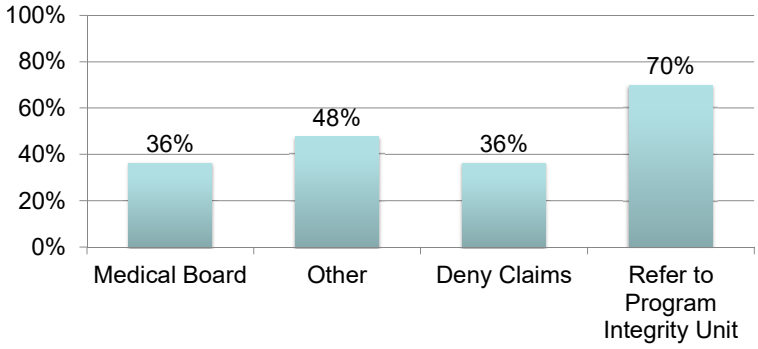


Lock-In Program Candidate Identification Criteria



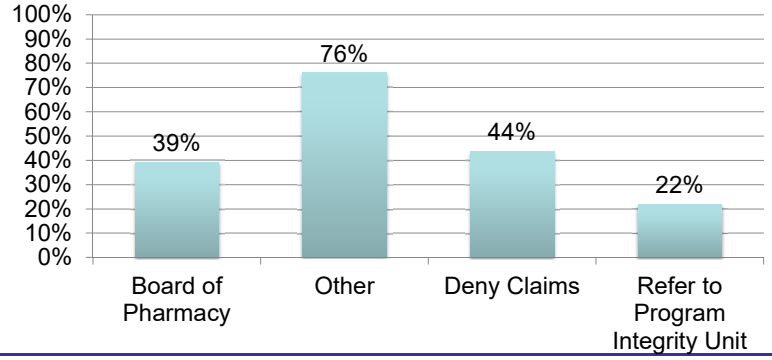
Fraud, Waste, and Abuse Detection – Prescriber

Action process initiates when possible fraud or abuse of controlled drugs by prescriber is detected

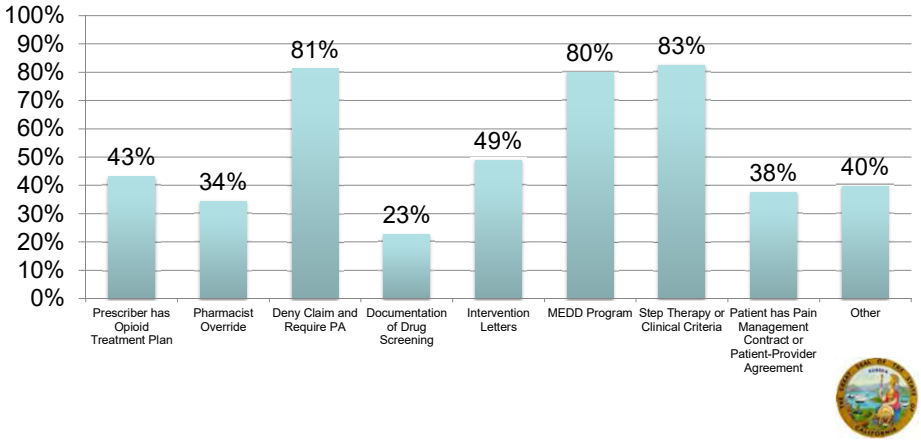


Fraud, Waste, and Abuse Detection – Pharmacy

Action process initiates when potential fraud or abuse of controlled drugs by pharmacy provider is detected



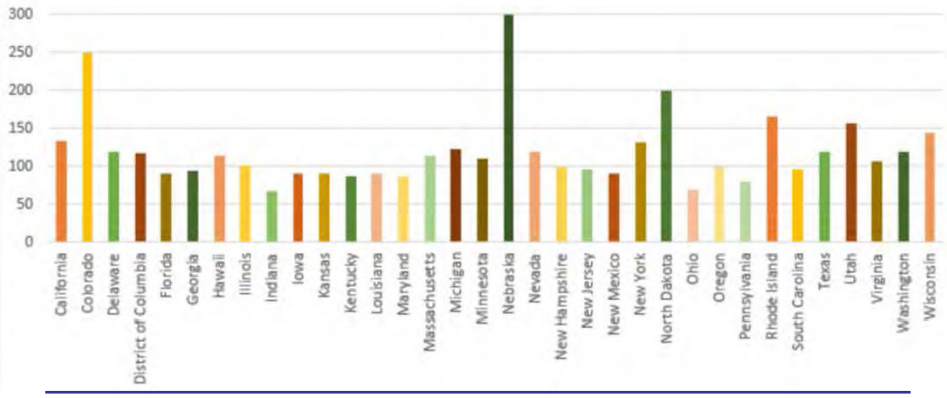
Measures Other Than Restricted Quantities and Days Supply to Manage Prescribing of Opioids



Opioid Guidelines & Morphine Equivalent Daily Dose (MEDD)

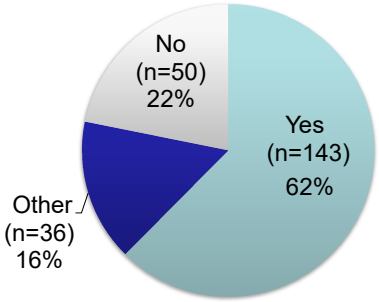
	All MCOs	All MCOs	CA	CA
Opioid Use Guidelines	Yes = 148	No = 81	Yes = 18	No = 8
MEDD	Yes = 192	No = 37	Yes = 17	No = 9
MEDD average	120 mg		134 mg	

Average MEDD Limit in Milligrams Per Day by State



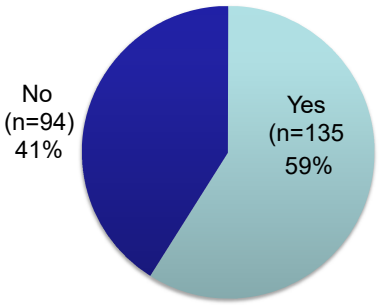
Edits in Place to Monitor Concurrent Opioids & Any Buprenorphine Drug

All MCOs	All MCOs	All MCOs	CA	CA	CA
Yes = 143	No = 50	Other = 36	Yes = 1	No = 16	Other = 9



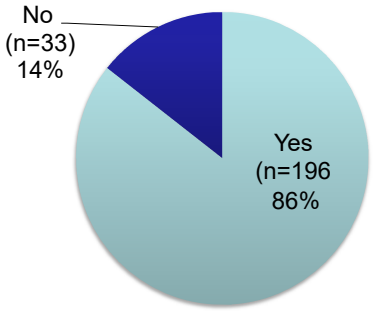
Antipsychotic Monitoring in Children

All MCOs	All MCOs	CA	CA
Yes = 135	No = 94	Yes = 2	No = 24



Restrictions in Place Limiting Quantity of Stimulants

All MCOs	All MCOs	CA	CA
Yes = 196	No = 33	Yes = 23	No = 3



E-Prescribing

- MMIS or Vend ϕ Ability to Electronically Provide Patient Drug History Data and Pharmacy Coverage Limitation to a Prescriber Prior to Prescribing Upon Inquiry

All MCOs	All MCOs	CA	CA
Yes = 159	No = 70	Yes = 18	No = 8

2019 Medi-Cal Drug Utilization Review (DUR) Fee-for-Service (FFS) Annual Report Highlights

Pauline Chan, R.Ph., MBA
February 25, 2020

FFY 2019 Medi-Cal FFS Annual Report to CMS

- FFY 2019 Report covers Medi-Cal DUR activities within the Federal fiscal year 2019 (October 1, 2018 to September 30, 2019)
- Demographics and Enrollees (monthly average)
  - 2,294,983 enrolled in Medi-Cal Fee-For Service program
  - 10,559,452 enrolled in Medi-Cal Managed Care plans

Prospective DUR (ProDUR)

- Medi-Cal FFS contracted with Conduent for ProDUR and claims processing during FFY 2019
- Global Medi-Cal DUR board advises and makes recommendations regarding prospective DUR criteria with final approval by DHCS

Early Refill Thresholds

- The ProDUR alert system at the point of service (POS) sets the following early refill percentage thresholds:
  - Non-controlled drugs: 75%
  - Scheduled II controlled drugs: 75%
  - Schedule III through V controlled drugs: 75%

Prescription Synchronization & Auto-Refill

- Neither Medi-Cal nor the California State Board of Pharmacy have policy prohibiting the auto-refill process that occurs at POS
- Medi-Cal does not have policy to require the synchronization of prescription refills

Retrospective DUR (RetroDUR)

- University of California, San Francisco, School of Pharmacy supported RetroDUR activities in FFY 2019 as a subcontractor to Conduent
- RetroDUR criteria are developed jointly by UCSF and DHCS with input and recommendation by the DUR board. DHCS approves the final criteria.

Physician Administered Drugs (PADs)

- Covered outpatient physician administered drugs (PADs) are paid through the physician and hospital program, with some PADs also paid through retail pharmacies
- No ProDUR criteria is set up for PADs paid through the physician and hospital program
- RetroDUR criteria has been established. Reporting on at least an annual basis is an integral part of the DUR program.

Opioid Guidelines & Morphine Equivalent Daily Dose (MEDD)

- Medi-Cal refers prescribers to the Medical Board of California's Guidelines for Prescribing Controlled Substances for Pain, as well as the CDC's Guidelines for Prescribing Opioids for Chronic Pain
- Medi-Cal provided information to prescribers on how to calculate MEDD. The names of the developer of the calculator includes:
  - The New York City Department of Health and Mental Hygiene (DOHMH)
  - The Washington State Agency Medical Directors' Group
  - The Centers for Disease Control and Prevention
- In February 2019, Medi-Cal published an educational bulletin on MEDD with links to online calculators on Medi-Cal DUR webpage
  - Emailed to all providers with subscription to the Medi-Cal Subscription Service (MCSS)

Monitoring

- Edits in place (additive toxicity alert) to monitor concurrent use of opioids with benzodiazepines and other central nervous system (CNS) depressants
- Edits in place (requires approved *Treatment Authorization Request*) to monitor antipsychotic medication use for all Medi-Cal children and adolescents 0-17 years of age
- Edits in place (age restrictions) for use of stimulants

Educational Outreach Summary

- DHCS published and distributed seven (7) Medi-Cal educational bulletins and alerts
- In addition, providers were identified for education on specific issues based on prescribing characteristics and received intervention letters. Topics addressed included:
  - Additive toxicity
  - Morphine Equivalent Daily Dose (MEDD)
  - Tramadol use in beneficiaries < 18 years of age
  - Codeine use in beneficiaries < 18 years of age
  - Zolpidem

State of California
MEDICAID DRUG UTILIZATION REVIEW

Centers for Medicare & Medicaid Services
Federal Fiscal Year 2019

ANNUAL REPORT
FEDERAL FISCAL YEAR 2019

This report covers the period
October 1, 2018 to September 30, 2019

Department of Health Care Services

Prepared by

Under the direction of the Medi-Cal Pharmacy Benefits Division
and the Global Medi-Cal Drug Use Review Board

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Global Medi-Cal
Drug Use Review (DUR) Program
Federal Fiscal Year (FFY) 2019 Annual Report
October 1, 2018 to September 30, 2019

TABLE OF CONTENTS

I. Centers for Medicare & Medicaid Survey…….. 1

II. Attachments

Attachment 1: Pharmacy Oral Counseling Compliance Report…….. 25

Attachment 2: Retrospective DUR Educational Outreach Summary... 26

Attachment 3: Summary of DUR Board Activities…….…. 33

Attachment 4: Generic Drug Substitution Policies …….……...…. 41

Attachment 5: Cost Savings/Cost Avoidance Methodology……..… 44

Attachment 6: Innovative Practices ……,……..... 45

Attachment 7: E-Prescribing Activity Summary…….…..... N/A

Attachment 8: Executive Summary……..……..……. 47

III. Tables

Table 1: Top Drug Claims Data Reviewed by the DUR Board……..... 48

Table 2: Generic Utilization Data…….……..…. 49

CMS SURVEY

I. DEMOGRAPHIC INFORMATION

State Name Abbreviation: CA

Medicaid Agency Information: Identify State person responsible for DUR Annual Report Preparation.

Name: Ivana Thompson, PharmD
Email Address: Ivana.Thompson@dhcs.ca.gov
Area Code/Phone Number: (916) 345-8642

1. On average, how many beneficiaries are enrolled in your state's Medicaid Fee-for-Service (FFS) program that have a pharmacy benefit? 2,294,983 beneficiaries

2. On average, how many of your state's Medicaid beneficiaries are enrolled in managed care plan(s)? 10,559,452 beneficiaries

II. PROSPECTIVE DUR (ProDUR)

1. Identify by name and indicate the type of your pharmacy POS vendor - (contractor, state-operated, or other organization).

   Contractor: Conduent

2. If not state-operated, is the POS vendor also the MMIS fiscal agent?

   ☒Yes ☐No

3. Identify prospective DUR criteria source.

   ☒ First Data Bank ☐Medi-Span ☐Other

   If the answer above is "Other," please specify:

   _____

4. Are new ProDUR criteria approved by the DUR Board?

   ☐Yes ☒No

   If answer above is "No," please explain:

   The DUR Board advises and makes recommendations regarding prospective DUR criteria; however, final approval is made by DHCS.

5. When the pharmacist receives a level-one ProDUR alert message that requires a pharmacist's review, does your system allow the pharmacist to override the alert using the "NCPDP drug use evaluation codes" (reason for service, professional service, and resolution)?

☒Yes ☐No ☐Partial

If you answered "partial," please explain:

_____

6. Do you receive and review follow-up periodic reports providing individual pharmacy provider activity in summary and/or in detail?

☒Yes ☐No

a) If the answer is "Yes," how often?

☐ Monthly ☐ Quarterly ☒ Annually ☐ Other, please explain.

_____

b) If the answer above is "No," please explain.

_____

c) If you receive reports, do you follow-up with those providers who routinely override with interventions?

☒Yes ☐No

d) If the answer to (6c) above is "Yes," by what method do you follow-up?

☒ Contact Pharmacy
☐ Refer to Program Integrity for Review
☐ Other, please explain.

_____

e) If the answer to (6c) above is "No," please explain why you do not follow-up with providers.

_____

7. Early Refill:

a) At what percent threshold do you set your system to edit?

Non-controlled drugs: 75%
Schedule II Controlled drugs: 75%
Schedule III through V Controlled drugs: 75%

b) When an early refill message occurs, does the state require prior authorization?

Non-controlled drugs: ☐Yes ☒No

c) When an early refill message occurs, does the state require prior authorization?

Controlled drugs: ☐Yes ☒No

d) For non-controlled drugs, if the answer to (7b) above is "Yes," who obtains authorization?

☐ Pharmacist ☐ Prescriber ☐ Either

e) For controlled drugs, if the answer to (7c) above is "Yes," who obtains authorization?

☐ Pharmacist ☐ Prescriber ☐ Either

f) For non-controlled drugs, if the answer to (7b) above is "No," can the pharmacist override at the point of service?

☒Yes ☐No

g) For controlled drugs, if the answer to (7c) above is "No," can the pharmacist override at the point of service?

☒Yes ☐No

8. When the pharmacist receives an early refill DUR alert message that requires the pharmacist's review, does your state's policy allow the pharmacist to override for situations such as:

a) Lost/stolen Rx ☒Yes ☐No
b) Vacation ☒Yes ☐No
c) Other, please explain. The pharmacist can override the early refill DUR alert message if medically necessary.

9. Does your system have an accumulation edit to prevent patients from continuously filling prescriptions early?

☐Yes ☒No

a) If "Yes," please explain your edit.

_____

b) If "No," do you plan to implement this edit? ☐Yes ☒No

10. Does the state Medicaid agency or the state's Board of Pharmacy have any policy prohibiting the auto-refill process that occurs at the POS (i.e., must obtain beneficiary's consent prior to enrolling in the auto-refill program)?

☐Yes ☒No

11. Does the state Medicaid agency have any policy that provides for the synchronization of prescription refills (i.e., if the patient wants and pharmacy provider permits the patient to obtain non-controlled, chronic medication refills at the same time, the state would allow this to occur to prevent the beneficiary from making multiple trips to the pharmacy within the same month)?

☐Yes ☒No

12. Has the state provided DUR data requested on **Table 1 – Top Drug Claims Data Reviewed by the DUR Board?**

☒Yes ☐No

13. Section 1927(g)(A) of the Social Security Act requires that the pharmacist offer patient counseling at the time of dispensing. Who in your state has responsibility for monitoring compliance with the oral counseling requirement? Check all that apply:

a) ☐ Medicaid agency
b) ☒ State Board of Pharmacy
c) ☐ Other, please explain.

_____

14. Has the state included **Attachment 1 – Pharmacy Oral Counseling Compliance Report**, a report on state efforts to monitor pharmacy compliance with the oral counseling requirement?

☒Yes ☐No

III. RETROSPECTIVE DUR (RetroDUR)

1. Identify, by name and type, the vendor that performed your Retro DUR activities during the time period covered by this report (company, academic institution, or other organization).

Academic institution: University of California, San Francisco (UCSF)

2. Who reviews and approves the RetroDUR criteria?

☐ State DUR board ☒ Other

If "Other," please explain:

Retrospective DUR criteria are developed jointly by UCSF and DHCS with input and recommendation by the DUR board. Final approval of criteria is made by DHCS.

3. Has the state included **Attachment 2 -Retrospective DUR Educational Outreach Summary**, a year end summary of the Top 10 problem types for which educational interventions were taken?

☒Yes ☐No

IV. DUR BOARD ACTIVITY

1. Has the state included a brief summary of DUR Board activities during the time period covered by this report as **Attachment 3 – Summary of DUR Board Activities**?

☒Yes ☐No

2. Does your state have an approved CMS Medication Therapy Management Program?

☐Yes ☒No

a) If "Yes", have you performed an analysis of the program's effectiveness?

☐Yes ☐No

b) If the answer to (2a) above is "Yes", please provide a brief summary of your findings:

_____

c) If the answer to (number 2) above is "Yes," is your DUR Board involved with this program?

☐Yes ☐No

d) If the answer to (number 2) above is "No," are you planning to develop and implement a program?

☒Yes ☐No

V. PHYSICIAN ADMINISTERED DRUGS

The Deficit Reduction Act required collection of NDC numbers for covered outpatient physician administered drugs. These drugs are paid through the physician and hospital programs. Has your MMIS been designed to incorporate this data into your DUR criteria for:

1. ProDUR?

☐Yes ☒No

If "No," do you have a plan to include this information in your DUR criteria in the future?

☐Yes ☒No

2. RetroDUR?

☒Yes ☐No

If "No," do you have a plan to include this information in your DUR criteria in the future?

☐Yes ☐No

VI. GENERIC POLICY AND UTILIZATION DATA

1. Has the state included a description of policies that may affect generic utilization percentage as **Attachment 4 - Generic Drug Substitution Policies**?

☒Yes ☐No

2. In addition to the requirement that the prescriber write in his own handwriting "Brand Medically Necessary" for a brand name drug to be dispensed in lieu of the generic equivalent, does your state have a more restrictive requirement?

☒Yes ☐No

If "Yes", check all that apply:

a) ☐ Require that a MedWatch Form be submitted
b) ☐ Require medical reason for override accompany prescriptions
c) ☐ Prior authorization is required
d) ☒ Other, please explain.

If a brand name drug does not appear on the Medi-Cal List of Contract Drugs, an approved *Treatment Authorization Request* demonstrating medical necessity may be required before dispensing.

3. Indicate the generic utilization percentage for all covered outpatient drugs paid during this reporting period, using the computation instructions in **Table 2 – Generic Utilization Data**.

   Number of Generic Claims: 7,226,221

   Total Number of Claims: 10,053,842

   Generic Utilization Percentage: 71.9%

4. Indicate the percentage dollars paid for generic covered outpatient drugs in relation to all covered outpatient drug claims paid during this reporting period using the computation instructions in **Table 2 - Generic Utilization Data**.

   Generic Dollars: $240,267,858

   Total Dollars: $3,536,418,863

   Generic Expenditure Percentage: 6.8%

VII. PROGRAM EVALUATION/COST SAVINGS/COST AVOIDANCE

1. Did your state conduct a DUR program evaluation of the estimated cost savings/cost avoidance?

   ☒Yes ☐No

2. Who conducted your program evaluation for the cost savings estimate/cost avoidance (company, academic institution, other institution) and (name of the entity)?

   Academic institution: University of California, San Francisco (UCSF)

3. Please provide your ProDUR and RetroDUR program cost savings/cost avoidance in the chart below.

ProDUR Total Estimated Avoided Costs	$217,616,344
RetroDUR Total Estimated Avoided Costs	$0
Other cost avoidance	$0
Grand Total estimated Avoided Costs	**$217,616,344**

4. Please provide the estimated percent impact of your state's cost savings/cost

avoidance program compared to total drug expenditures for covered outpatient drugs.

Use the following formula:

Divide the estimated Grand Total Estimated Avoided Costs from Question 3 above by the total dollar amount provided in Section VI, Question 4. Then multiply this number by 100.

Grand Estimated Net Savings Amount ÷ Total Dollar Amount × 100 = **6.2%**
($217,616,344 ÷ $3,536,418,863 × 100 = 6.2%)

5. State has provided the Medicaid Cost Savings/Cost Avoidance Evaluation as **Attachment 5 – Cost Savings/Cost Avoidance Methodology**.

☒Yes ☐No

VIII. FRAUD, WASTE, AND ABUSE DETECTION

A. LOCK-IN or PATIENT REVIEW AND RESTRICTIVE PROGRAMS

1. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **beneficiaries**?

☒Yes ☐No

If "Yes," what action(s) does this process initiate? Check all that apply.

a) ☐ Deny claim and require prior authorization
b) ☐ Refer recipient to Lock In Program
c) ☐ Refer to Program Integrity Unit
d) ☒ Other (e.g. SURS, Office of Inspector General), please explain.

22CCR §50793 details available utilization restrictions when the Department has determined that a beneficiary is misusing or abusing Medi-Cal benefits, including being subjected to one or more of the following forms of utilization restriction:

(1) Prior authorization for all Medi-Cal services.
(2) Prior authorization for specific Medi-Cal services.
(3) Restriction to utilization of a specific, beneficiary- or Department-selected pharmacy.
(4) Restriction to a specific, beneficiary- or Department-selected primary provider of medical services.

Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process

for complaints which entails an initial case review and if warranted, assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.

2. Do you have a "lock-in" program for beneficiaries with potential misuse or abuse of controlled substances?

☐Yes ☒No

a) If "Yes", what criteria does your state use to identify candidates for lock-in? Check all that apply.

☐ Number of controlled substances (CS)
☐ Different prescribers of CS
☐ Multiple pharmacies
☐ Number days' supply of CS
☐ Exclusivity of short acting opioids
☐ Multiple ER visits
☐ PDMP data
☐ Other, please explain.

_____

b) If "Yes" do you restrict the beneficiary to:

- prescriber only ☐Yes ☐No
- pharmacy only ☐Yes ☐No
- prescriber and pharmacy ☐Yes ☐No

c) If the answer to (number 2) above is "Yes," what is the usual "lock-in" time period?

☐ 12 months
☐ 18 months
☐ 24 months
☐ Other, please explain.

_____

3. If the answer to (number 2) above is "Yes," on average, what percentage of the FFS population is in lock-in status annually? _____%

4. If the answer to (number 2) above is "Yes," please provide an estimate of the savings attributed to the lock-in program for the fiscal year under review as part of Attachment 5.

$_____

5. Do you have a documented process in place that identifies possible fraud or abuse of controlled drugs by **prescribers**?

☒Yes ☐No

If "Yes," what actions does this process initiate? Check all that apply.

a) ☒ Deny claims written by this prescriber
b) ☒ Refer to Program Integrity Unit
c) ☐ Refer to the appropriate Medical Board
d) ☒ Other, please explain.

Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving possible fraud or abuse of controlled drugs by prescribers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and – if warranted – assignment of a case to an investigator/auditor.

Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and prescribing trends. Current utilization controls include suspended provider lists, provider sanctions for a specified time period, provider sanctions from prescribing select medications, contracted drug list compliance, code 1 restrictions, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.

6. Do you have a documented process in place that identifies potential fraud or abuse of controlled drugs by **pharmacy providers**?

☒Yes ☐No

If "Yes," what actions does this process initiate? Check all that apply.

a) ☐ Deny claim
b) ☒ Refer to Program Integrity Unit
c) ☐ Refer to Board of Pharmacy
d) ☒ Other, please explain.

Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working cases involving potential fraud or abuse of controlled drugs by pharmacy providers. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and – if warranted – assignment of a case to an investigator/auditor.

Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and pharmacy dispensing trends. Current utilization controls

include suspended pharmacy provider lists, restrictions placed upon individual pharmacist licenses by the State Board of Pharmacy, contracted drug list compliance, code 1 restrictions documentation, treatment authorization requests, maximum dispensing quantity restrictions, and maximum dispensing restrictions during a specified time period.

7. Do you have a documented process in place that identifies potential fraud or abuse of non-controlled drugs by **beneficiaries**?

☒Yes ☐No

If "Yes," please explain your program for fraud, waste, or abuse of non-controlled substances.

Audit & Investigations, Medical Review Branch (MRB), Special Investigative Unit (SIU) or Investigations Branch (IB) is responsible for working potential fraud or abuse of non-controlled drugs by beneficiaries. MRB, SIU, and IB has an intake process for complaints that entails an initial case review and – if warranted – assignment of a case to an investigator/auditor. Subsequent actions are dependent upon the outcome of the investigation, which looks at claims data and trends.

B. PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

1. Does your state have a Prescription Drug Monitoring Program (PDMP)?

☒Yes ☐No

a) If the answer above is "Yes" does your agency have the ability to query the state's PDMP database?

☒Yes ☐No

b) If the answer to (number 1) above is "Yes", do you require prescribers (in your provider agreement with the agency) to access the PDMP patient history before prescribing restricted substances?

☐Yes ☒No

c) If the answer to (number 1a) above is "Yes", please explain how the state applies this information to control fraud and abuse.

The California Department of Justice has a Prescription Drug Monitoring Program (PDMP) system called the Controlled Substance Utilization Review and Evaluation System (CURES), which allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances,

pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access timely patient controlled substance history information.

Access to such information helps prescribers and pharmacists better evaluate their patients' care, allowing them to make better prescribing and dispensing decisions, and cut down on prescription drug abuse in California.

Audit & Investigations, Investigations Branch (IB) uses all available information to develop and work cases, initiates audits, and assists in investigations. IB also examines PDMP information on prescribers, dispensers, and beneficiaries during the course of their usual work.

d) If the answer to (number 1a) above is "Yes", do you also have access to border states' PDMP information?

☐Yes ☒No

e) If the answer to (number 1a) above is "Yes", do you also have PDMP data (i.e., outside of MMIS, such as a controlled substance that was paid for by using cash) integrated into your POS edits?

☐Yes ☒No

f) If the answer to (number 1) above is "Yes", are there barriers that hinder the agency from fully accessing the PDMP that prevent the program from being utilized the way it was intended to be to curb abuse?

☒Yes ☐No

g) If the answer to (f) above is "Yes", please explain the barriers (i.e., lag time in prescription data being submitted, prescribers not accessing, pharmacists unable to view prescription history before filling script).

The following barriers exist that hinder the agency from fully accessing the PDMP in the way it was intended:

- Inability to access border states' PDMP information
- Lag time for prescription data being submitted
- Ambiguous regulations governing access to PDMP data

2. Have you had any changes to your state's Prescription Drug Monitoring Program during this reporting period that have improved the agency's ability to access PDMP data?

☒Yes ☐No

If "Yes" please explain.

Effective for dates of service on or after October 2, 2018, it is now mandatory to consult the CURES 2.0 database prior to prescribing, ordering, administering, or furnishing a Schedule II – IV controlled substance.

C. PAIN MANAGEMENT CONTROLS

1. Does your program obtain the DEA Active Controlled Substance Registrant's File in order to identify prescribers not authorized to prescribe controlled drugs?

☐Yes ☒No

a) If the answer above is "Yes," do you apply this DEA file to your ProDur POS edits to prevent unauthorized prescribing?

☐Yes ☐No

b) If the answer to (a) above is "Yes," please explain how the information is applied

_____

c) If the answer to (a) above is "No" do you plan to obtain the DEA Active Controlled Substance Registrant's file and apply it to your POS edits?

☐Yes ☐No

2. Do you apply this DEA file to your RetroDUR reviews?

☐Yes ☒No

If "Yes" please explain how it is applied.

_____

3. Do you have a measure (i.e., prior authorization, quantity limits) in place to either monitor or manage the prescribing of methadone for pain management?

☒Yes ☐No

If "No," please explain why you do not have a measure in place to either manage or monitor the prescribing of methadone for pain management.

_____

D. OPIOIDS

1. Do you currently have POS edits in place to limit the quantity dispensed of an initial opioid prescription?

   ☐ Yes for all opioids ☒ Yes for some opioids ☐ No for all opioids

   a) If there is more than one quantity limit for the various opioids please explain.

      Opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.

   b) What is the maximum number of days allowed for an initial opioid prescription?

      _100_ # of days

   c) If you have different days allowed for the initial limit for the various opioids, please explain.

   _____

2. For subsequent prescriptions, do you have POS edits in place to limit the quantity dispensed of short-acting opioids?

   ☒ Yes ☐ No

   a) If "Yes" what is your maximum days supply per prescription limitation?

      ☐ 30 day supply
      ☐ 90 day supply
      ☒ Other, please explain: Short-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.

3. Do you currently have POS edits in place to limit the quantity of long-acting opioids?

   ☒ Yes ☐ No

   a) If "Yes" what is your maximum days supply per prescription limitation?

      ☐ 30 day supply
      ☐ 90 day supply
      ☒ Other, please explain: Long-acting opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.

4. Do you have measures other than restricted quantities and days supply in place to either monitor or manage the prescribing of opioids?

☒Yes ☐No

a) If "Yes," please check all that apply:

☐ Pharmacist override
☐ Deny claim and require PA
☒ Intervention letters
☐ Morphine equivalent daily dose (MEDD) program
☐ Step therapy or Clinical criteria
☐ Requirement that patient has a pain management contract or Patient-Provider agreement
☐ Requirement that prescriber has an opioid treatment plan for patients
☐ Require documentation of urine drug screening results
☒ Other, please explain what additional opioid prescribing controls are in place: California has a Statewide Opioid Safety (SOS) Workgroup to improve coordination and expand joint efforts to address opioid misuse, addiction, and overdose deaths.

b) If the answer to (number 4) above is "No," please explain what you do in lieu of the above or why you do not have measures in place to either manage or monitor the prescribing of opioids.

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5. Do you currently have edits in place to monitor opioids and benzodiazepines being used concurrently?

☒Yes ☐No

If "Yes" please explain.

Effective June 1, 2018, the Medi-Cal fee-for-service prospective DUR system was updated to generate an alert for additive toxicity (AT) when a patient reaches a threshold of four active prescriptions within the following therapeutic categories: opioid pain or cough medications, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with central nervous system (CNS) depressant properties.

6. Do you perform any RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of opioid use disorder (OUD) or opioid poisoning diagnosis?

☒Yes ☐No

a) If the answer to (number 6) above is "Yes," please indicate how often.

☐ Monthly ☐ Quarterly ☒ Annually ☐ Other, please explain.

_____

b) If the answer to (number 6) above is "No," do you plan on implementing a RetroDUR activity and/or provider education in regard to beneficiaries with a diagnosis history of OUD or opioid poisoning in the future?

☐Yes ☐No

7. Does your state Medicaid agency develop and provide prescribers with pain management or opioid prescribing guidelines?

☒Yes ☐No

a) ☒ Does your state Medicaid agency refer prescribers to the CDC's Guideline for Prescribing Opioids for Chronic Pain?
b) ☒ Other guidelines
c) ☐ No guidelines are offered
d) ☐ Please identify "other" or "referred" guidelines:
The Medical Board of California Guidelines for Prescribing Controlled Substances for Pain.

8. Do you have a drug utilization management strategy that supports abuse deterrent opioid use to prevent opioid misuse and abuse (i.e. presence of an abuse deterrent opioid with preferred status on your preferred drug list)?

☒Yes ☐No

If "Yes," please explain.

Effective August 1, 2017, multiple strengths of morphine sulfate/naltrexone were added to the Medi-Cal List of Contract Drugs.

E. MORPHINE EQUIVALENT DAILY DOSE (MEDD)

1. Have you set recommended maximum morphine equivalent daily dose measures?

☐Yes ☒No

a) If "Yes," what is your maximum morphine equivalent daily dose limit in milligrams?

_____mg per day

b) If "Yes," please explain (i.e. are you in the process of tapering patients to achieve

this limit)?

c) If "No," please explain the measure or program you utilize.

All opioids have an established maximum quantity per dispensing and a maximum of three (3) dispensings within any 75-day period.

2. Do you provide information to your prescribers on how to calculate the morphine equivalent daily dosage or do you provide a calculator developed elsewhere?

☒Yes ☐No

Please name the developer of the calculator: 1) the New York City Department of Health and Mental Hygiene (DOHMH); 2) the Washington State Agency Medical Directors' Group; and 3) the Centers for Disease Control and Prevention

If "Yes" how is the information disseminated?

☐ Website
☐ Provider notice
☐ Educational seminar
☒ Other, please explain.

In February 2019, the Medi-Cal DUR program published an educational bulletin entitled, "*Clinical Review Update: Morphine Equivalent Daily Dose"* to the Medi-Cal DUR website. This bulletin defined morphine equivalent daily dose (MEDD) and provided evidence to support using MEDD as an indicator of potential dose-related risk for prescription opioid overdose. The bulletin provided links to several online MEDD calculators, as well as additional resources to providers. The bulletin was also emailed to all providers who subscribe to the Medi-Cal Subscription Service.

3. Do you have an algorithm in your POS system that alerts the pharmacy provider that the morphine equivalent daily dose prescribed has been exceeded?

☐Yes ☒No

If "Yes," do you require prior authorization if the MEDD limit is exceeded?

☐Yes ☐No

F. BUPRENORPHINE and BUPRENORPHINE/NALOXONE COMBINATIONS

1. Does your agency set total mg per day limits on the use of buprenorphine and buprenorphine/naloxone combination drugs?

☒Yes ☐No

If "Yes", please specify the total mg/day?

☐ 12 mg
☐ 16 mg
☐ 24 mg
☒ Other, please explain: There is a maximum quantity of four dosage units per day, regardless of strength. The maximum allowable total daily dose is 48 mg.

2. What are your limitations on the allowable length of this treatment?

☐ 6 months
☐ 12 months
☒ No limit
☐ Other, please explain.

3. Do you require that the maximum mg per day allowable be reduced after a set period of time?

☐Yes ☒No

a) If "Yes," what is your reduced (maintenance) dosage?
☐ 8 mg
☐ 12 mg
☐ 16 mg
☐ Other, please explain.

_____

b) If "Yes," what are your limitations on the allowable length of the reduced dosage treatment?

☐ 6 months
☐ 12 months
☐ No limit
☐ Other, please explain.

4. Do you have at least one preferred buprenorphine/naloxone combination product available without prior authorization?

☒Yes ☐No

5. Do you currently have edits in place to monitor opioids being used concurrently with any buprenorphine drug?

☐Yes ☒No ☐ Other, please explain.

If "Yes," can the POS pharmacist override the edit?

☐Yes ☐No

6. Do you have at least one naloxone opioid overdose product available without prior authorization?

☒Yes ☐No

7. Does your state board of pharmacy and/or state Medicaid agency allow pharmacists to dispense naloxone prescribed independently or by collaborative practice agreements, standing orders, or other predetermined protocols?

☒Yes ☐No

8. Does your state agency cover Methadone for a substance use disorder (i.e. Methadone Treatment Center)?

☒Yes ☐No

G. ANTIPSYCHOTICS/STIMULANTS

ANTIPSYCHOTICS

1. Do you currently have restrictions in place to limit the quantity of antipsychotics?

☐Yes ☒No

If restriction is other than quantity limit, please explain.
An approved *Treatment Authorization Request* is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 – 17 years of age. An approved *Treatment Authorization Request* is also required for beneficiaries residing in skilled nursing facilities (SNFs).

2. Do you have a documented program in place to either manage or monitor the appropriate use of antipsychotic drugs in children??

☒Yes ☐No

a) If "Yes," do you either manage or monitor:

☐ Only children in foster care

☒ All children
☐ Other, please explain.

---

b) If "Yes," do you have edits in place to monitor (check all that apply):

☒ Child's Age ☒ Dosage ☒ Polypharmacy ☒ Other

Please briefly explain the specifics of your antipsychotic monitoring program(s).

An approved *Treatment Authorization Request* is required for any antipsychotic medication for all Medi-Cal beneficiaries 0 – 17 years of age.

In addition, DHCS Pharmacy Benefits Division, DHCS Behavioral Health Division, and California Department of Social Services (CDSS) continue to collaborate on a Quality Improvement Project entitled, "Improving the Use of Psychotropic Medication among Children and Youth in Foster Care." The purpose of this program is to reduce the rate of antipsychotic polypharmacy, improve the rate of compliance with age-specific antipsychotic dose recommended guidelines, and improve the rate of children and youth in foster care with at least one psychotropic medication who have an annual metabolic risk assessment. The goals are to reduce polypharmacy and improve compliance with dosing guidelines and annual metabolic risk assessment.

c) If you do not have an antipsychotic monitoring program in place, do you plan on implementing a program in the future?

☐ Yes ☐ No

d) If "No," please explain why you will not be implementing a program to monitor the appropriate use of antipsychotic drugs in children.

STIMULANTS

3. Do you currently have restrictions in place to limit the quantity of stimulants?

☐ Yes ☒ No

4. Do you have any documented program in place to either manage or monitor the appropriate use of stimulant drugs in children?

☒ Yes ☐ No

a) If "Yes," do you either manage or monitor:

☐ Only children in foster care
☒ All children
☐ Other, please explain.

b) If "Yes," do you have edits in place to monitor (check all that apply):

☒ Child's Age ☐ Dosage ☐ Polypharmacy ☒ Other

Please briefly explain the specifics of your antipsychotic monitoring program(s).

The use of stimulants for Medi-Cal beneficiaries is restricted to use in Attention Deficit Disorder in individuals from 4 years through 16 years of age only. Any use outside of these restrictions requires an approved *Treatment Authorization Request*.

c) If you do not have a documented stimulant monitoring program in place, do you plan on implementing a program in the future?

☐Yes ☐No

d) If "No," please explain why you will not be implementing a program to monitor the appropriate use of stimulant drugs in children.

IX. INNOVATIVE PRACTICES

Have you developed any innovative practices during the past year which you have included in **Attachment 6 - Innovative Practices** (i.e., Substance Use Disorder, Hepatitis C, Cystic Fibrosis, MEDD, Value Based Purchasing)?

☒Yes ☐No

X. E-PRESCRIBING

1. Does your MMIS or pharmacy vendor have a portal to electronically provide patient drug history data and pharmacy coverage limitations to a prescriber prior to prescribing upon inquiry?

☐Yes ☒No

a) If "Yes," do you have a methodology to evaluate the effectiveness of providing drug information and medication history prior to prescribing?

☐Yes ☐No

b) If "Yes," please explain the evaluation methodology in **Attachment 7 – E-Prescribing Activity Summary**.

c) If the answer to (number 1) above is "No," are you planning to develop this capability?

☐Yes ☒No

2. Does your system use the NCPDP Origin Code that indicates the prescription source?

☐Yes ☒No

XI. MANAGED CARE ORGANIZATIONS (MCOs)

1. How many MCOs are enrolled in your state Medicaid program?

__26__ MCO(s) (Insert number of MCOs in the blank including 0 if none)

If "Zero" or "None," please skip the rest of this section.

2. Is your pharmacy program included in the capitation rate (carved in)?

☐Yes ☐No ☒Partial

If "partial," please specify the drug categories that are carved out.

- Selected HIV/AIDS/Hepatitis B treatment drugs;
- Selected alcohol and heroin detoxification and dependency treatment drugs;
- Selected coagulation factors; and
- Selected drugs used to treat psychiatric conditions (including antipsychotics and MAO inhibitors)

3. Does the state set requirements for the MCO's pharmacy benefit (i.e., same PDL, same ProDUR/RetroDUR)?

☒Yes ☐No

If "Yes," do please check all requirements that apply below:

☒ Formulary Reviews ☐ Same PDL ☐ Same ProDUR ☐ Same RetroDUR

If "Yes," please briefly explain your policy:

Medi-Cal MCOs are required to provide a pharmacy benefit that is comparable to the Medi-Cal FFS pharmacy program and their preferred drug lists (PDLs) are required to be comparable to the Medi-Cal List of Contract Drugs. While all drugs included on the Medi-Cal List of Contract Drugs do not need to be included on the MCOs' PDLs, comparable means that the drugs on the PDLs must have the same mechanism of action sub-class within all major therapeutic categories of drugs included in the Medi-Cal List of Contract Drugs.

Starting in FFY 2018, the DUR Board expanded to become the Global Medi-Cal DUR Board, with MCO representatives now included as Board members. MCOs utilize the Global Medi-Cal DUR Board and educational components of the Medi-Cal DUR program. However, MCOs maintain their current proprietary claims processing procedures and protocols and MCPs individually administer the systematic components related to the prospective and retrospective DUR processes. As is the case with the Fee-For-Service (FFS) program, MCOs are not required to implement all DUR Board recommended actions, nor are they required to mirror the Medi-Cal DUR activities.

If "No," do you plan to set standards in the future?

☐Yes ☐No

4. Did all of your managed care plans submit their DUR reports?

☒Yes ☐No

If "No," please explain why.

_____

XII. EXECUTIVE SUMMARY - Attachment 8 – Executive Summar

ATTACHMENT 1 – PHARMACY ORAL COUNSELING COMPLIANCE REPORT

Monitoring Pharmacy Compliance with OBRA 1990 DUR Requirements

California pharmacy regulations require pharmacies to maintain patient medication profiles and counsel patients regarding their prescription medication before dispensing. Consultation provides the pharmacist with the opportunity to educate patients who present new prescriptions and protect them from potential problems associated with a new medication by discussing possible side effects, contraindications and the importance of following directions. Consultation also provides the pharmacist one more opportunity to prevent dispensing errors by inspecting the medication container's contents to assure that the proper drug is dispensed.

Compliance to these requirements is the responsibility of the California Department of Consumer Affairs, Board of Pharmacy, which compiles annual reports that are available at: https://www.dca.ca.gov/publications/annual_reports.shtml.

As part of its ongoing activities, the California Board of Pharmacy investigates complaints involving care provided in pharmacies. The California Board of Pharmacy typically will inspect the pharmacy in question at the start of each complaint investigation. Other inspections the Board performs include but are not limited to initial licensure, changes in ownership, change in location or a remodel, or simply a random inspection. A major function of an inspector's activities during these inspections is education of licensees regarding compliance with laws and regulations.

When an inspector, who is a licensed pharmacist, visits a pharmacy to investigate a complaint or inspect a pharmacy, the inspector observes whether patient consultation is occurring and specifically notes the progress and components of the consultations; e.g., the temporal relationship between review of the patient profile and the consultation. Failure to consult or perform prospective drug utilization review prior to consultation results in a "correction ordered" and, possibly, a notice of violation. To ensure compliance, inspectors revisit pharmacies and follow up on correction notices. Violation notices usually result in the pharmacist, pharmacist-in-charge, and pharmacy management meeting with a subcommittee of the Board to discuss the violation.

The above-referenced Board of Pharmacy regulations were determined previously by the Centers for Medicare & Medicaid Services, in order to comply with the prospective DUR requirements of OBRA 90.

A specific report about compliance with oral counseling requirements is not available from the California State Board of Pharmacy. As described by this Board, they typically evaluate compliance whenever a pharmacy is brought to the Board’s attention through issues of fraud or abuse or a complaint of any sort. Verification of oral counseling is contained within these reports (made to various state and federal agencies) and is not separated out.

ATTACHMENT 2 – RETROSPECTIVE DUR EDUCATIONAL OUTREACH SUMMARY

DHCS publishes and distributes Medi-Cal educational bulletins and alerts to all Medi-Cal providers. In addition, providers are identified for education on specific issues based on characteristics of their prescribing and receive intervention letters. Providers who receive an intervention letter are requested to complete and return a response survey. Medi-Cal educational bulletins are available to the public on the Medi-Cal DUR website at: http://files.medi-cal.ca.gov/pubsdoco/dur/edarticles.asp.

1. Alert: New Naloxone Regulations Effective on January 1, 2019 – January 2019

Summary: This educational alert reviewed California Assembly Bill 2760 (Wood, Chapter 324) that was signed into law in 2018 and became effective on January 1, 2019. AB 2760 requires California prescribers to offer a prescription to a patient for either naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid-induced respiratory depression, as a rescue medication under certain conditions.

2. Clinical Review Update: Morphine Equivalent Daily Dose – February 2019

Summary: This educational bulletin reviewed the morphine equivalent daily dose (MEDD) and how it is being used to indicate potential dose-related risk for prescription opioid overdose. This article also summarized best practices for prescribing opioids, identified resources available that promote responsible opioid prescribing, and described recent state legislation related to prescription opioids.

3. Drug Safety Communication: Updated Adverse Effects from Fluoroquinolone Antibiotics – March 2019

Summary: This educational alert summarized an FDA warning based on epidemiological studies and cases from the FDA Adverse Event Reporting System (FAERS) database that found fluoroquinolone antibiotics could increase the occurrence of rare but serious events of aortic dissections or ruptures of an aortic aneurysm, which can lead to dangerous bleeding or even death. The FDA is requiring inclusion of these new risks in the prescribing information and patient Medication Guide for all fluoroquinolones.

4. Drug Safety Communication: Risks with Sudden Discontinuation of Opioids – April 2019

Summary: This educational alert was based on an FDA warning of 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. Examples of serious harm include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide. The FDA is requiring expanded guidance within the prescribing information of opioids that are intended for use in the outpatient setting on how to safely decrease the dose in patients who are physically dependent on opioids.

5. Drug Safety Communication: Sleep Behavior Risks with Select Sleep Aids – June 2019

Summary: This educational alert was based on an FDA announcement regarding 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. While rare, these complex sleep behaviors have resulted in serious injuries and death. Safety label changes include a Boxed Warning added to the prescribing information and patient Medication Guides and a Contraindication to avoid use of these drugs in patients who have previously experienced a complex sleep behavior with the use of eszopiclone, zaleplon, and zolpidem.

6. Clinical Review Update: Concomitant Anticholinergic and Antipsychotic Use – August 2019

Summary: This educational bulletin focused on understanding the role of anticholinergic medications in the prevention and treatment of antipsychotic-induced extrapyramidal symptoms (EPS). The bulletin also describes factors that should be considered when deciding to initiate and/or continue the concomitant use of anticholinergic with antipsychotic medication therapy.

7. 2019 Immunization Updates: Flu, HepA, HPV, Measles, CA School Requirements – September 2019

Summary: This educational bulletin is an annual publication provided by the DUR program to provide updates on immunization guidelines, products, policy and/or research each year. Links to recommended immunization schedules for 2019 in the United States are also provided. The summary for 2019 included updates for influenza vaccine, Hepatitis A (HepA) vaccine, human papillomavirus (HPV) vaccine, and measles, as well as a review of changes in vaccination requirements for California schools.

The Medi-Cal DUR program also sends educational intervention letters to selected providers and pharmacies on certain topics in conjunction with the educational bulletins. The purpose of the educational intervention letters is to improve the quality of care of Medi-Cal beneficiaries. Providers are informed of the goal of each intervention and receive educational materials, along with suggested recommendations for action. A response survey is included with each letter to promote dialogue between the Medi-Cal DUR program and the providers and pharmacies. In FFY 2019, the following five mailings were sent to providers:

1. Additive Toxicity (AT) Alert Letter – January 2019

Objectives:
- To identify beneficiaries at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants.
- To help inform health care providers and patients of the serious risks attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics.

Methods: The study population included 31 beneficiaries who were continuously eligible in the Medi-Cal fee-for-service program between October 1, 2018, and January 31, 2019. Each beneficiary generated an AT alert with pharmacist override during December 2018 and had at least one paid claim for both an opioid and a benzodiazepine, as well as paid claims for at least two additional CNS depressants between October 1, 2018, and December 31, 2018. Those with claims with practice locations including SNF, ICF, home health, and hospice, and diagnostic codes indicating palliative care or cancer treatment were excluded. A total of 67 prescribers were identified for educational outreach letters, which were mailed on January 18, 2019. Any paid claims for gabapentin during the same time period were also included on patient profiles.

2. MEDD Letter – April 2019

Objective:
- To educate providers about morphine equivalent daily dose (MEDD) thresholds and updated legislation regarding prescribing opioids in California.

Methods: 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.

3. Tramadol Letter – July 2019

Objective:
- To inform health care providers and patients of the serious risks attributed to

prescribing tramadol to patients younger than 18 years of age.

Methods: 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.

4. Codeine Letter – August 2019

Objective:

- To inform health care providers and patients of the serious risks attributed to prescribing codeine to patients younger than 18 years of age.

Methods: 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.

5. Zolpidem Letter – August 2019

Objective:

- To determine whether there was inappropriate use of zolpidem products, based on FDA warnings that female patients have lower clearance rates than males.

Methods: Educational outreach letters were mailed on August 20, 2019, to the top 100 prescribers of zolpidem in the Medi-Cal fee-for-service 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.

ATTACHMENT 3 – SUMMARY OF DUR BOARD ACTIVITIES

The DUR Board met four times during FFY 2019. The Board members are listed below the summary.

Prospective DUR Criteria Presented

- Therapeutic Duplication (TD) Alert – An issue was discovered within the Medi-Cal prospective DUR system in which turning off the ingredient duplication (ID) alert for a drug may lead instead to a therapeutic duplication (TD) alert, unless the TD alert is also turned off for a specific drug. This is due to the Duplicate Therapy Module™ combining ID and TD alerts into one single alert. The issue was discovered when investigating why there were so many TD alerts being generated for quetiapine. The Board had previously recommended turning off the ID alert for quetiapine, which then caused the ID alerts that had been generated by two formulations of quetiapine to instead trigger TD alerts. The same problem was observed with lithium, which had the ID alert turned off for all non-300 mg formulations. The Board recommended to turn off the TD alert for lithium for non-300 mg formulations and to turn back on the ID alert for all formulations of quetiapine, in order to distinguish between true therapeutic duplication with other antipsychotic medications.
- Additive Toxicity (AT) Alert: Gabapentinoids – A proposal to add gabapentinoids to the list of drugs for the AT alert based on side effect profile, literature review, and analysis of pharmacy claims data was presented. States are limiting claims to FDA-approved diagnoses or have taken legislative action to classify gabapentin as a scheduled drug, in order to allow gabapentin claims to be reported as part of the prescription drug monitoring program. Effective April 15, 2019, both pregabalin and gabapentin were added to the list of drugs for the AT alert based on side effect profile, literature review, and analysis of pharmacy claims data. An initial review demonstrated a 12% increase in AT alerts since that time, and alert burden will continue to be monitored over time.
- Review of new Generic Code Number (GCN) sequence numbers: The DUR Board recommended turning on additional alerts for 55 new GCNs that matched drugs appearing on the Medi-Cal target drug list for prospective DUR.

Retrospective DUR Criteria Presented

- Review of Retrospective DUR Criteria: New Additions to the Medi-Cal List of Contract Drugs in FFY 2017 – During FFY 2017 there were a total of 16 new prescription medications added to the Medi-Cal List of Contract Drugs. Utilization data (total number of paid claims and utilizing beneficiaries with at least one paid claim) were reviewed for each of these drugs. Thirteen drugs had low utilization (< 20 utilizing beneficiaries during all of the months reviewed) and were not reported in detail. The Board did not suggest additional evaluation for any of these drugs.
- Hepatitis C Virus (HCV) Drugs: HCV medication utilization is reviewed on an annual basis, primarily to evaluate potential HCV reinfection and retreatment in the Medi-Cal FFS population. Data showed a 32% decrease in total utilizing beneficiaries

with a paid claim for an HCV treatment medication since the previous evaluation. However, after the July 2018 policy change a slight increase was noted in new starts (29.5 in July and August 2018, in comparison to 22.4 new starts in the preceding 10 months). A review of drug utilization over time showed an increase in beneficiaries with paid claims for glecaprevir/pibrentasvir, which was added to the Medi-Cal Fee-for-Service List of Contract Drugs on January 1, 2018. Of note, there were no claims for ombitasvir/paritaprevir/ritonavir/dasabuvir or simeprevir during FFY 2018. A review of medical claims data found that all beneficiaries with a paid claim for an HCV treatment medication had at least one HCV-RNA level, HCV genotype test, and comprehensive metabolic panel, which follows AASLD-IDSA recommended guidelines. The Board recommended continuing with annual review.

- Gabapentinoids – A retrospective DUR review found 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 showed increasing use of gabapentinoids over time and only 12% of continuously eligible FFS beneficiaries had an FDA-approved indication for a gabapentinoid within the last five years. The Board agreed that gabapentinoids, specifically gabapentin, should be the topic of an educational bulletin.

Provider-specific Interventions

Educational articles and alerts:

- Alert: New Naloxone Regulations Effective on January 1, 2019
- Clinical Review Update: Morphine Equivalent Daily Dose
- Drug Safety Communication: Updated Adverse Effects from Fluoroquinolones
- Drug Safety Communication: Risks with Sudden Discontinuation of Opioids
- Drug Safety Communication: Sleep Behavior Risks with Select Sleep Aids
- Clinical Review Update: Concomitant Anticholinergic and Antipsychotic Use
- 2019 Immunization Updates: Flu, HepA, HPV, Measles, CA School Requirements

Provider intervention letters:

- Additive Toxicity Letter – January 2019
- MEDD – April 2019
- Tramadol Letter – July 2019
- Codeine Letter – August 2019
- Zolpidem Letter – August 2019

Ongoing DUR Board Projects

The DUR Board goals for FFY 2019 were as follows:

- Advise DHCS regarding the revision of DUR reports to include drugs commonly used in both Medi-Cal Fee-for-Service (FFS) and Managed Care Organizations (MCOs)
- Promote dialogue, collaboration among MCOs
    - Present best practices and projects
    - Share innovative ideas and lessons learned

  - Update list of priority areas (topic clusters)
  - Disseminate DUR educational bulletins
  - Integrate/align FFS and MCO DUR action items
- Align goals with DHCS Quality Strategy
  - Better health, better care, lower cost
- Advise DHCS in the implementation of Medicaid Drug Utilization and Review Minimum Standards for the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
- Priority Area Topic Clusters
  - Optimizing Drug Prescribing and Dispensing, including specialty drugs
  - Optimizing Pain Management and Opioids
  - Optimizing Chronic Disease Management, including prevention

DUR Board Members

The following members served on the DUR Board, either in part or for the entire duration, of FFY 2019:

- Timothy E. Albertson, M.D., M.P.H., Ph.D. – Chair, Department of Internal Medicine, Division of Pulmonary and Critical Care Medicine and Professor of Medicine and Pharmacology, UC Davis Medical Center, Sacramento, California
- Michael Blatt, Pharm.D. – Pharmacy Director, Central California Alliance for Health
- Chris Chan, Pharm.D. – Independent Pharmacy Consultant
- Lakshmi Dhanvanthari, M.D. – Chief Medical Officer, Health Plan of San Joaquin
- José Dryjanski, M.D. – Regional Chair Infectious Disease SCPMG and Regional Chair P & T SCPMG, Chief Infectious Disease Kaiser Woodland Hills
- Stan Leung, Pharm.D. – Director, Pharmacy Services. Partnership HealthPlan of California
- Johanna Liu, Pharm.D., MBA, FCPhA – Director of Quality & Pharmacy, Santa Clara Family Health Plan, San Jose, California
- Janeen McBride, Pharm.D. – Principal, Government Programs, MedImpact Healthcare Systems, Inc., San Diego, California
- Robert Mowers, Pharm.D. – Coordinator Managed Care Pharmacy Services, Department of Pharmacy Services, UC Davis Health System, Sacramento, California
- Yana Paulson, Pharm.D. – Chief Pharmacy Officer, L.A. Care Health Plan, Adjunct Assistant Professor, UOP School of Pharmacy
- Randall S. Stafford, M.D., Ph.D. – Director, Program on Prevention Outcomes and Practices, Stanford Prevention Research Center, and Professor of Medicine, Stanford University School of Medicine, Palo Alto, California
- Marilyn Stebbins, Pharm.D. – Professor of Clinical Pharmacy, UCSF School of Pharmacy, San Francisco, California
- Vic Walker, R.Ph. – Former DUR pharmacist and head of the Pharmacy Data Analysis Group, California Department of Healthcare Services
- Andrew L. Wong, M.D. – Chief of Rheumatology, Olive View-UCLA Medical Center, Sylmar, California and Professor of Clinical Medicine, David Geffen School of

Medicine at UCLA, Los Angeles, California

- Iris Young, Pharm.D., CPHQ – Director, Pharmacy Quality and Medication Safety & PGY2 Medication Use Safety Program, Kaiser Permanente, Northern California Regional Pharmacy Operations & National Pharmacy Programs and Services
- Ramiro Zuniga, M.D., MBA, AAFP – Medical Director, California Health & Wellness, Health Net of California and Associate Clinical Professor Department of Family and Community Medicine (VCF), UC Davis School of Medicine, Sacramento, California

ATTACHMENT 4 - GENERIC DRUG SUBSTITUTION POLICIES

Among possible factors contributing to the Medi-Cal fee-for-service generic utilization percentage, the most impactful are the following: 1) supplemental rebate contracts with manufacturers; 2) carve-out drugs; and 3) generic drug pricing policies.

1) Restrictions to the Medi-Cal List of Contract Drugs

The Medi-Cal Drug Rebate program negotiates supplemental rebate contracts with pharmaceutical manufacturers and collects rebates greater than rebates obtainable through federal contracts alone. As a result, the net cost to the State for some brand name drugs can be lower than the therapeutically equivalent generic drug. In some cases, contracted drugs are payable at the point of service, while their generic equivalents require prior authorization. On the Medi-Cal List of Contract Drugs, these drugs can be identified through restrictions to the NDC labeler code. The current Medi-Cal List of Contract Drugs is available here:
http://files.medi-cal.ca.gov/pubsdoco/manual/man_query.asp?wSearch=%28%23filename+drugscdl%2A%2Edoc+OR+%23filename+drugscdl%2A%2Ezip%29&wFLogo=Contract+Drugs+List&wFLogoH=52&wFLogoW=516&wAlt=Contract+Drugs+List&wPath=N.

2) Carve-out Pharmacy Benefits

The Medi-Cal fee-for-service program pays for certain carved-out therapeutic classes of drugs for beneficiaries in both the Medi-Cal fee-for-service program and the Medi-Cal managed care program. Most notably, this applies to selected psychiatric drugs, alcohol and heroin detoxification and dependency treatment drugs, coagulation factors, and drugs used in treatment of Human Immunodeficiency Virus (HIV) and AIDS. These classes of drugs are largely single-source innovator products and consistently account for a large portion of Medi-Cal drug benefit expenditures in the Medi-Cal fee-for-service population. For a complete description of the carved-out drugs, please see:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcptwoplan_z01.doc.

3) Policies encouraging generic equivalent substitution for drugs dispensed through the Medi-Cal program.

In cases where generic drugs are more cost-effective, Medi-Cal encourages use of generic drugs. The providers, to the extent permitted by law, shall dispense the lowest cost drug product within the generic drug type in stock, which meets the medical needs of the beneficiary.

California Business and Professions Code Section 4073 states:

(a) A pharmacist filling a prescription order for a drug product prescribed by its trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) and accepted by the federal

Food and Drug Administration (FDA), of those drug products having the same active chemical ingredients.

(b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in his or her own handwriting, “Do not substitute,” or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked “Do not substitute”; provided that the prescriber personally initials the box or checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate “Do not substitute,” or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription “Do not substitute.” In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber.

(c) Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b). The person who selects the drug product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug product as would be incurred in filling a prescription for a drug product prescribed by generic name. There shall be no liability on the prescriber for an act or omission by a pharmacist in selecting, preparing, or dispensing a drug product pursuant to this section. In no case shall the pharmacist select a drug product pursuant to this section unless the drug product selected costs the patient less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any professional fee that may be charged by the pharmacist.

(d) This section shall apply to all prescriptions, including those presented by or on behalf of persons receiving assistance from the federal government or pursuant to the California Medical Assistance Program set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(e) When a substitution is made pursuant to this section, the use of the cost-saving drug product dispensed shall be communicated to the patient and the name of the dispensed drug product shall be indicated on the prescription label, except where the prescriber orders otherwise.

The following policies affect generic utilization rate by establishing reimbursement rates for drugs dispensed through the Medi-Cal program:

Reimbursement for any legend and non-legend drug covered under the Medi- Cal program is the lowest of:

- Maximum Allowable Ingredient Cost (MAIC) plus current professional fee
- Federal Upper Limit (FUL) plus current professional fees
- Estimated Acquisition Cost (EAC) plus current professional fees
- Charge to the general public

Among these, whenever available, MAIC* and FUL** promote the use of generic equivalents unless restricted on the Contract Drug List. The rates established by MAIC or FUL are generally much lower than the cost of branded products, which discourages providers from filling prescriptions with name brand drugs. Full reimbursement of prescription ingredient cost requires use of a brand of a multiple source drug, which costs no more than the program specified price limits. When medically necessary for a specific recipient, approval of reimbursement may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting authorization from a Medi-Cal consultant.

***The Maximum Allowable Ingredient Cost (MAIC**)
The Maximum Allowable Ingredient Cost (MAIC) program establishes maximum ingredient cost limits for generically equivalent drugs. Each cost limit is established only when there are three or more generically equivalent drugs available for purchase and dispensing by retail pharmacies within California.

****Federal Upper Limit (FUL)**
Federal Upper Limit (FUL) is an upper-limit of reimbursement for certain multiple source drugs established independently from the California MAIC Program by the United States Department of Health and Human Services (DHHS).

The federally required FUL is administered by the Medi-Cal program in a similar manner as the MAIC program. The major difference is that changes to the FUL list of drugs and respective price limits are issued periodically by DHHS and then implemented by Medi-Cal. When a drug is listed on both the MAIC and FUL price lists, the reimbursement rate is the lower of the MAIC or FUL.

ATTACHMENT 5 – COST SAVINGS/COST AVOIDANCE METHODOLOGY

Prospective DUR alerts and educational bulletins provide health care providers and pharmacists with specific, focused, and comprehensive drug information. If DUR alerts and educational bulletins are reviewed as intended, then notification of a potential drug therapy problem through a DUR alert or the knowledge gained from educational bulletins will lead to appropriate action, including:

- Discontinuing unnecessary prescriptions
- Reducing quantities of medications prescribed
- Switching to safer drug therapies
- Adding a drug therapy recommended in evidence-based guidelines
- Appropriate monitoring of patients taking prescription drugs

The Medi-Cal DUR program has saved money by encouraging appropriate drug therapy in order to reduce total healthcare expenditures. Estimated prescription drug savings as a direct result of the prospective DUR system for FFY 2019 are shown in Table 1.

Table 1. Prospective DUR Cost-Savings for Federal Fiscal Year (FFY) 2019.

Prospective DUR alert	Total claims cancelled or not overriden[1]	Average reimbursement dollars paid to pharmacies per claim[2]	Multiplier[3]	Total estimated costs avoided through prospective DUR
Over Utilization (Early Refill)	726,856	$511	0.1	$37,142,342
Therapeutic Duplication	325,512	$351	0.8	$91,403,770
Ingredient Duplication	212,013	$304	0.8	$51,561,562
Under Utilization (Late Refill)	93,911	$302	0.8	$22,688,898
High Dose	64,103	$104	0.8	$5,333,370
Drug-Pregnancy	25,804	$37	0.8	$763,798
Additive Toxicity	25,554	$127	0.8	$2,596,286
Low Dose	17,032	$143	0.8	$1,948,461
Drug-Drug Interaction	5,250	$943	0.8	$3,960,600
Drug-Disease Contraindication	2,529	$70	0.8	$141,624
Drug Age	404	$173	0.8	$55,914
Drug Allergy	249	$99	0.8	$19,721
TOTAL: All Alerts	***1,499,217***	***$340***		***$217,616,344***

[1]Multiple alerts can be generated per claim, so there may be duplicate alerts cancelled or overridden.
[2]Average reimbursement dollars paid to pharmacies per claim was calculated for each alert by looking at the total number of paid claims (including overrides) and total reimbursement dollars paid to pharmacies per claim (does not include adjustment for any rebates) for all drugs that generated that particular alert in FFY 2019.
[3]The use of this multiplier allows for an adjustment of estimated costs using a conservative estimate that 90% of early refill claims are resubmitted and paid and that 20% of the remaining alerts are duplicate alerts for the same claim.

ATTACHMENT 6 – INNOVATIVE PRACTICES

The Medi-Cal DUR Program plays an integral role in the Department of Health Care Services' Strategy for Quality Improvement in Healthcare initiative. DHCS continues to collaborate statewide to prevent prescription drug overdose, including with the state's Prescription Drug Overdose Prevention Initiative. The overarching strategy for this initiative includes safe prescribing, access to treatment, naloxone distribution, a public education campaign, and data informed and driven interventions. The goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD.

The DUR program also helped disseminate important materials and resources developed elsewhere in the state, including the California Health Care Foundation's Opioid Safety Toolkit, information about the Naloxone Distribution Project (NDP), a project funded by SAMHSA and administered by DHCS to combat opioid overdose-related deaths throughout California, and resources available from the California State Board of Pharmacy, including a no-cost webinar that fulfills the training requirement for pharmacists to furnish naloxone to patients without a prescription and a revised training guide, "Opioid Safety: Focus on Furnishing Naloxone – A Guide for California Community Pharmacists."

In order to continue addressing polypharmacy of CNS depressants, the DUR Board had previously recommended that the additive toxicity (AT) alert be updated to reflect only additive toxicity effects from multiple CNS depressants, including opioids, benzodiazepines, skeletal muscle relaxants, other sleep drugs and tranquilizers (non-benzodiazepine), antipsychotic medications, and other selected psychotropic medications with CNS depressant properties. In FFY 2019, gabapentinoids were added to the list of drugs that could generate an AT alert and, as a result, gabapentin was the top drug to generate AT alerts in FFY 2019.

Both independently and in collaboration, the DUR Board continues to evaluate opioid pharmacy claims data in order to: 1) characterize the nature and magnitude of opioid use in the Medi-Cal fee-for-service population and 2) develop effective policies and programs to reduce the adverse impact of opioid abuse.

ATTACHMENT 8 – EXECUTIVE SUMMARY

The purpose of Drug Utilization Review (DUR) is to improve the quality and cost-effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. California's Medi-Cal DUR program is the responsibility of the Department of Health Care Services (DHCS), and includes prospective DUR reviews, retrospective DUR reviews, and educational interventions for providers and pharmacies.

During federal fiscal year (FFY) 2019, California's Global Medi-Cal DUR Board (the "Board") included ten pharmacists and six physicians, meeting OBRA 1990 requirements. The Board held four meetings in FFY 2019, with each meeting divided up into two distinct sections: 1) old business and follow-ups; and 2) new business that included placeholders for updates from DHCS and the DUR Board, drug utilization reports, prospective and retrospective DUR reviews, and descriptions of educational bulletins and/or alerts.

The Board is responsible for advising and making recommendations to DHCS for the Medi-Cal population. For FFY 2019 the Board advised and made recommendations for: 1) prospective DUR criteria review and evaluation; 2) focused retrospective analyses of claims data in order to study drug use in the Medi-Cal population; 3) the development and implementation of educational interventions to improve drug use in the Medi-Cal population; and 4) best practices for Medi-Cal managed care plans (MCPs).

Over the course of FFY 2019 the Board reviewed prospective DUR criteria for 55 drugs and comprehensively reviewed the status of ingredient duplication (ID) and therapeutic duplication (TD) alerts for lithium and quetiapine. In addition, retrospective DUR criteria for Hepatitis C Virus (HCV) medications and gabapentinoids, as well as all medications that became available on the Medi-Cal Contract Drugs List in FFY 2018 were presented to the Board. A total of seven educational bulletins and alerts were published on the Medi-Cal website in order to educate and inform Medi-Cal providers and beneficiaries on timely and relevant topics related to medication use. A total of five educational mailings were sent to selected prescribers to improve the quality of care for Medi-Cal beneficiaries. Finally, in FFY 2018, the Board continued to collaborate with key state agencies and national experts, and actively worked to incorporate a variety of Medi-Cal MCP best practices across multiple plans into the Board meeting agenda.

This Annual Report was prepared through a collaborative effort between the California Department of Health Care Services, the Global Medi-Cal Drug Use Review Board, DXC Technology, Inc., and the University of California, San Francisco.

TABLE 1 – TOP DRUG CLAIMS DATA REVIEWED BY THE DUR BOARD

Top 10 PA Requests by Drug Name	Top 10 PA Requests by Drug Class	Top 5 Claim Denial Reasons (i.e. QL, Early Refill, PA, Duplication)	Top 10 Drug Names by Amount Paid	% of Total Spent for Drugs by Amount Paid	Top 10 Drug Names by Claim Count	Drugs By Claim Count % of Total Claims
ARIPIPRAZOLE	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	Claim requires an approved Treatment Authorization Request (TAR) due to beneficiary age	ARIPIPRAZOLE	10.1%	IBUPROFEN	2.4%
PALIPERIDONE PALMITATE	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Claim requires an approved TAR due to exceeding quantity limits, days supply, and/or frequency	LURASIDONE HCL	6.1%	AMOXICILLIN	1.1%
RISPERIDONE	OPIOID ANALGESICS	Claim requires an approved TAR because claim exceeds the 6 prescription limit	PALIPERIDONE PALMITATE	5.4%	ALBUTEROL SULFATE	0.9%
QUETIAPINE FUMARATE	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	Claim requires an approved TAR because beneficiary does not have the appropriate documented diagnosis on file for this drug	BICTEGRAV/ EMTRICIT/ TENOFOV ALA	4.6%	QUETIAPINE FUMARATE	0.9%
HYDROCODONE/ ACETAMINOPHEN	ANTICONVULSANTS	Duplicate claim	ELVITEG/COB/ EMTRI/TENOF ALAFEN	3.5%	CEPHALEXIN	0.8%
BREXPIPRAZOLE	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, BUTYROPHENONES	XXXXXXX	COAGULATION FACTOR VIIA, RECOMB	3.0%	FERROUS SULFATE	0.8%
OLANZAPINE	LAXATIVES AND CATHARTICS	XXXXXXX	ANTIHEMOPHIL.FVIII, FULL LENGTH	2.9%	ARIPIPRAZOLE	0.8%
HALOPERIDOL DECANOATE	INSULINS	XXXXXXX	ABACAVIR/ DOLUTEGRAVIR/ LAMIVUDI	2.8%	HYDROCODONE/ACETAMINOPHEN	0.7%
PALIPERIDONE	TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	XXXXXXX	EMTRICITABINE/TENOFOVIR (TDF)	2.6%	DOCUSATE SODIUM	0.7%
HALOPERIDOL	INFANT FORMULAS	XXXXXXX	ANTIHEMOPH. FVIII REC, FC FUSION	1.7%	LORATADINE	0.7%

TABLE 2 - GENERIC UTILIZATION DATA

Single-Source (S) Drugs		Non-Innovator (N) Drugs		Innovator Multi-Source (I) Drugs	
Total Number of Claims	Total Reimbursement Amount Less Co-Pay	Total Number of Claims	Total Reimbursement Amount Less Co-Pay	Total Number of Claims	Total Reimbursement Amount Less Co-Pay
1,672,226	$2,849,635,819	7,226,221	$240,267,858	678,691	$423,507,461

KEY:
Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market.

Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market.

Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity.

UCSF School of Pharmacy

FFY 2019 DUR Annual Report to CMS: Additional Data

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Department of Clinical Pharmacy

FFS Pharmacy Utilization by Age Group

Medi-Cal FFS Pharmacy Utilization by Age Group - FFY 2019				
Age Group	**Total Paid Claims**	**% Change from FFY 2018**	**Total Utilizing Beneficiaries**	**% Change from FFY 2018**
0 - 12	1,026,158	-10.0%	238,800	-9.1%
13 - 18	681,141	-3.5%	107,573	-1.3%
19 - 39	3,180,739	0.3%	647,737	-0.5%
40 - 64	4,426,882	-0.4%	654,794	2.5%
65+	790,155	-5.5%	145,586	-6.8%
Total	10,105,076	-1.9%	1,794,491	-1.3%

Top 20 Drug Therapeutic Categories

Rank	Drug Therapeutic Category Description	Total Paid Claims	% Change FFY 2018	Total Utilizing Beneficiaries	% Change FFY 2018
1	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SEROTONIN ANTAGNST	1,652,828	1.9%	626,352	0.7%
2	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	387,590	-3.1%	338,851	-3.4%
3	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	445,598	3.5%	193,613	3.0%
4	PENICILLIN ANTIBIOTICS	196,441	-6.8%	181,665	-6.6%
5	ANTICONVULSANTS	339,012	-3.0%	158,328	-2.3%
6	PLATELET AGGREGATION INHIBITORS	199,365	-11.2%	136,745	-10.8%
7	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	180,861	1.7%	121,167	3.5%
8	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	172,057	-5.6%	118,589	-7.2%
9	ANTIHISTAMINES - 2ND GENERATION	168,229	-2.2%	114,597	0.3%
10	ANTIHYPERTENSIVES, ACE INHIBITORS	171,214	-3.6%	113,772	-1.6%
11	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	137,520	-20.7%	113,500	-21.3%
12	LAXATIVES AND CATHARTICS	170,339	-7.5%	113,171	-7.7%
13	INSULINS	205,734	-4.2%	111,712	-3.6%
14	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	163,142	0.2%	109,750	2.1%
15	IRON REPLACEMENT	143,944	-8.0%	108,134	-7.4%
16	ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC	237,375	-2.1%	93,098	-2.7%
17	ANTIEMETIC/ANTIVERTIGO AGENTS	107,357	16.0%	92,408	19.5%
18	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	94,117	-2.7%	88,335	-2.7%
19	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	147,840	0.2%	83,159	-0.1%
20	GLUCOCORTICOIDS	98,240	-3.8%	76,396	-3.9%

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Top 20 Drugs

Rank	Drug	Total Paid Claims	% Change FFY 2018	Total Utilizing Beneficiaries	% Change FFY 2018
1	IBUPROFEN	316,714	-3.0%	279,837	-3.4%
2	QUETIAPINE FUMARATE	559,270	1.0%	213,294	-0.3%
3	ARIPIPRAZOLE	420,109	2.3%	182,060	1.7%
4	RISPERIDONE	328,541	-0.6%	131,433	-1.6%
5	ASPIRIN	188,280	-13.2%	129,970	-12.9%
6	AMOXICILLIN	136,500	-8.1%	125,665	-8.1%
7	OLANZAPINE	328,288	5.3%	124,792	4.1%
8	ALBUTEROL SULFATE	169,204	-5.8%	118,788	-7.7%
9	METFORMIN HCL	163,142	0.2%	109,750	2.1%
10	FERROUS SULFATE	143,488	-8.1%	107,971	-7.3%
11	LORATADINE	153,527	-8.0%	104,184	-6.8%
12	DOCUSATE SODIUM	147,771	-8.1%	99,849	-8.0%
13	CEPHALEXIN	93,830	-2.7%	88,222	-2.7%
14	LISINOPRIL	127,481	-1.3%	86,754	0.9%
15	BENZTROPINE MESYLATE	219,252	-0.9%	86,077	-1.6%
16	ATORVASTATIN CALCIUM	127,770	10.3%	85,203	12.2%
17	HYDROCODONE/ACETAMINOPHEN	99,157	-19.3%	81,903	-19.4%
18	LURASIDONE HCL	165,020	4.0%	69,145	2.5%
19	AZITHROMYCIN	65,867	-6.5%	60,519	-6.9%
20	PRENATAL VITAMIN NO. 95	66,678	82.5%	59,578	83.3%

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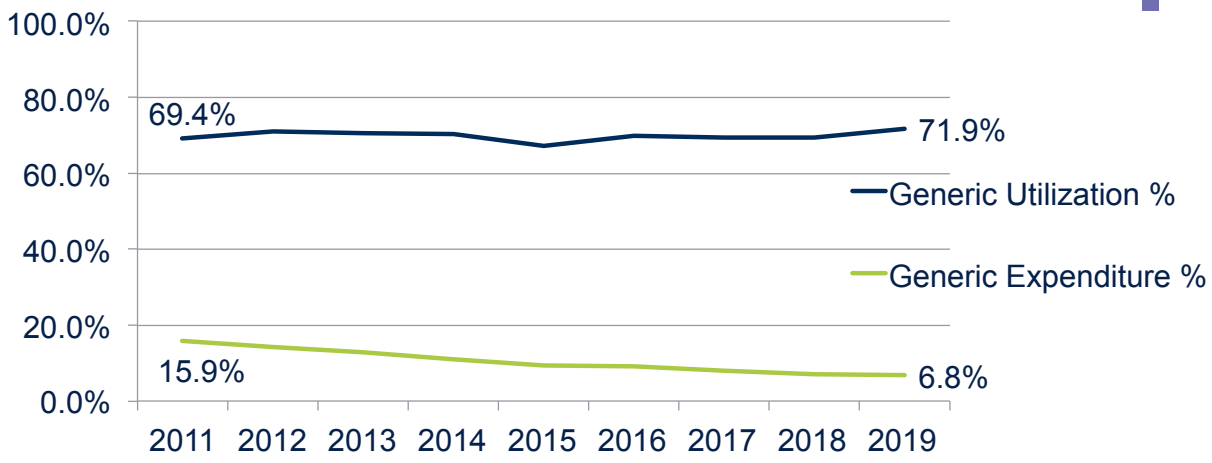
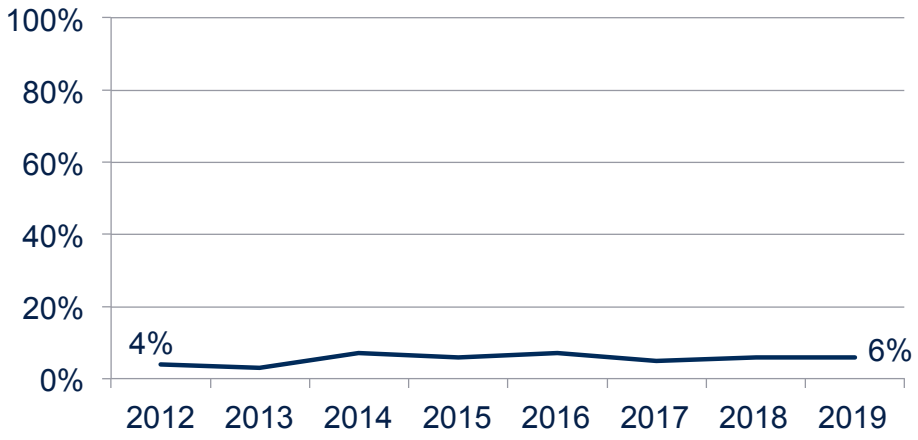
Trends: Generics



Trends: DUR Cost-Savings Estimate



UCSF School of Pharmacy

Global Medi-Cal DUR Updates: Q4 2019

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Department of Clinical Pharmacy

Topics for Discussion

- Fee-for-Service Prospective DUR
  - New GCNs Q4 2019
- Educational Outreach
  - Mailing Update: GINA Guidelines
  - Mailing Update: Gabapentin
  - Mailing Update: Additive Toxicity – 2020

Topics for Discussion (cont.)

- Retrospective DUR
  - Global Quarterly Report: 3Q2019 (July – September 2019)
  - FFS Quarterly Report: 4Q2019 (October – December 2019)
  - Evaluation Report: 4Q2019 (October – December 2019)
- Publications
  - December 2019: Gabapentin Bulletin
  - Update to Additive Toxicity Bulletin

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New GCN Alert Profiles

Background

- Each week new Generic Code Numbers (GCNs) are added
- Overutilization (ER), Drug-Pregnancy (PG) and Drug-Drug Interactions (DD) alerts are automatically turned on for all new GCNs
- New GCNs are reviewed weekly for additional alerts
- New GCNs with alerts turned on other than ER, PG, and DD are provided at each Board meeting for review

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New GCN Alert Profiles (cont.)

Table 1. New GCNs for Existing DUR Target Drugs: Q4 2019

Drug Description	Alerts Turned On
ACETAMINOPHEN	ID, HD
ALBUTEROL SULFATE	TD, ID, HD, LD
AMLODIPINE BESYLATE/CELECOXIB	MC, TD, LR, ID, HD, LD
ASENAPINE	MC, TD, LR, AT, ID, HD, LD
DICLOFENAC SODIUM/LIDOCAINE	DA, MC, TD, ID, HD, LD
DICLOFENAC/MENTHOL/TAPE	DA, MC, TD, ID, HD, LD
DIGOXIN	TD, LR, ID, HD, LD
DIVALPROEX SODIUM	DA, LR, ID, HD, LD
DULOXETINE HCL	TD, LR, ID, PA, HD, LD
GABAPENTIN/LIDOCAINE	DA, LR, AT, ID, HD, LD
SODIUM/POTAS/CHLORIDE/DEXTROSE	HD, LD
TESTOSTERONE UNDECANOATE	DA, TD, LR, ID, HD, LD

DA	Drug-Allergy
MC	Drug-Disease
TD	Therapeutic Duplication
LR	Late Refill
AT	Additive Toxicity
ID	Ingredient Duplication
PA	Drug-Age
HD	High Dose
LD	Low Dose

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Board questions/recommendations?

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Mailing Update: GINA Guidelines Letter

- A total of 346 letters were mailed between January 16, 2020 and January 30, 2020
  - Letters included DUR article, provider survey, name/DOB of all patients meeting the following inclusion/exclusion criteria:
    - A documented history of asthma
    - Paid claims for three or more SABAs since January 1, 2019
    - At least one paid claim for a SABA since October 1, 2019
    - No paid claims for asthma controller medications since January 1, 2019
    - No medical claims for a condition that may complicate asthma treatment since January 1, 2019

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Mailing Update: GINA Letter (cont.)

- Final outcomes to be presented at May 2021 meeting:
  - Primary: % of continuously-eligible patients with paid claims for SABAs alone within 12 months following the mailing
  - Secondary: % of continuously-eligible patients with paid claims for ICS treatment within 12 months following the mailing
- Provider response rate and returned mail rate (within 90 days of the mailing) will also be reported

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Mailing Update: Gabapentin Letter

- Letters were mailed on January 30, 2020 to the top 150 prescribers of gabapentin (by total number of paid claims) in the Medi-Cal program
  - Represented 10% of all paid claims (1.8% of prescribers)
  - Each had > 700 paid claims for gabapentin during 2019
- Letters included DUR article and provider survey
- Decision made to create additional mailing to address patient-specific concomitant prescribing of gabapentin and opioids (with special attention to high-dose gabapentin claims)

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Mailing Update: Gabapentin Letter (cont.)

- Final outcomes to be presented at May 2021 meeting:
  - Primary: Provider-specific total paid claims for gabapentin within 12 months following the mailing
  - Secondary: Total initial paid claims for gabapentin within 12 months following the mailing
- Provider response rate and returned mail rate (within 90 days of the mailing) will also be reported

Board questions/recommendations?

Mailing Update: Additive Toxicity (AT)

- Board recommended repeating the AT mailing
- A total of 73 letters were mailed on January 30, 2020
  - Represented 29 beneficiaries that generated an AT alert (with pharmacist override) during December 2019
    - At least one paid claim for both an opioid and a benzodiazepine, and paid claims for at least two additional CNS depressants (10/1/19 - 12/31/19)
    - No paid claims at SNF, ICF, home health, hospice practice locations and no diagnostic codes indicating palliative care or cancer treatment
  - Letters included DUR article, naloxone handout, patient profiles

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Mailing Update: AT Letter (cont.)

- Final outcomes to be presented at November 2020 meeting:
  - Primary: Total continuously-eligible beneficiaries without active paid claims for both opioids and benzodiazepines after 6 months following the mailing
  - Secondary: Total continuously-eligible beneficiaries with a paid claim for naloxone within the 6 months following the mailing
- Provider response rate and returned mail rate (within 90 days of the mailing) will also be reported

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Board questions/recommendations?

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Future Educational Outreach Topics

DUR Educational Outreach to Pharmacies/Providers

- Concomitant prescribing of gabapentin and opioids (in progress)
- Updated ACOG guidelines for postpartum pain
- Updated NAMS guidelines for hormone replacement therapy
- Updated ADA opioid guidelines to dentists
- Oseltamivir or zanamivir paid claims + influenza vaccine
- Statin use with cardiovascular disease
- Chronic use of PPIs
- Chronic use of temazepam/zolpidem

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Board questions/recommendations?

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Global Quarterly Report: 3Q2019

- 30% of eligible Medi-Cal enrollees had a paid pharmacy claim through the Medi-Cal program
  - 14% of eligible Medi-Cal fee-for-service enrollees
  - 33% of Medi-Cal managed care plan (MCP) enrollees
- Across all population aid code groups, the vast majority of utilizing beneficiaries are MCP enrollees (range from 98% of OTLIC to 88% of OTHER)
- Will continue to present quarterly data at each Board meeting

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Board questions/recommendations?

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FFS Quarterly Report: 4Q2019

- 15% of eligible Medi-Cal FFS enrollees had a paid claim through the Medi-Cal FFS program, compared to 2% of MCP enrollees
- 32% increase in average paid claims per day for PROTON-PUMP INHIBITORS from 4Q2018
  - OMEPRAZOLE added to CDL (dates of service on or after May 1, 2019)
- Significant increases in the use of NALOXONE and BUPRENORPHINE HCL/NALOXONE HCL compared to 4Q2018, most likely due to AB 2760 (effective January 1, 2019)

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Board questions/recommendations?

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New: Quarterly Evaluation Reports

- Quarterly evaluation reports have replaced the biennial report due to be presented in February 2021
- Biennial report too dense, timing between original article and biennial evaluation was variable
- Evaluations will now be completed two years after the quarter the original article was published
  - Board meetings during 2020 will include two quarters of articles
  - Board meetings during 2021 and beyond will include one quarter

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Quarterly Evaluation Report: 4Q2019

- One article to evaluate from 4Q2016 and 1Q2017:
  - Improving the Quality of Care: Risks Associated with Use of Fluoroquinolones – published February 2017

Background

- Fluoroquinolones should not be used as first-line therapy in community settings when other treatment options are available.
- On July 26, 2016, the FDA approved safety labeling changes for fluoroquinolones, including recommendations to limit their use in patients with less serious bacterial infections.
- Within the Medi-Cal fee-for-service population approximately two-thirds (n = 33,483; 68%) of fluoroquinolone use from December 1, 2015, through November 30, 2016, appeared to be potentially inappropriate based on the new FDA recommendations

Purpose: Fluoroquinolone Evaluation

- Review fluoroquinolone use in the Medi-Cal fee-for-service population since the original DUR bulletin was published
- Review relevant safety information and clinical recommendations for fluoroquinolones for updates

Data Criteria

- Same inclusion/exclusion criteria as the published article
- Inclusion criteria:
  - At least one paid claim for a fluoroquinolone through the Medi-Cal FFS program between 11/1/18 and 10/31/19 (the measurement year).
- Exclusion criteria:
  - Beneficiaries with a paid claim not in the community (outpatient) setting
  - Beneficiaries with any indication of penicillin or other drug allergy that would impact the use of fluoroquinolones as a first-line therapy

Methods

- Within the study population, any beneficiary with one of the following primary or secondary ICD-9-CM diagnostic codes within the seven-day window of the index date was coded as a potentially inappropriate use of fluoroquinolones:
  - Acute bacterial sinusitis (461)
  - Acute bacterial exacerbation of chronic bronchitis (491.21)
  - Uncomplicated UTIs (595.00, 595.89, 595.90, or 599)
- Compared ICD9 and ICD10 coding and found no difference so used ICD9 to be consistent with original article

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Results

Medi-Cal fee-for-service population	12/01/15 – 11/30/16	11/01/18 – 10/31/19	% change
Beneficiaries identified with at least one paid claim for a fluoroquinolone during the measurement year	***49,276***	***29,876***	***-40%***
% overall with potentially inappropriate use of fluoroquinolones	68%	57%	***-11%***
% females with potentially inappropriate use	71%	61%	***-10%***
% younger than 18 years of age with potentially inappropriate use	56%	44%	***-12%***
% residing in Los Angeles County region with potentially inappropriate use	78%	63%	***-15%***

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Analysis

- 40% decrease in the total FFS beneficiaries with ≥ 1 paid claim for a fluoroquinolone during the measurement year
  - Eligible Medi-Cal FFS population decreased by only 10% during this same time period
- Overall decrease in potentially inappropriate use of fluoroquinolones among the study population by 11%
  - Still higher overall among females, primarily due to higher rates of potentially inappropriate use of fluoroquinolones for uncomplicated UTI

Board Recommendation

- Consider repeat of educational outreach letter to top prescribers of fluoroquinolones in the Medi-Cal program
  - Can include the two additional safety alerts on fluoroquinolones published by the DUR program as enclosures

Board questions/recommendations?

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Future Topics: RetroDUR Reviews

- Annual review of drugs added to the Medi-Cal List of Contract Drugs (ongoing, presented each November)
- HCV medications (ongoing, presented each February)
- Opioid prescribing by dentists
- NSAIDs
- Pharmacist furnishing of hormonal contraceptives
- Assessment of opioid use and mortality (stratified by gender)
- Antipsychotic polypharmacy in adults
- Topic discussed today: Antipsychotic use < 18 years of age

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Future Topics: Adult Core Set Measures

- Antidepressant Medication Management (AMM-AD)
- Concurrent Use of Opioids and Benzodiazepines (COB-AD)
- Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)
- Flu Vaccinations for Adults Ages 18–64 (FVA-AD)
- Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

Future Topics: Child Core Set Measures

- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Asthma Medication Ratio: Ages 5–18 (AMR-CH)
- Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)
- Childhood Immunization Status (CIS-CH)
- Immunizations for Adolescents (IMA-CH)

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DUR Publications

December 2019: Bulletin

- Improving the Quality of Care: Risks Associated with Use of Gabapentin

Updates to July 2018: Bulletin

- ProDUR Update: Additive Toxicity Alert Now Focused Only On CNS Depressants
  - Table of drugs was updated on January 23, 2020

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Future Topics: Publications

Alerts:

- California Upgrades Immunization Registry to CAIR2

Bulletins:

- Antihyperglycemic medications (in progress)
- Pharmacist furnishing of naloxone
- Annual immunization update (published each September)
- Managing pain in population with comorbid mental health conditions
- Pharmacist furnishing of hormonal contraception
- Hypertension medication adherence

Board questions/recommendations?

QUARTERLY SUMMARY
GLOBAL MEDI-CAL DRUG USE REVIEW
REPORT PERIOD: 3RD QUARTER 2019 (JULY – SEPTEMBER 2019)

Executive Summary

The Global DUR quarterly report provides information on retrospective drug utilization for all paid pharmacy claims for beneficiaries in the Medi-Cal program. For this report, the retrospective data cover the third quarter of 2019 (2019 Q3).

In 2019 Q3, approximately 30% of eligible Medi-Cal enrollees had a paid pharmacy claim through the Medi-Cal program, including 14% of eligible Medi-Cal fee-for-service enrollees and 33% of Medi-Cal managed care plan (MCP) enrollees (**Table 1.1**). Among all Medi-Cal beneficiaries with a paid claim through the Medi-Cal program in 2019 Q3, 9% were FFS enrollees, 90% were MCP enrollees, and 1% of beneficiaries had enrollments in both FFS and MCP during the quarter. When data from 2019 Q3 were compared to the prior year (2018 Q3), data from 2019 Q3 showed a 3% decrease in total eligible beneficiaries, a 3% decreased in total utilizing beneficiaries, and a 4% decrease in total paid pharmacy claims.

When beneficiaries eligible for Medi-Cal were stratified by population aid code group (**Tables 1.2 – 1.5**), 30% were Affordable Care Act (ACA), 11% were Optional Targeted Low Income Children (OTLIC), and 16% were Seniors and Persons with Disabilities (SPD). Within the population aid code groups, the vast majority of utilizing beneficiaries were MCP enrollees, including 93% of the ACA population, 98% of the OTLIC population, 90% of the SPD population, and 88% of the remaining (OTHER) population. These tables also include the total number of beneficiaries that were continuously-eligible within each population aid code group. Continuous eligibility is plan-specific and is measured for 2019 Q3 from July 1, 2019 – September 1, 2019.

As shown in **Tables 2.1 – 2.3**, there was an decrease in total utilizing beneficiaries and total paid claims across almost all age groups for both FFS and MCP enrollees in comparison to the prior-year quarter. Exceptions include the 13 – 18 year age group and in the 40 – 64 year age group, in which total FFS utilizing beneficiaries increased by 2% (for both age groups) in comparison to the prior year.

The greatest decrease in total utilizing beneficiaries and total paid claims within the top 20 drug therapeutic categories by total utilizing beneficiaries (**Table 3**) was seen in the OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS drug therapeutic category, which posted a 1% decrease in total percentage of utilizing beneficiaries with a paid claim and an 18% decrease in total paid claims in comparison to the prior-year quarter. Similar results are shown on **Table 5**, where HYDROCODONE/ACETAMINOPHEN also posted a 1% decrease in total percentage of utilizing beneficiaries with a paid claim and an 18% decrease in total paid claims in comparison to the prior-year quarter.

Tables 4.1 – **4.4** once again show the top 20 drug therapeutic categories by total continuously-eligible utilizing beneficiaries in 2019 Q3, stratified by population aid code group and **Tables 6.1 – 6.4** show the top 20 drugs by total continuously-eligible utilizing beneficiaries in 2019 Q3, stratified by population aid code group. Within each of these tables, the mean days' supply per utilizing beneficiary is shown for both FFS and MCP enrollees.

Tables 1.1-1.5. Summary of Global Medi-Cal Pharmacy Utilization.

Table 1.1 shows pharmacy utilization in the Medi-Cal program, including the percent change from the prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted twice (represents 0.6% of utilizing beneficiaries). **Tables 1.2-1.5** show pharmacy utilization in the Medi-Cal program, **stratified by population aid code group**

Table 1: Global Medi-Cal Pharmacy Utilization Measures for the Entire Medi-Cal Population			
Category	**Current Quarter 2019 Q3**	**Prior-Year Quarter 2018 Q3**	**% Change from *Prior Year***
Total Eligible Beneficiaries	15,353,863	15,773,328	**-2.7%**
Total Utilizing Beneficiaries	4,540,144	4,676,489	**-2.9%**
Total Paid Rx Claims	25,081,148	26,027,337	**-3.6%**
Average Paid Rx Claims per Eligible Beneficiary	1.63	1.65	**-1.0%**
Average Paid Rx Claims per Utilizing Beneficiary	5.52	5.57	**-0.7%**
Fee-for-Service Enrollees			
Total Eligible Beneficiaries	3,110,417	3,208,762	**-3.1%**
Total Utilizing Beneficiaries	445,798	454,018	**-1.8%**
Total Paid Rx Claims	1,622,675	1,627,952	**-0.3%**
Average Paid Rx Claims per Eligible Beneficiary	0.52	0.51	**2.8%**
Average Paid Rx Claims per Utilizing Beneficiary	3.64	3.59	**1.5%**
Managed Care Plan Enrollees			
Total Eligible Beneficiaries	12,642,297	12,978,801	**-2.6%**
Total Utilizing Beneficiaries	4,123,249	4,249,991	**-3.0%**
Total Paid Rx Claims	23,455,367	12,386,876	**-3.8%**
Average Paid Rx Claims per Eligible Beneficiary	1.86	1.88	**-1.3%**
Average Paid Rx Claims per Utilizing Beneficiary	5.69	5.74	**-0.9%**

Table 1.2 shows pharmacy utilization within the **Affordable Care Act (ACA)** population, which consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U. Continuous eligibility is plan-specific and is measured from July 1, 2019 – September 1, 2019.

Among the ACA population, 58% of total utilizing beneficiaries were continuously-eligible within the same plan during 2019 Q3 (39% of FFS enrollees and 58% of MCP enrollees).

Table 1.2: Global Medi-Cal Pharmacy Utilization Measures for the ACA Population			
Category	**Current Quarter 2019 Q3**	**Prior-Year Quarter 2018 Q3**	**% Change from *Prior Year***
Total Eligible Beneficiaries	4,539,462	4,625,549	**-1.9%**
Total Utilizing Beneficiaries	1,578,794	1,599,901	**-1.3%**
Total Paid Rx Claims	10,067,083	10,322,640	**-2.5%**
Average Paid Rx Claims per Eligible Beneficiary	2.22	2.23	**-0.6%**
Average Paid Rx Claims per Utilizing Beneficiary	6.38	6.45	**-1.2%**
Continuously-Eligible Total Eligible Beneficiaries	3,606,220	3,670,455	**-1.8%**
Continuously-Eligible Total Utilizing Beneficiaries	912,851	951,710	**-4.1%**
Continuously-Eligible Total Paid Rx Claims	6,124,237	6,399,937	**-4.3%**
Fee-for-Service Enrollees			
Total Eligible Beneficiaries	911,317	922,668	**-1.3%**
Total Utilizing Beneficiaries	119,948	117,148	**2.3%**
Total Paid Rx Claims	480,883	464,055	**3.5%**
Average Paid Rx Claims per Eligible Beneficiary	0.53	0.50	**4.7%**
Average Paid Rx Claims per Utilizing Beneficiary	4.01	3.96	**1.2%**
Continuously-Eligible Total Eligible Beneficiaries	537,038	538,860	**-0.3%**
Continuously-Eligible Total Utilizing Beneficiaries	46,624	44,287	**5.3%**
Continuously-Eligible Total Paid Rx Claims	127,347	118,865	**7.1%**
Managed Care Plan Enrollees			
Total Eligible Beneficiaries	3,760,508	3,839,981	**-2.1%**
Total Utilizing Beneficiaries	1,473,154	1,497,566	**-1.7%**
Total Paid Rx Claims	9,586,200	9,858,512	**-2.8%**
Average Paid Rx Claims per Eligible Beneficiary	2.55	2.57	**-0.7%**
Average Paid Rx Claims per Utilizing Beneficiary	6.51	6.58	**-1.2%**
Continuously-Eligible Total Eligible Beneficiaries	2,932,433	2,988,772	**-1.9%**
Continuously-Eligible Total Utilizing Beneficiaries	837,200	876,719	**-4.5%**
Continuously-Eligible Total Paid Rx Claims	2,913,250	3,055,627	**-4.7%**

Table 1.3 shows pharmacy utilization within the **Optional Targeted Low Income Children (OTLIC)** population consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9. Continuous eligibility is plan-specific and is measured from July 1, 2019 – September 1, 2019.

Among the OTLIC population, 44% of total utilizing beneficiaries were continuously-eligible within the same plan during 2019 Q3 (31% of FFS enrollees and 44% of MCP enrollees).

Table 1.3: Global Medi-Cal Pharmacy Utilization Measures for the OTLIC Population

Category	Current Quarter 2019 Q3	Prior-Year Quarter 2018 Q3	% Change from *Prior Year*
Total Eligible Beneficiaries	1,623,843	1,639,786	-1.0%
Total Utilizing Beneficiaries	326,325	322,650	1.1%
Total Paid Rx Claims	866,980	841,539	2.9%
Average Paid Rx Claims per Eligible Beneficiary	0.53	0.51	3.9%
Average Paid Rx Claims per Utilizing Beneficiary	2.66	2.61	1.8%
Continuously-Eligible Total Eligible Beneficiaries	1,272,897	1,280,170	-0.6%
Continuously-Eligible Total Utilizing Beneficiaries	143,377	146,990	-2.5%
Continuously-Eligible Total Paid Rx Claims	549,116	557,969	-1.6%
Fee-for-Service Enrollees			
Total Eligible Beneficiaries	112,285	106,337	5.3%
Total Utilizing Beneficiaries	6,874	6,059	11.9%
Total Paid Rx Claims	15,543	13,396	13.8%
Average Paid Rx Claims per Eligible Beneficiary	0.14	0.13	9.0%
Average Paid Rx Claims per Utilizing Beneficiary	2.26	2.21	2.2%
Continuously-Eligible Total Eligible Beneficiaries	38,216	35,983	6.2%
Continuously-Eligible Total Utilizing Beneficiaries	2,115	1,717	23.2%
Continuously-Eligible Total Paid Rx Claims	3,990	3,104	28.5%
Managed Care Plan Enrollees			
Total Eligible Beneficiaries	1,546,690	1,566,941	-1.3%
Total Utilizing Beneficiaries	320,079	317,157	0.9%
Total Paid Rx Claims	851,437	828,149	2.7%
Average Paid Rx Claims per Eligible Beneficiary	0.55	0.53	4.0%
Average Paid Rx Claims per Utilizing Beneficiary	2.66	2.61	1.8%
Continuously-Eligible Total Eligible Beneficiaries	1,197,291	1,298,692	-7.8%
Continuously-Eligible Total Utilizing Beneficiaries	138,388	142,550	-2.9%
Continuously-Eligible Total Paid Rx Claims	270,911	276,357	-2.0%

Table 1.4 shows pharmacy utilization within the **Seniors and Persons with Disabilities (SPD)** population, which consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7. Continuous eligibility is plan-specific and is measured from July 1, 2019 – September 1, 2019.

Among the SPD population, 64% of total utilizing beneficiaries were continuously-eligible within the same plan during 2019 Q3 (52% of FFS enrollees and 64% of MCP enrollees).

Table 1.4: Global Medi-Cal Pharmacy Utilization Measures for the SPD Population

Category	Current Quarter 2019 Q3	Prior-Year Quarter 2018 Q3	% Change from *Prior Year*
Total Eligible Beneficiaries	2,467,632	2,510,785	**-1.7%**
Total Utilizing Beneficiaries	892,934	949,340	**-5.9%**
Total Paid Rx Claims	7,382,866	7,952,576	**-7.2%**
Average Paid Rx Claims per Eligible Beneficiary	2.99	3.17	**-5.5%**
Average Paid Rx Claims per Utilizing Beneficiary	8.27	8.38	**-1.3%**
Continuously-Eligible Total Eligible Beneficiaries	2,049,591	2,088,610	**-1.9%**
Continuously-Eligible Total Utilizing Beneficiaries	567,636	627,233	**-9.5%**
Continuously-Eligible Total Paid Rx Claims	4,514,111	4,978,024	**-9.3%**
Fee-for-Service Enrollees			
Total Eligible Beneficiaries	520,189	530,152	**-1.9%**
Total Utilizing Beneficiaries	96,007	103,247	**-7.0%**
Total Paid Rx Claims	459,719	488,762	**-5.9%**
Average Paid Rx Claims per Eligible Beneficiary	0.88	0.92	**-4.1%**
Average Paid Rx Claims per Utilizing Beneficiary	4.79	4.73	**1.2%**
Continuously-Eligible Total Eligible Beneficiaries	383,318	392,187	**-2.3%**
Continuously-Eligible Total Utilizing Beneficiaries	50,281	53,598	**-6.2%**
Continuously-Eligible Total Paid Rx Claims	135,182	142,600	**-5.2%**
Managed Care Plan Enrollees			
Total Eligible Beneficiaries	1,985,387	2,017,632	**-1.6%**
Total Utilizing Beneficiaries	801,888	851,094	**-5.8%**
Total Paid Rx Claims	6,923,147	7,463,944	**-7.3%**
Average Paid Rx Claims per Eligible Beneficiary	3.49	3.70	**-5.7%**
Average Paid Rx Claims per Utilizing Beneficiary	8.63	8.77	**-1.6%**
Continuously-Eligible Total Eligible Beneficiaries	1,616,475	1,647,221	**-1.9%**
Continuously-Eligible Total Utilizing Beneficiaries	507,835	563,220	**-9.8%**
Continuously-Eligible Total Paid Rx Claims	2,117,866	2,341,445	**-9.5%**

Table 1.5 shows pharmacy utilization within the **Other Populations (OTHER)** population, which consists of all aid codes not categorized under ACA, OTLIC, or SPD. Continuous eligibility is plan-specific and is measured from July 1, 2019 – September 1, 2019.

Among the OTHER population, 48% of total utilizing beneficiaries were continuously-eligible within the same plan during 2019 Q3 (36% of FFS enrollees and 48% of MCP enrollees).

Table 1.5: Global Medi-Cal Pharmacy Utilization Measures for the OTHER Population			
Category	**Current Quarter 2019 Q3**	**Prior-Year Quarter 2018 Q3**	**% Change from *Prior Year***
Total Eligible Beneficiaries	6,954,357	7,246,424	**-4.2%**
Total Utilizing Beneficiaries	1,771,884	1,834,060	**-3.5%**
Total Paid Rx Claims	6,753,468	6,890,046	**-2.0%**
Average Paid Rx Claims per Eligible Beneficiary	0.97	0.95	**2.1%**
Average Paid Rx Claims per Utilizing Beneficiary	3.81	3.76	**1.4%**
Continuously-Eligible Total Eligible Beneficiaries	5,407,731	5,642,256	**-4.2%**
Continuously-Eligible Total Utilizing Beneficiaries	849,532	903,830	**-6.0%**
Continuously-Eligible Total Paid Rx Claims	4,158,533	4,364,153	**-4.7%**
Fee-for-Service Enrollees			
Total Eligible Beneficiaries	1,603,424	1,690,609	**-5.4%**
Total Utilizing Beneficiaries	224,537	229,185	**-2.1%**
Total Paid Rx Claims	659,774	654,526	**0.8%**
Average Paid Rx Claims per Eligible Beneficiary	0.41	0.39	**5.9%**
Average Paid Rx Claims per Utilizing Beneficiary	2.94	2.86	**2.8%**
Continuously-Eligible Total Eligible Beneficiaries	902,765	966,389	**-6.6%**
Continuously-Eligible Total Utilizing Beneficiaries	81,925	82,607	**-0.8%**
Continuously-Eligible Total Paid Rx Claims	175,862	172,213	**2.1%**
Managed Care Plan Enrollees			
Total Eligible Beneficiaries	5,537,054	5,753,774	**-3.9%**
Total Utilizing Beneficiaries	1,556,410	1,614,691	**-3.7%**
Total Paid Rx Claims	6,093,694	6,235,467	**-2.3%**
Average Paid Rx Claims per Eligible Beneficiary	1.10	1.08	**1.5%**
Average Paid Rx Claims per Utilizing Beneficiary	3.92	3.86	**1.4%**
Continuously-Eligible Total Eligible Beneficiaries	4,314,927	4,475,236	**-3.6%**
Continuously-Eligible Total Utilizing Beneficiaries	741,867	793,192	**-6.5%**
Continuously-Eligible Total Paid Rx Claims	1,893,138	1,996,489	**-5.2%**

Table 2.1 – 2.3. Pharmacy Utilization by Age Group in the Medi-Cal Population.

These tables present pharmacy utilization data in the Medi-Cal program broken out by age group, including the percent change from the prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 2.2** and **Table 2.3**, as enrollment status may change.

Table 2.1: Pharmacy Utilization by Age Group for the Entire Medi-Cal Population

Age Group (years)	Current Quarter 2019 Q3 Total Paid Claims	Prior-Year Quarter 2018 Q3 Total Paid Claims	% Change from *Prior Year*	Current Quarter 2019 Q3 Total Utilizing Beneficiaries	Prior-Year Quarter 2018 Q3 Total Utilizing Beneficiaries	% Change from *Prior Year*
0 – 12	2,303,832	2,367,768	-2.7%	855,609	890,586	-3.9%
13 – 18	1,294,670	1,279,492	1.2%	406,597	407,187	-0.1%
19 – 39	5,527,470	5,656,817	-2.3%	1,259,694	1,290,865	-2.4%
40 – 64	13,626,631	14,304,175	-4.7%	1,596,592	1,646,557	-3.0%
65+	2,328,545	2,419,082	-3.7%	421,652	441,293	-4.5%
Total*	25,081,148	26,027,337	-3.6%	4,540,144	4,676,489	-2.9%

* Unknowns represent less than 1% of total

Table 2.2: Pharmacy Utilization by Age Group for the Medi-Cal FFS Population Only

Age Group (years)	Current Quarter 2019 Q3 Total Paid Claims	Prior-Year Quarter 2018 Q3 Total Paid Claims	% Change from *Prior Year*	Current Quarter 2019 Q3 Total Utilizing Beneficiaries	Prior-Year Quarter 2018 Q3 Total Utilizing Beneficiaries	% Change from *Prior Year*
0 – 12	154,828	163,838	-5.5%	60,191	63,306	-4.9%
13 – 18	95,017	93,991	1.1%	25,185	24,812	1.5%
19 – 39	469,222	473,675	-0.9%	149,219	153,773	-3.0%
40 – 64	713,040	700,750	1.8%	150,860	148,527	1.6%
65+	190,568	195,698	-2.6%	60,343	63,600	-5.1%
Total*	1,622,675	1,627,952	-0.3%	445,798	454,018	-1.8%

* Unknowns represent less than 1% of total

Table 2.3: Pharmacy Utilization by Age Group for the Medi-Cal MCP Population Only

Age Group (years)	Current Quarter 2019 Q3 Total Paid Claims	Prior-Year Quarter 2018 Q3 Total Paid Claims	% Change from *Prior Year*	Current Quarter 2019 Q3 Total Utilizing Beneficiaries	Prior-Year Quarter 2018 Q3 Total Utilizing Beneficiaries	% Change from *Prior Year*
0 – 12	2,148,269	2,199,870	-2.4%	798,516	829,500	-3.7%
13 – 18	1,199,457	1,184,721	1.2%	382,627	383,412	-0.2%
19 – 39	5,057,636	5,179,593	-2.4%	1,120,883	1,146,923	-2.3%
40 – 64	12,912,364	13,600,425	-5.1%	1,458,262	1,510,807	-3.5%
65+	2,137,641	2,222,267	-3.8%	362,961	379,349	-4.3%
Total*	23,455,367	24,386,876	-3.8%	4,123,249	4,249,991	-3.0%

* Unknowns represent less than 1% of total

Table 3. Top 20 Drug Therapeutic Categories in the Medi-Cal Population.

This table presents the top 20 drug therapeutic categories in the Medi-Cal program, by **total utilizing beneficiaries.** The current quarter is compared to the prior-year quarter in order to illustrate changes in utilization for these drugs. The prior-year quarter ranking of the drug therapeutic category is listed for reference.

Table 3: Top 20 Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q3 Total Paid Claims	% Change from *Prior Year*	Current Quarter 2019 Q3 Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change from *Prior Year*
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	1,199,392	-4.8%	914,299	20.1%	-0.4%
2	2	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	907,870	-4.7%	490,854	10.8%	0.2%
3	3	PENICILLIN ANTIBIOTICS	487,472	-4.5%	449,044	9.9%	-0.1%
4	5	ANTIHISTAMINES - 2ND GENERATION	695,992	4.6%	438,028	9.7%	0.8%
5	4	ANTICONVULSANTS	920,798	-2.5%	416,495	9.2%	0.2%
6	7	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	599,434	-0.8%	369,761	8.1%	0.1%
7	11	VITAMIN D PREPARATIONS	637,637	4.9%	352,835	7.8%	0.8%
8	9	TOPICAL ANTI-INFLAMMATORY STEROIDAL	432,416	-3.4%	350,528	7.7%	0.0%
9	6	PLATELET AGGREGATION INHIBITORS	644,462	-13.6%	349,984	7.7%	-0.7%
10	12	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	662,681	-3.1%	319,840	7.0%	0.1%
11	10	ANTIHYPERTENSIVES, ACE INHIBITORS	601,580	-8.7%	319,672	7.0%	-0.2%
12	13	PROTON-PUMP INHIBITORS	561,492	-4.6%	314,654	6.9%	0.0%
13	14	LAXATIVES AND CATHARTICS	453,036	-3.7%	305,533	6.7%	0.0%
14	8	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	491,610	-18.3%	303,119	6.7%	-1.3%
15	15	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	554,790	-5.3%	298,753	6.6%	0.1%
16	17	CALCIUM CHANNEL BLOCKING AGENTS	463,278	-4.2%	244,156	5.4%	0.1%
17	16	ANTIHISTAMINES - 1ST GENERATION	349,071	-6.2%	238,908	5.3%	-0.2%
18	18	NASAL ANTI-INFLAMMATORY STEROIDS	324,892	3.7%	224,256	4.9%	0.2%
19	23	ANTIEMETIC/ANTIVERTIGO AGENTS	271,748	4.8%	221,266	4.9%	0.4%
20	19	BETA-ADRENERGIC BLOCKING AGENTS	410,553	-6.8%	211,623	4.7%	0.0%

Tables 4.1 – 4.4. Top 20 Drug Therapeutic Categories in the Continuosly-Eligible Medi-Cal Population by Population Aid Code Group, Stratified by Program.

These tables present the top 20 drug therapeutic categories in the Medi-Cal program by **total continuously-eligible utilizing beneficiaries from each population aid code group, stratified by Medi-Cal program.** Mean days' supply per utilizing beneficiary is included for reference. Continuous eligibility is plan-specific and is measured from July 1, 2019 – September 1, 2019.

Table 4.1 presents the top 20 drug therapeutic categories in the **Affordable Care Act (ACA)** population, which consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U.

Table 4.1: Top 20 Drug Therapeutic Categories by *Total Continuously-Eligible ACA Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Therapeutic Category Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	59	53	145,415	11.7%	16.3%
2	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	18	30	140,447	16.5%	15.3%
3	ANTICONVULSANTS	39	41	101,087	10.4%	11.1%
4	ANTIHYPERTENSIVES, ACE INHIBITORS	57	55	96,697	10.5%	10.7%
5	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	56	54	88,221	9.9%	9.7%
6	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	39	43	84,700	6.6%	9.4%
7	PROTON-PUMP INHIBITORS	42	47	79,478	6.7%	8.9%
8	CALCIUM CHANNEL BLOCKING AGENTS	53	51	68,990	6.1%	7.7%
9	VITAMIN D PREPARATIONS	51	48	65,233	1.2%	7.6%
10	PLATELET AGGREGATION INHIBITORS	59	55	62,889	3.6%	7.2%
11	BETA-ADRENERGIC BLOCKING AGENTS	51	49	60,152	4.9%	6.7%
12	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	8	24	58,820	5.8%	6.5%
13	ANTIHISTAMINES - 2ND GENERATION	42	40	57,942	3.0%	6.6%
14	INSULINS	41	41	54,144	6.7%	5.9%
15	INFLUENZA VIRUS VACCINES	2	4	52,973	5.4%	5.8%
16	BLOOD SUGAR DIAGNOSTICS	88	48	51,525	0.0%	6.0%
17	THYROID HORMONES	58	52	48,517	4.1%	5.4%
18	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	26	29	48,082	4.1%	5.3%
19	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	58	54	47,107	3.4%	5.3%
20	SKELETAL MUSCLE RELAXANTS	26	30	46,005	2.3%	5.2%

Table 4.2 presents the top 20 drug therapeutic categories in the **Optional Targeted Low Income Children (OTLIC)** population, which consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9.

Table 4.2: Top 20 Drug Therapeutic Categories by *Total Continuously-Eligible OTLIC Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Therapeutic Category Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	9	26	21,218	15.2%	14.8%
2	ANTIHISTAMINES - 2ND GENERATION	33	39	20,584	7.6%	14.5%
3	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	25	33	17,541	13.2%	12.2%
4	PENICILLIN ANTIBIOTICS	10	18	16,821	15.9%	11.6%
5	TOPICAL ANTI-INFLAMMATORY STEROIDAL	19	27	11,096	6.2%	7.7%
6	NASAL ANTI-INFLAMMATORY STEROIDS	37	46	10,441	5.9%	7.3%
7	TOPICAL ANTIBIOTICS	22	29	7,963	1.8%	5.6%
8	GLUCOCORTICOIDS, ORALLY INHALED	34	45	7,274	5.3%	5.1%
9	LEUKOTRIENE RECEPTOR ANTAGONISTS	38	41	6,551	4.5%	4.6%
10	ANALGESIC/ANTIPYRETICS,NON-SALICYLATE	8	27	6,477	5.1%	4.5%
11	ANTIHISTAMINES - 1ST GENERATION	14	27	6,052	3.4%	4.2%
12	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	10	21	5,876	5.7%	4.1%
13	GLUCOCORTICOIDS	10	27	5,655	5.3%	3.9%
14	MACROLIDE ANTIBIOTICS	8	24	5,429	4.6%	3.8%
15	ANTIEMETIC/ANTIVERTIGO AGENTS	6	15	5,109	4.3%	3.5%
16	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	36	43	5,009	5.1%	3.5%
17	CONTRACEPTIVES,ORAL	56	61	4,349	1.9%	3.1%
18	ANTICONVULSANTS	38	43	3,698	4.2%	2.6%
19	KERATOLYTICS	29	35	3,659	0.6%	2.6%
20	LAXATIVES AND CATHARTICS	26	33	3,643	0.9%	2.6%

Table 4.3 presents the top 20 drug therapeutic categories in the **Seniors and Persons with Disabilities (SPD)** population, which consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7.

Table 4.3: Top 20 Drug Therapeutic Categories by *Total Continuously-Eligible SPD Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Therapeutic Category Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	PLATELET AGGREGATION INHIBITORS	58	48	108,537	21.3%	19.0%
2	ANTICONVULSANTS	36	45	102,830	15.6%	18.3%
3	VITAMIN D PREPARATIONS	44	42	84,448	3.7%	16.1%
4	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	46	51	82,116	5.7%	15.3%
5	LAXATIVES AND CATHARTICS	39	34	66,158	15.2%	11.4%
6	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE,SER OTONIN ANTAGNST	39	38	62,449	6.3%	11.4%
7	ANTIHISTAMINES - 2ND GENERATION	43	40	57,474	14.2%	9.8%
8	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	23	34	49,758	2.5%	9.4%
9	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	38	44	48,498	3.8%	9.0%
10	PROTON-PUMP INHIBITORS	39	47	48,454	4.1%	9.0%
11	CALCIUM CHANNEL BLOCKING AGENTS	45	51	46,066	3.5%	8.5%
12	ANTIHYPERTENSIVES, ACE INHIBITORS	48	52	45,696	3.7%	8.5%
13	CALCIUM REPLACEMENT	56	42	42,830	6.3%	7.7%
14	BETA-ADRENERGIC BLOCKING AGENTS	43	48	40,090	3.3%	7.4%
15	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	47	52	39,173	2.8%	7.3%
16	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	16	32	35,729	2.0%	6.7%
17	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	25	36	34,386	3.1%	6.3%
18	BLOOD SUGAR DIAGNOSTICS	36	46	32,333	0.0%	6.3%
19	ANTIHISTAMINES - 1ST GENERATION	29	36	29,682	4.6%	5.3%
20	INSULINS	35	42	29,590	3.2%	5.4%

Table 4.4 presents the top 20 drug therapeutic categories in the **Other Populations (OTHER)** population, which consists of all aid codes not categorized under ACA, OTLIC, or SPD.

Table 4.4: Top 20 Drug Therapeutic Categories by *Total Continuously-Eligible OTHER Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	**Drug Therapeutic Category Description**	**FFS**	**MCP**	**All Medi-Cal**	**% FFS**	**% MCP**
1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	13	32	154,698	17.6%	18.3%
2	PENICILLIN ANTIBIOTICS	9	23	83,592	8.3%	10.0%
3	ANTIHISTAMINES - 2ND GENERATION	35	42	78,435	4.4%	9.9%
4	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	22	36	70,325	5.5%	8.6%
5	TOPICAL ANTI-INFLAMMATORY STEROIDAL	20	32	52,900	3.6%	6.5%
6	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	35	48	46,775	5.0%	5.6%
7	ANTICONVULSANTS	34	49	45,852	4.9%	5.5%
8	ANALGESIC/ANTIPYRETICS,NON-SALICYLATE	10	33	41,564	3.0%	4.9%
9	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	58	55	40,829	4.2%	4.9%
10	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	5	28	39,212	4.5%	4.6%
11	NASAL ANTI-INFLAMMATORY STEROIDS	36	47	38,189	2.3%	4.8%
12	PROTON-PUMP INHIBITORS	38	50	36,002	3.5%	4.4%
13	ANTIHISTAMINES - 1ST GENERATION	20	35	35,923	2.9%	4.4%
14	CONTRACEPTIVES,ORAL	59	68	34,324	4.6%	4.0%
15	VITAMIN D PREPARATIONS	50	50	34,117	0.8%	4.4%
16	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	52	58	33,800	5.3%	3.9%
17	ANTIEMETIC/ANTIVERTIGO AGENTS	8	20	32,527	3.9%	3.8%
18	ANTIHYPERTENSIVES, ACE INHIBITORS	56	59	32,254	4.2%	3.8%
19	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	9	27	32,245	4.3%	3.7%
20	GLUCOCORTICOIDS	11	34	31,967	2.9%	3.9%

Table 5. Top 20 Drugs in the Medi-Cal Population.

This table presents the top 20 drugs in the Medi-Cal program, by **total utilizing beneficiaries.** The current quarter is compared to the prior-year quarter in order to illustrate changes in utilization for these drugs. The prior-year quarter ranking of each drug is listed for reference.

Table 5: Top 20 Drugs by *Total Utilizing Beneficiaries* for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q3 Total Paid Claims	% Change from *Prior Year*	Current Quarter 2019 Q3 Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change from *Prior Year*
1	1	IBUPROFEN	857,879	-4.3%	685,478	15.1%	-0.2%
2	2	ALBUTEROL SULFATE	599,632	-0.9%	371,951	8.2%	0.1%
3	5	ATORVASTATIN CALCIUM	619,735	2.3%	336,719	7.4%	0.6%
4	4	AMOXICILLIN	357,253	-4.7%	327,713	7.2%	-0.1%
5	3	ASPIRIN	588,553	-14.8%	323,042	7.1%	-0.8%
6	6	METFORMIN HCL	554,790	-5.3%	298,753	6.6%	0.1%
7	7	LORATADINE	465,716	-0.7%	290,949	6.4%	0.2%
8	9	FLUTICASONE PROPIONATE	391,827	4.9%	266,362	5.9%	0.4%
9	10	LISINOPRIL	467,454	-6.9%	247,110	5.4%	0.0%
10	8	HYDROCODONE/ACETAMINOPHEN	364,074	-18.0%	217,402	4.8%	-0.9%
11	17	CHOLECALCIFEROL (VITAMIN D3)	380,376	6.6%	217,274	4.8%	0.5%
12	11	OMEPRAZOLE	380,380	-4.3%	214,731	4.7%	0.1%
13	13	AMLODIPINE BESYLATE	399,725	-3.8%	211,407	4.7%	0.1%
14	14	GABAPENTIN	427,332	-2.3%	209,329	4.6%	0.1%
15	12	CEPHALEXIN	220,844	-3.8%	205,625	4.5%	0.0%
16	15	BLOOD SUGAR DIAGNOSTIC	356,950	-5.2%	203,280	4.5%	0.0%
17	16	ACETAMINOPHEN	231,053	-2.4%	196,251	4.3%	0.0%
18	19	LEVOTHYROXINE SODIUM	343,512	-5.1%	167,255	3.7%	0.0%
19	18	FERROUS SULFATE	259,442	-6.6%	166,895	3.7%	-0.1%
20	20	TRIAMCINOLONE ACETONIDE	196,850	-2.6%	160,634	3.5%	0.0%

Tables 6.1 – 6.4. Top 20 Drugs in the Medi-Cal Population, by Population Aid Code Group and Program.

These tables present utilization of the top 20 drugs in the Medi-Cal program by **total continuously-eligible utilizing beneficiaries from each population aid code group, stratified by Medi-Cal program.** Mean days' supply per utilizing beneficiary is included for reference. Continuous eligibility is plan-specific and is measured from July 1, 2019 – September 1, 2019.

Table 6.1 presents the top 20 drugs in the **Affordable Care Act (ACA)** population, which consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U.

Table 6.1: Top 20 Drugs by *Total Continuously-Eligible ACA Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	ATORVASTATIN CALCIUM	58	55	101,077	8.5%	11.3%
2	IBUPROFEN	14	29	89,046	12.2%	9.6%
3	METFORMIN HCL	56	57	88,221	9.9%	9.7%
4	LISINOPRIL	56	58	76,487	8.3%	8.4%
5	AMLODIPINE BESYLATE	54	54	60,872	5.1%	6.8%
6	GABAPENTIN	38	45	58,724	5.3%	6.5%
7	OMEPRAZOLE	58	48	54,882	2.9%	6.2%
8	ASPIRIN	62	57	54,846	2.7%	6.3%
9	BLOOD SUGAR DIAGNOSTIC	88	51	51,524	0.0%	6.0%
10	ALBUTEROL SULFATE	26	33	47,973	4.1%	5.3%
11	LEVOTHYROXINE SODIUM	58	56	46,534	3.9%	5.2%
12	LOSARTAN POTASSIUM	59	57	43,444	3.1%	4.9%
13	HYDROCODONE/ACETAMINOPHEN	7	27	43,440	4.2%	4.8%
14	CHOLECALCIFEROL (VITAMIN D3)	48	47	39,302	0.1%	4.6%
15	FLUTICASONE PROPIONATE	37	43	39,229	2.2%	4.5%
16	LORATADINE	43	44	38,191	2.3%	4.3%
17	HYDROCHLOROTHIAZIDE	58	60	37,578	3.5%	4.2%
18	FLU VACC QS2019-20(6MOS UP)/PF	2	4	35,085	3.5%	3.9%
19	INSULIN GLARGINE,HUM.REC.ANLOG	41	46	29,644	3.6%	3.2%
20	AMOXICILLIN	9	24	28,996	3.9%	3.1%

Table 6.2 presents the top 20 drugs in the **Optional Targeted Low Income Children (OTLIC)** population, which consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9.

Table 6.2: Top 20 Drugs by *Total Continuously-Eligible OTLIC Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	IBUPROFEN	8	26	19,861	14.9%	13.8%
2	ALBUTEROL SULFATE	25	33	17,739	13.1%	12.4%
3	FLUTICASONE PROPIONATE	36	45	13,682	8.9%	9.6%
4	AMOXICILLIN	10	10	13,413	12.1%	9.3%
5	LORATADINE	33	40	12,486	6.1%	8.8%
6	CETIRIZINE HCL	33	36	7,858	1.5%	5.6%
7	MONTELUKAST SODIUM	38	41	6,548	4.5%	4.6%
8	ACETAMINOPHEN	8	27	6,479	5.1%	4.5%
9	CEPHALEXIN	10	21	5,861	5.7%	4.1%
10	AZITHROMYCIN	6	24	5,242	4.2%	3.7%
11	TRIAMCINOLONE ACETONIDE	19	30	5,055	2.9%	3.5%
12	HYDROCORTISONE	20	25	4,684	3.0%	3.3%
13	DIPHENHYDRAMINE HCL	12	24	3,834	1.4%	2.7%
14	CLINDAMYCIN PHOSPHATE	31	35	3,692	0.7%	2.6%
15	ONDANSETRON	7	13	3,582	1.6%	2.5%
16	BENZOYL PEROXIDE	29	35	3,578	0.6%	2.5%
17	PROMETHAZINE/DEXTROMETHORPHAN	11	47	3,577	2.7%	2.5%
18	METHYLPHENIDATE HCL	36	40	2,936	1.7%	2.1%
19	POLYETHYLENE GLYCOL 3350	26	32	2,865	0.3%	2.0%
20	AMOXICILLIN/POTASSIUM CLAV	10	11	2,766	3.3%	1.9%

Table 6.3 presents the top 20 drugs in the **Seniors and Persons with Disabilities (SPD)** population, which consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7.

Table 6.3: Top 20 Drugs by *Total Continuously-Eligible SPD Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	ASPIRIN	58	48	102,159	21.2%	17.8%
2	ATORVASTATIN CALCIUM	47	52	54,549	3.9%	10.1%
3	CHOLECALCIFEROL (VITAMIN D3)	37	43	50,333	0.5%	9.8%
4	LORATADINE	43	42	42,675	12.6%	7.1%
5	DOCUSATE SODIUM	40	38	41,594	13.6%	6.8%
6	GABAPENTIN	36	44	40,113	3.2%	7.4%
7	AMLODIPINE BESYLATE	46	51	39,311	3.0%	7.3%
8	METFORMIN HCL	47	52	39,173	2.8%	7.3%
9	ALBUTEROL SULFATE	25	36	33,787	2.9%	6.2%
10	LISINOPRIL	48	53	33,580	2.7%	6.2%
11	ERGOCALCIFEROL (VITAMIN D2)	45	41	32,924	3.1%	6.1%
12	BLOOD SUGAR DIAGNOSTIC	36	46	32,327	0.0%	6.3%
13	OMEPRAZOLE	42	45	30,791	0.9%	5.9%
14	IBUPROFEN	18	30	27,963	1.6%	5.2%
15	HYDROCODONE/ACETAMINOPHEN	16	33	27,267	1.5%	5.1%
16	FERROUS SULFATE	46	45	26,239	7.7%	4.3%
17	LEVOTHYROXINE SODIUM	43	51	25,830	3.1%	4.7%
18	FOLIC ACID	44	43	24,647	8.1%	4.0%
19	LOSARTAN POTASSIUM	53	54	24,574	1.3%	4.6%
20	TRAZODONE HCL	36	41	20,701	1.5%	3.9%

Table 6.4 presents the top 20 drugs in the **Other Populations (OTHER)** population, which consists of all aid codes not categorized under ACA, OTLIC, or SPD.

Table 6.4: Top 20 Drug by *Total Continuously-Eligible OTHER Utilizing Beneficiaries* for the Entire Medi-Cal Population, by Program

		Current Quarter 2019 Q3				
		Mean Days' Supply per Utilizing Beneficiary		Total Continuously-Eligible Utilizing Beneficiaries		
Rank	Drug Description	FFS	MCP	All Medi-Cal	% FFS	% MCP
1	IBUPROFEN	11	31	128,373	15.0%	15.1%
2	ALBUTEROL SULFATE	22	36	71,584	5.5%	8.8%
3	AMOXICILLIN	9	25	65,190	6.2%	7.8%
4	LORATADINE	36	44	50,723	3.4%	6.3%
5	FLUTICASONE PROPIONATE	36	46	48,846	3.3%	6.1%
6	ACETAMINOPHEN	10	33	41,616	3.0%	4.9%
7	METFORMIN HCL	52	58	33,800	5.3%	3.9%
8	CEPHALEXIN	9	27	32,158	4.3%	3.7%
9	FERROUS SULFATE	55	55	29,257	5.4%	3.2%
10	HYDROCODONE/ACETAMINOPHEN	5	30	28,467	3.2%	3.4%
11	ATORVASTATIN CALCIUM	56	56	28,449	2.9%	3.4%
12	CETIRIZINE HCL	35	38	26,382	0.9%	3.4%
13	LISINOPRIL	56	61	26,063	3.3%	3.1%
14	OMEPRAZOLE	36	47	25,416	1.8%	3.2%
15	AZITHROMYCIN	5	34	25,313	2.3%	3.1%
16	LEVOTHYROXINE SODIUM	53	57	23,699	2.6%	2.8%
17	TRIAMCINOLONE ACETONIDE	21	34	23,041	1.6%	2.8%
18	MONTELUKAST SODIUM	40	41	22,308	1.6%	2.8%
19	HYDROCORTISONE	18	30	22,172	1.8%	2.7%
20	GABAPENTIN	35	47	21,023	1.8%	2.6%

QUARTERLY SUMMARY
MEDI-CAL FEE-FOR-SERVICE PROGRAM DRUG USE REVIEW
REPORT PERIOD: 4th QUARTER 2019 (OCTOBER – DECEMBER 2019)

Executive Summary

The DUR quarterly report provides information on both prospective and retrospective drug utilization for all claims processed by the Medi-Cal Fee-for-Service (FFS) program, including the carved-out drug claims for the Medi-Cal Managed Care Plans (MCPs). For this quarterly report, the prospective and retrospective data cover the fourth quarter of 2019 (2019 Q4). All tables can be found in **Appendix A** and definitions of selected terms can be found in **Appendix B**.

Prospective DUR

As shown in Table 1.1, in comparison to the prior quarter (2019 Q3), in 2019 Q4 overall drug claims, DUR drug claims, total DUR alerts, total alert overrides, and total alert cancels all decreased. In comparison to the prior-year quarter (2018 Q4), overall drug claims decreased by 1% while total DUR alerts increased by 1%.

A comparison between 2019 Q4 and 2019 Q3 showed very little change among the summary of alert transactions by therapeutic problem (**Table 1.2**) and among the top 10 drugs for each of the 12 prospective DUR alerts (**Tables 2.1-2.12**).

Retrospective DUR

In 2019 Q4, approximately 15% of eligible Medi-Cal FFS enrollees had a paid claim through the Medi-Cal fee-for-service program, compared with only 2% of Medi-Cal MCP enrollees (**Table 3.2** and **Table 3.3**). Among all Medi-Cal beneficiaries with a paid claim through the Medi-Cal fee-for-service program in 2019 Q4, 61% were FFS enrollees and 40% were MCP enrollees (numbers add up to slightly more than 100% due to < 1% of beneficiaries being enrolled in both programs during the quarter).

As shown in **Tables 4.1 – 4.3**, there was an across-the-board decrease in utilizing beneficiaries and paid claims processed by the FFS program in comparison to both the prior-year quarter and the prior quarter within the 13 – 18 year age group. All other age groups showed variation between the FFS and MCP populations.

A review of the top 20 drug therapeutic categories in the FFS population (**Table 5.2**) by percentage of utilizing beneficiaries with a paid claim showed a 32% increase in average paid claims per day and a 44% increase in total utilizing beneficiaries with a paid claim in comparison to last year for PROTON-PUMP INHIBITORS, which may be attributed to the addition of OMEPRAZOLE to the Medi-Cal Fee-for-Service List of Contract Drugs (CDL) for dates of service on or after May 1, 2019.

Table 6.3 shows significant increases in the use of NALOXONE and BUPRENORPHINE HCL/NALOXONE HCL in the MCP population during 2019 Q4 when compared to the prior-year quarter, most likely due to Assembly Bill 2760 (Wood, Chapter 324), which was effective the first day of 2019 Q1.

Appendix A: Prospective and Retrospective DUR Tables

Tables 1.1-1.2. Summary of Prospective DUR Alert Transactions in the Medi-Cal Fee-for-Service Program.

Table 1.1 provides summary level data (by volume) on pharmacy claims and DUR alert activities, including data and percent change from the prior quarter. Alerts are generated after adjudication of drug claims which exceed or otherwise fall outside of certain prescribed parameters. Please see **Appendix B** for definitions of terms used in this DUR report.

Table 1.1: Summary of Alert Transactions					
Category	Current Quarter 2019 Q4 (Oct – Dec 2019)	Prior Quarter 2019 Q3 (Jul – Sept 2019)	% Change from *Prior Quarter*	Prior-Year Quarter 2018 Q4 (Oct – Dec 2018)	% Change from *Prior-Year Quarter*
Drug Claims	7,649,437	7,891,599	-3.1%	7,760,490	-1.4%
DUR Drug Claims	3,628,850	3,723,043	-2.5%	3,714,099	-2.3%
Total Alerts	1,056,097	1,063,242	-0.7%	1,049,489	0.6%
Total Alert Overrides	673,242	685,078	-1.7%	675,741	-0.4%
Total Alert Cancels	197	227	-13.2%	254	-22.4%

Note: Drug claims receiving multiple alerts can be adjudicated by pharmacists by responding to only one conflict code, followed by an intervention code and outcome code. The remaining alerts on the claim cannot be tracked as they are overridden by the pharmacist's response to a single alert. For example, a single claim can generate up to eight different alerts, but the pharmacist can override all eight alerts by choosing to override only one alert. In addition, the number of cancelled alerts may be underrepresented due to the system's inability to capture claims that were not adjudicated.

Table 1.2 provides a summary of the number of drug claims and alerts generated for each therapeutic problem type (sorted by alert frequency). Total alerts not adjudicated may be overrepresented, as claims with multiple alerts that have been adjudicated under one alert will show up as not adjudicated for the remaining alerts.

Table 1.2: Summary of Alert Transactions by Therapeutic Problem Type – 2019 Q4							
Therapeutic Problem Type	Total Alerts	Total Alert Over-rides	% Alert Over-rides	Total Alert Cancels	% Alert Cancels	Total Alerts Not Adjud-icated	% Alerts Not Adjud-icated
Therapeutic Duplication (TD)	326,101	247,954	76.0%	32	0.0%	78,115	24.0%
Early Refill (ER)	285,187	95,873	33.6%	109	0.0%	189,205	66.3%
Ingredient Duplication (ID)	223,276	163,944	73.4%	27	0.0%	59,305	26.6%
Late Refill (LR)	101,787	79,815	78.4%	16	0.0%	21,956	21.6%
Total High Dose (HD)	43,730	28,447	65.1%	4	0.0%	15,279	34.9%
Additive Toxicity (AT)	40,693	32,821	80.7%	3	0.0%	7,869	19.3%
Drug-Pregnancy (PG)	19,075	13,145	68.9%	2	0.0%	5,928	31.1%
Total Low Dose (LD)	10,271	6,905	67.2%	1	0.0%	3,365	32.8%
Drug-Drug (DD)	3,225	2,412	74.8%	0	0.0%	813	25.2%
Drug-Disease (MC)	2,389	1,678	70.2%	0	0.0%	711	29.8%
Drug-Age (PA)	239	177	74.1%	0	0.0%	62	25.9%
Drug-Allergy (DA)	124	71	57.3%	0	0.0%	53	42.7%

Tables 2.1-2.12. Prospective DUR Alert Transactions by Therapeutic Problem Type in the Medi-Cal Fee-for-Service Program.

Each of the following tables provides greater detail of each of the 12 DUR alerts with the top 10 drugs generating each respective alert. For each of the top 10 drugs, data are provided for the total number of adjudicated alerts, alert overrides, alert cancels, paid claims, and the percentage of paid claims with alert overrides. **Tables are listed in order of DUR alert priority, which is determined by the DUR Board.**

Table 2.1: Top 10 Drugs by Therapeutic Problem Type – Drug-Allergy (DA) – 2019 Q4

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	PHENYTOIN SODIUM EXTENDED	43	43	0	1,390	3.1%
2	PHENYTOIN	24	24	0	644	3.7%
3	MORPHINE SULFATE	6	6	0	1,043	0.6%
4	IBUPROFEN	5	5	0	76,079	0.0%
5	OXYCODONE HCL	5	5	0	3,881	0.1%
6	OXYCODONE HCL/ACETAMINOPHEN	5	5	0	3,404	0.1%
7	AMOXICILLIN	4	4	0	31,416	0.0%
8	AMOXICILLIN/POTASSIUM CLAV	4	4	0	10,611	0.0%
9	NAPROXEN	4	4	0	11,602	0.0%
10	ELVITEG/COB/EMTRI/TENOF ALAFEN	2	2	0	8,219	0.0%

Table 2.2: Top 10 Drugs by Therapeutic Problem Type – Drug-Pregnancy (PG) – 2019 Q4

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	IBUPROFEN	12,275	12,273	2	76,079	16.1%
2	NORETHINDRONE	2,185	2,185	0	3,062	71.4%
3	NAPROXEN	432	432	0	11,602	3.7%
4	MISOPROSTOL	324	324	0	404	80.2%
5	METHYLERGONOVINE MALEATE	252	252	0	127	198.4%
6	LISINOPRIL	115	115	0	30,293	0.4%
7	METHIMAZOLE	110	110	0	1,283	8.6%
8	INDOMETHACIN	106	106	0	725	14.6%
9	ULIPRISTAL ACETATE	81	81	0	96	84.4%
10	PROPYLTHIOURACIL	68	68	0	99	68.7%

Table 2.3: Top 10 Drugs by Therapeutic Problem Type – Drug-Disease (MC) – 2019 Q4

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	POTASSIUM CHLORIDE	449	449	0	3,036	14.8%
2	METFORMIN HCL	294	294	0	38,618	0.8%
3	HALOPERIDOL	252	252	0	18,723	1.3%
4	PROPRANOLOL HCL	159	159	0	4,023	4.0%
5	METOPROLOL SUCCINATE	71	71	0	6,290	1.1%
6	METOPROLOL TARTRATE	68	68	0	5,962	1.1%
7	CARBAMAZEPINE	53	53	0	2,475	2.1%
8	NORETHINDRONE-E.ESTRADIOL-IRON	48	48	0	3,123	1.5%
9	LEVONORGESTREL-ETHIN ESTRADIOL	45	45	0	3,124	1.4%
10	HALOPERIDOL DECANOATE	35	35	0	4,440	0.8%

Table 2.4: Top 10 Drugs by Therapeutic Problem Type – Drug-Drug Interaction (DD) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	GEMFIBROZIL	301	301	0	1,764	17.1%
2	ATORVASTATIN CALCIUM	284	284	0	32,055	0.9%
3	SIMVASTATIN	197	197	0	7,353	2.7%
4	BUPRENORPHINE HCL/ NALOXONE HCL	172	172	0	46,461	0.4%
5	AMLODIPINE BESYLATE	142	142	0	21,387	0.7%
6	NALTREXONE HCL	61	61	0	8,549	0.7%
7	PIOGLITAZONE HCL	61	61	0	2,356	2.6%
8	HYDROXYCHLOROQUINE SULFATE	58	58	0	1,499	3.9%
9	ELVITEG/COB/EMTRI/TENOF ALAFEN	57	57	0	8,219	0.7%
10	CYCLOSPORINE, MODIFIED	45	45	0	292	15.4%

Table 2.5: Top 10 Drugs by Therapeutic Problem Type – Therapeutic Duplication (TD) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	40,253	40,248	5	137,480	29.3%
2	OLANZAPINE	28,397	28,394	3	81,897	34.7%
3	ARIPIPRAZOLE	22,511	22,511	0	106,118	21.2%
4	RISPERIDONE	21,287	21,285	2	80,107	26.6%
5	LURASIDONE HCL	13,510	13,510	0	40,831	33.1%
6	CLOZAPINE	13,045	13,044	1	22,047	59.2%
7	HALOPERIDOL	12,600	12,597	3	18,723	67.3%
8	PALIPERIDONE PALMITATE	7,682	7,682	0	20,377	37.7%
9	CHLORPROMAZINE HCL	5,664	5,663	1	6,159	91.9%
10	ZIPRASIDONE HCL	4,930	4,928	2	14,994	32.9%

Table 2.6: Top 10 Drugs by Therapeutic Problem Type – Overutilization (ER) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	8,900	8,893	7	137,480	6.5%
2	ARIPIPRAZOLE	6,641	6,633	8	106,118	6.3%
3	OLANZAPINE	4,723	4,720	3	81,897	5.8%
4	RISPERIDONE	4,423	4,420	3	80,107	5.5%
5	BENZTROPINE MESYLATE	3,824	3,821	3	53,342	7.2%
6	LITHIUM CARBONATE	2,588	2,588	0	28,824	9.0%
7	LURASIDONE HCL	2,570	2,566	4	40,831	6.3%
8	METFORMIN HCL	2,026	2,024	2	38,618	5.2%
9	BUPRENORPHINE HCL/ NALOXONE HCL	2,009	2,009	0	46,461	4.3%
10	BICTEGRAV/EMTRICIT/TENOFOV ALA	1,980	1,978	2	20,399	9.7%

Table 2.7: Top 10 Drugs by Therapeutic Problem Type – Underutilization (LR) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ARIPIPRAZOLE	13,139	13,135	4	106,118	12.4%
2	QUETIAPINE FUMARATE	12,798	12,797	1	137,480	9.3%
3	RISPERIDONE	7,953	7,951	2	80,107	9.9%
4	OLANZAPINE	7,660	7,658	2	81,897	9.4%
5	BENZTROPINE MESYLATE	5,810	5,809	1	53,342	10.9%
6	LURASIDONE HCL	5,064	5,062	2	40,831	12.4%
7	LITHIUM CARBONATE	3,736	3,736	0	28,824	13.0%
8	ATORVASTATIN CALCIUM	3,232	3,232	0	32,055	10.1%
9	LEVOTHYROXINE SODIUM	2,410	2,409	1	22,538	10.7%
10	GABAPENTIN	2,338	2,338	0	23,400	10.0%

Table 2.8: Top 10 Drugs by Therapeutic Problem Type – Additive Toxicity (AT) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	GABAPENTIN	2,494	2,494	0	23,400	10.7%
2	LITHIUM CARBONATE	1,570	1,570	0	28,824	5.4%
3	LORAZEPAM	1,380	1,380	0	6,414	21.5%
4	BACLOFEN	1,330	1,330	0	12,126	11.0%
5	QUETIAPINE FUMARATE	1,240	1,240	0	137,480	0.9%
6	CLONAZEPAM	1,155	1,154	1	5,445	21.2%
7	HYDROCODONE/ACETAMINOPHEN	1,052	1,052	0	22,138	4.8%
8	ARIPIPRAZOLE	743	743	0	106,118	0.7%
9	BUSPIRONE HCL	670	670	0	3,573	18.8%
10	OLANZAPINE	664	664	0	81,897	0.8%

Table 2.9: Top 10 Drugs by Therapeutic Problem Type – Ingredient Duplication (ID) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	29,369	29,363	6	137,480	21.4%
2	OLANZAPINE	15,595	15,592	3	81,897	19.0%
3	ARIPIPRAZOLE	12,282	12,280	2	106,118	11.6%
4	RISPERIDONE	11,420	11,420	0	80,107	14.3%
5	ALBUTEROL SULFATE	7,965	7,965	0	42,376	18.8%
6	CLOZAPINE	6,947	6,947	0	22,047	31.5%
7	LURASIDONE HCL	6,197	6,197	0	40,831	15.2%
8	LEVOTHYROXINE SODIUM	3,120	3,120	0	22,538	13.8%
9	ZIPRASIDONE HCL	3,060	3,059	1	14,994	20.4%
10	BENZTROPINE MESYLATE	2,305	2,305	0	53,342	4.3%

Table 2.10: Top 10 Drugs by Therapeutic Problem Type – Drug-Age (PA) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	AMITRIPTYLINE HCL	138	138	0	2,776	5.0%
2	DOXEPIN HCL	13	13	0	368	3.5%
3	ACETAMINOPHEN WITH CODEINE	9	9	0	4,695	0.2%
4	ARIPIPRAZOLE	5	5	0	106,118	0.0%
5	OLANZAPINE	5	5	0	81,897	0.0%
6	CODEINE PHOSPHATE/GUAIFENESIN	4	4	0	2,791	0.1%
7	GUANFACINE HCL	4	4	0	6,148	0.1%
8	DIPHENHYDRAMINE HCL	3	3	0	11,958	0.0%
9	QUETIAPINE FUMARATE	3	3	0	137,480	0.0%
10	RISPERIDONE	3	3	0	80,107	0.0%

Table 2.11: Top 10 Drugs by Therapeutic Problem Type – High Dose (HD) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	OLANZAPINE	7,518	7,517	1	81,897	9.2%
2	IBUPROFEN	2,104	2,104	0	76,079	2.8%
3	RISPERIDONE	2,085	2,085	0	80,107	2.6%
4	QUETIAPINE FUMARATE	1,320	1,320	0	137,480	1.0%
5	AMOXICILLIN	980	980	0	31,416	3.1%
6	GABAPENTIN	970	970	0	23,400	4.1%
7	AMOXICILLIN/POTASSIUM CLAV	792	792	0	10,611	7.5%
8	HYDROCODONE/ACETAMINOPHEN	761	761	0	22,138	3.4%
9	ARIPIPRAZOLE	487	487	0	106,118	0.5%
10	PROMETHAZINE/ DEXTROMETHORPHAN	461	461	0	13,527	3.4%

Table 2.12: Top 10 Drugs by Therapeutic Problem Type – Low Dose (LD) – 2019 Q4						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	AZITHROMYCIN	838	838	0	16,877	5.0%
2	DIVALPROEX SODIUM	676	676	0	9,954	6.8%
3	ERYTHROMYCIN ETHYLSUCCINATE	463	463	0	1,598	29.0%
4	DULOXETINE HCL	453	453	0	3,877	11.7%
5	AMOXICILLIN/POTASSIUM CLAV	338	338	0	10,611	3.2%
6	BUPROPION HCL	283	283	0	5,444	5.2%
7	AMOXICILLIN	250	250	0	31,416	0.8%
8	ALBUTEROL SULFATE	240	240	0	42,376	0.6%
9	SULFAMETHOXAZOLE/TRIMETHOPRIM	190	190	0	12,145	1.6%
10	CHLOROTHIAZIDE	164	164	0	302	54.3%

Tables 3.1-3.3. Summary of Medi-Cal Fee-for-Service Pharmacy Utilization.
These tables shows pharmacy utilization in the Medi-Cal Fee-for-Service program, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 3.2** and **Table 3.3**, as enrollment status may change.

Table 3.1: Fee-for-Service Pharmacy Utilization Measures for the Entire Medi-Cal Population

Category	Current Quarter 2019 Q4	Prior Quarter 2019 Q3	Prior-Year Quarter 2018 Q4	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	15,093,951	15,357,540	15,594,706	-1.7%	-3.2%
Total Utilizing Beneficiaries	709,541	718,207	715,508	-1.2%	-0.8%
Total Paid Rx Claims	2,451,041	2,505,661	2,502,009	-2.2%	-2.0%
Average Paid Rx Claims per Eligible Beneficiary	0.16	0.16	0.16	-0.5%	1.2%
Average Paid Rx Claims per Utilizing Beneficiary	3.45	3.49	3.50	-1.0%	-1.2%

Table 3.2: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal FFS Population Only

Category	Current Quarter 2019 Q4	Prior Quarter 2019 Q3	Prior-Year Quarter 2018 Q4	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	2,982,793	3,113,848	3,189,100	-4.2%	-6.5%
Total Utilizing Beneficiaries	433,476	436,855	444,912	-0.8%	-2.6%
Total Paid Rx Claims	1,548,574	1,583,516	1,588,272	-2.2%	-2.5%
Average Paid Rx Claims per Eligible Beneficiary	0.52	0.51	0.50	1.8%	4.2%
Average Paid Rx Claims per Utilizing Beneficiary	3.57	3.62	3.57	-1.3%	0.1%

Table 3.3: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal MCP Population Only

Category	Current Quarter 2019 Q4	Prior Quarter 2019 Q3	Prior-Year Quarter 2018 Q4	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	12,498,025	12,642,793	12,811,595	-1.1%	-2.4%
Total Utilizing Beneficiaries	281,729	287,252	276,182	-1.9%	2.0%
Total Paid Rx Claims	908,836	928,788	920,386	-2.1%	-1.3%
Average Paid Rx Claims per Eligible Beneficiary	0.07	0.07	0.07	-1.0%	1.2%
Average Paid Rx Claims per Utilizing Beneficiary	3.23	3.23	3.33	-0.2%	-3.2%

Tables 4.1-4.3. Fee-for-Service Pharmacy Utilization by Age Group in the Medi-Cal Population.

These tables present pharmacy utilization data in the Medi-Cal Fee-for-Service program, broken out by age group, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 4.2** and **Table 4.3**, as enrollment status may change.

Table 4.1: Fee-for-Service Pharmacy Utilization by Age Group for the Entire Medi-Cal Population

Age Group (years)	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
0 – 12	238,998	**5.8%**	-8.6%	78,763	**6.3%**	-6.7%
13 – 18	162,958	-2.4%	-4.2%	42,910	-3.0%	-3.2%
19 – 39	778,695	-2.7%	-0.2%	247,247	-2.7%	-0.1%
40 – 64	1,079,430	-3.2%	-1.0%	277,957	-1.7%	**1.5%**
65+	190,960	-3.1%	-4.4%	62,664	-0.6%	-4.2%
Total*	2,451,041	-2.2%	-2.0%	709,541	-1.2%	-0.8%

Table 4.2: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal FFS Population Only

Age Group (years)	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
0 – 12	160,941	**11.4%**	-4.9%	61,722	**8.9%**	-4.2%
13 – 18	89,704	-2.6%	-1.3%	23,966	-2.9%	-0.2%
19 – 39	442,845	-3.7%	-2.5%	141,998	-3.4%	-3.8%
40 – 64	674,032	-3.6%	-1.4%	146,825	-1.5%	**0.0%**
65+	181,052	-3.4%	-5.1%	58,965	-0.8%	-5.1%
Total*	1,548,574	-2.2%	-2.5%	433,476	-0.8%	-2.6%

Table 4.3: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal MCP Population Only

Age Group (years)	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
0 – 12	78,515	-4.0%	-15.4%	17,390	-2.4%	-14.7%
13 – 18	73,479	-2.3%	-7.6%	19,240	-3.4%	-6.7%
19 – 39	338,730	-1.4%	**2.8%**	108,043	-1.6%	**5.2%**
40 – 64	407,788	-2.4%	-0.4%	133,250	-2.0%	**3.2%**
65+	10,324	**0.6%**	**10.2%**	3,806	**3.1%**	**11.9%**
Total*	908,836	-2.1%	-1.3%	281,729	-1.9%	**2.0%**

* Unknowns represent less than 1% of total

Tables 5.1-5.3. Top 20 Fee-for-Service Drug Therapeutic Categories in the Medi-Cal Population.

These tables present utilization of the top 20 drug therapeutic categories in the Medi-Cal Fee-for-Service program, by **total utilizing beneficiaries.** The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization and reimbursement dollars paid to pharmacies for these top utilized drugs. The prior-year quarter ranking of the drug therapeutic category is listed for reference.

Table 5.1: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE ,SEROTONIN ANTAGNST	407,312	-2.5%	-0.9%	153,948	21.7%	-1.9%	-0.5%
2	2	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	92,946	0.4%	-1.9%	81,422	11.5%	1.1%	-1.6%
3	3	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	112,928	-1.4%	2.8%	49,007	6.9%	-0.7%	3.5%
4	4	PENICILLIN ANTIBIOTICS	45,462	9.2%	-2.8%	42,092	5.9%	9.4%	-2.5%
5	5	ANTICONVULSANTS	79,980	-4.7%	-6.3%	37,560	5.3%	-4.3%	-4.4%
6	6	PLATELET AGGREGATION INHIBITORS	45,583	-6.9%	-10.9%	31,236	4.4%	-6.1%	-10.0%
7	9	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	43,628	-4.5%	-1.3%	29,670	4.2%	-3.6%	2.1%
8	8	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	42,643	16.3%	-0.9%	29,404	4.1%	20.8%	0.3%
9	15	ANTIHISTAMINES - 2ND GENERATION	43,409	1.9%	12.6%	29,343	4.1%	3.2%	16.0%
10	12	ANTIHYPERTENSIVES, ACE INHIBITORS	40,265	-4.2%	-5.5%	27,217	3.8%	-3.2%	-2.2%
11	10	LAXATIVES AND CATHARTICS	40,951	-4.9%	-5.9%	26,821	3.8%	-5.3%	-7.2%
12	14	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	38,596	-6.1%	-3.1%	26,449	3.7%	-5.1%	0.2%
13	11	INSULINS	48,224	-3.5%	-7.6%	26,172	3.7%	-4.8%	-6.6%
14	7	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	30,190	-10.0%	-16.1%	25,149	3.5%	-9.6%	-15.3%
15	13	IRON REPLACEMENT	33,041	-9.5%	-7.9%	24,683	3.5%	-9.6%	-7.2%
16	17	ANTIEMETIC/ANTIVERTIGO AGENTS	27,285	0.7%	8.2%	23,824	3.4%	2.4%	10.6%
17	16	ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC	57,668	-3.1%	-3.2%	22,603	3.2%	-2.2%	-2.8%
18	20	PROTON-PUMP INHIBITORS	31,582	-2.2%	28.0%	21,298	3.0%	-2.1%	39.5%
19	18	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	21,681	-11.3%	-4.7%	20,421	2.9%	-11.0%	-4.4%
20	19	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	35,440	-4.6%	-3.4%	19,901	2.8%	-4.1%	-3.1%

Table 5.2: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	91,724	**0.5%**	**-1.8%**	80,475	18.6%	**1.3%**	**-1.5%**
2	2	PENICILLIN ANTIBIOTICS	44,619	**9.2%**	**-2.5%**	41,476	9.6%	**9.4%**	**-2.2%**
3	4	ANTICONVULSANTS	66,100	**-5.0%**	**-4.0%**	31,950	7.4%	**-4.4%**	**-1.9%**
4	3	PLATELET AGGREGATION INHIBITORS	44,714	**-6.9%**	**-11.0%**	30,727	7.1%	**-6.1%**	**-10.1%**
5	6	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	43,210	**-4.5%**	**-1.2%**	29,386	6.8%	**-3.6%**	**2.1%**
6	12	ANTIHISTAMINES - 2ND GENERATION	42,437	**2.0%**	**12.9%**	28,827	6.7%	**3.3%**	**16.2%**
7	7	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	39,783	**18.1%**	**1.1%**	28,038	6.5%	**22.1%**	**1.7%**
8	9	ANTIHYPERTENSIVES, ACE INHIBITORS	37,335	**-4.1%**	**-5.0%**	25,731	5.9%	**-3.1%**	**-1.6%**
9	8	LAXATIVES AND CATHARTICS	39,036	**-4.8%**	**-5.4%**	25,626	5.9%	**-5.2%**	**-6.7%**
10	11	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	36,527	**-6.5%**	**-3.0%**	25,369	5.9%	**-5.3%**	**0.4%**
11	5	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	29,745	**-10.1%**	**-16.1%**	24,774	5.7%	**-9.5%**	**-15.2%**
12	10	IRON REPLACEMENT	32,201	**-9.5%**	**-7.6%**	24,182	5.6%	**-9.6%**	**-7.0%**
13	14	ANTIEMETIC/ANTIVERTIGO AGENTS	26,290	**0.9%**	**9.3%**	23,107	5.3%	**2.6%**	**11.6%**
14	20	PROTON-PUMP INHIBITORS	29,897	**-2.0%**	**32.3%**	20,448	4.7%	**-2.0%**	**43.7%**
15	13	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	21,319	**-11.2%**	**-4.6%**	20,127	4.6%	**-10.9%**	**-4.2%**
16	15	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	35,044	**-4.5%**	**-3.3%**	19,638	4.5%	**-4.0%**	**-3.0%**
17	17	PRENATAL VITAMIN PREPARATIONS	20,155	**-7.0%**	**0.2%**	17,721	4.1%	**-7.1%**	**-1.3%**
18	16	ANTIHISTAMINES - 1ST GENERATION	24,371	**-0.1%**	**-2.7%**	17,549	4.1%	**-0.7%**	**-3.0%**
19	18	INSULINS	29,584	**-4.9%**	**-2.4%**	17,011	3.9%	**-4.4%**	**-1.5%**
20	19	GLUCOCORTICOIDS	20,489	**14.0%**	**-1.1%**	16,761	3.9%	**16.9%**	**-0.2%**

Table 5.3: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	ANTIPSYCHOTIC,ATYPICAL,DOPAMINE ,SEROTONIN ANTAGNST	372,995	-2.2%	-0.4%	141,460	50.2%	-1.6%	-0.1%
2	2	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	104,847	-1.2%	3.0%	45,520	16.2%	-0.5%	3.6%
3	3	ANTIPARKINSONISM DRUGS,ANTICHOLINERGIC	52,980	-2.9%	-2.4%	20,777	7.4%	-2.2%	-2.2%
4	10	OPIOID ANTAGONISTS	20,476	-7.3%	84.7%	16,445	5.8%	-9.9%	91.9%
5	4	OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE	51,604	4.1%	23.1%	16,279	5.8%	5.1%	25.0%
6	5	BIPOLAR DISORDER DRUGS	26,759	-2.5%	-1.8%	11,032	3.9%	-1.7%	-1.6%
7	8	ARV-NUCLEOSIDE,NUCLEOTIDE RTI,INTEGRASE INHIBITORS	25,635	3.2%	19.5%	10,870	3.9%	3.0%	22.7%
8	6	INSULINS	18,894	-1.3%	-14.7%	9,405	3.3%	-5.3%	-14.8%
9	7	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	17,316	-8.4%	-24.1%	8,873	3.2%	-3.5%	-15.3%
10	9	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	21,975	-1.8%	-2.4%	8,340	3.0%	-3.4%	-5.0%
11	11	ANTICONVULSANTS	14,137	-2.7%	-14.9%	5,770	2.1%	-4.5%	-15.8%
12	13	ANTIPSYCHOTICS,PHENOTHIAZINES	11,293	-2.5%	-5.3%	4,132	1.5%	-1.7%	-6.4%
13	12	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	8,556	-7.9%	-22.3%	3,762	1.3%	-6.8%	-18.8%
14	17	OPIOID ANALGESICS	6,552	2.7%	12.4%	3,233	1.2%	0.6%	8.1%
15	14	ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB	7,383	-7.7%	-24.1%	3,107	1.1%	-7.0%	-20.0%
16	22	ANTI-ALCOHOLIC PREPARATIONS	5,141	6.0%	97.3%	2,750	1.0%	9.3%	114.0%
17	18	ARTV NUCLEOSIDE,NUCLEOTIDE,NON-NUCLEOSIDE RTI COMB	5,348	-11.0%	-27.7%	2,270	0.8%	-5.3%	-24.5%
18	16	HEPATITIS B TREATMENT AGENTS	5,047	-9.2%	33.0%	2,213	0.8%	-8.4%	32.7%
19	20	AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)	2,389	6.3%	22.3%	1,922	0.7%	6.6%	20.5%
20	21	ANTICONVULSANT - BENZODIAZEPINE TYPE	4,271	-12.7%	-7.7%	1,847	0.7%	-17.6%	-11.6%

Tables 6.1-6.3. Top 20 Fee-for-Service Drugs in the Medi-Cal Population.

These tables present the utilization of the top 20 drugs in the Medi-Cal Fee-for-Service program, by **total utilizing beneficiaries.** The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization for these drugs. The prior-year quarter ranking of each drug is listed for reference.

Table 6.1: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	IBUPROFEN	76,061	2.1%	-1.9%	67,338	9.5%	2.7%	-1.7%
2	2	QUETIAPINE FUMARATE	137,461	-2.1%	-1.4%	52,277	7.4%	-1.7%	-1.2%
3	3	ARIPIPRAZOLE	106,107	-1.5%	2.1%	45,867	6.5%	-0.9%	2.6%
4	5	RISPERIDONE	80,098	-3.7%	-2.5%	31,793	4.5%	-3.4%	-2.7%
5	6	OLANZAPINE	81,864	-2.4%	2.1%	31,269	4.4%	-1.2%	3.2%
6	8	ALBUTEROL SULFATE	42,161	17.9%	0.1%	29,507	4.2%	22.6%	0.6%
7	4	ASPIRIN	42,488	-7.3%	-12.9%	29,315	4.1%	-6.4%	-12.0%
8	7	AMOXICILLIN	31,404	9.8%	-3.7%	28,989	4.1%	10.2%	-3.2%
9	10	METFORMIN HCL	38,596	-6.1%	-3.1%	26,449	3.7%	-5.1%	0.2%
10	9	FERROUS SULFATE	32,961	-9.5%	-7.8%	24,653	3.5%	-9.6%	-7.2%
11	12	LORATADINE	35,543	0.1%	-4.5%	23,702	3.3%	1.8%	-4.0%
12	11	DOCUSATE SODIUM	35,552	-4.8%	-6.5%	23,604	3.3%	-5.8%	-7.9%
13	17	ATORVASTATIN CALCIUM	32,018	-3.1%	5.5%	21,689	3.1%	-2.3%	9.2%
14	16	LISINOPRIL	30,266	-4.2%	-2.9%	21,007	3.0%	-3.1%	0.6%
15	13	BENZTROPINE MESYLATE	53,339	-3.0%	-3.0%	20,935	3.0%	-2.1%	-2.6%
16	15	CEPHALEXIN	21,599	-11.4%	-4.8%	20,395	2.9%	-11.0%	-4.3%
17	14	HYDROCODONE/ ACETAMINOPHEN	22,100	-9.7%	-14.9%	18,378	2.6%	-9.8%	-14.0%
18	18	LURASIDONE HCL	40,828	-2.2%	0.4%	17,061	2.4%	-1.6%	0.4%
19	19	AZITHROMYCIN	16,664	43.9%	4.2%	15,337	2.2%	46.1%	5.1%
20	20	FLUTICASONE PROPIONATE	19,272	10.5%	49.5%	15,083	2.1%	12.2%	54.1%

Table 6.2: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Benefici-aries	% Utilizing Benefici-aries with a Paid Claim	% Change Total Utilizing Benefici-aries from *Prior Quarter*	% Change Utilizing Total Utilizing Benefici-aries *Prior-Year Quarter*
1	1	IBUPROFEN	75,251	**2.2%**	**-1.9%**	66,646	15.4%	**2.9%**	**-1.6%**
2	2	ASPIRIN	41,692	**-7.4%**	**-13.0%**	28,856	6.7%	**-6.5%**	**-12.0%**
3	3	AMOXICILLIN	30,939	**9.7%**	**-3.4%**	28,640	6.6%	**10.2%**	**-3.0%**
4	4	ALBUTEROL SULFATE	39,889	**19.3%**	**1.2%**	28,432	6.6%	**23.6%**	**1.5%**
5	7	METFORMIN HCL	36,527	**-6.5%**	**-3.0%**	25,369	5.9%	**-5.3%**	**0.4%**
6	5	FERROUS SULFATE	32,177	**-9.5%**	**-7.5%**	24,169	5.6%	**-9.6%**	**-6.9%**
7	8	LORATADINE	35,078	**0.3%**	**-4.5%**	23,439	5.4%	**1.9%**	**-4.0%**
8	6	DOCUSATE SODIUM	35,158	**-4.8%**	**-6.5%**	23,324	5.4%	**-5.7%**	**-7.9%**
9	12	ATORVASTATIN CALCIUM	31,699	**-3.1%**	**5.6%**	21,470	5.0%	**-2.4%**	**9.2%**
10	11	LISINOPRIL	29,312	**-4.0%**	**-2.7%**	20,474	4.7%	**-2.9%**	**0.8%**
11	10	CEPHALEXIN	21,244	**-11.3%**	**-4.7%**	20,103	4.6%	**-10.9%**	**-4.2%**
12	9	HYDROCODONE/ ACETAMINOPHEN	21,737	**-9.8%**	**-14.9%**	18,067	4.2%	**-9.8%**	**-13.9%**
13	13	AZITHROMYCIN	16,358	**44.2%**	**4.6%**	15,142	3.5%	**46.3%**	**5.5%**
14	20	FLUTICASONE PROPIONATE	18,352	**11.2%**	**53.9%**	14,513	3.4%	**12.8%**	**58.2%**
15	18	PRENATAL VITAMIN NO.95	16,426	**-7.6%**	**12.8%**	14,496	3.3%	**-7.8%**	**11.7%**
16	16	AMLODIPINE BESYLATE	20,915	**-2.6%**	**0.9%**	13,742	3.2%	**-1.5%**	**3.5%**
17	19	GABAPENTIN	22,708	**-4.9%**	**1.5%**	13,327	3.1%	**-5.0%**	**3.1%**
18	15	FOLIC ACID	22,987	**-5.7%**	**-6.4%**	13,320	3.1%	**-6.0%**	**-5.0%**
19	14	ACETAMINOPHEN	12,907	**23.9%**	**-14.1%**	12,074	2.8%	**22.0%**	**-14.2%**
20	17	PROMETHAZINE/ DEXTROMETHORPHAN	13,478	**83.8%**	**-8.0%**	11,990	2.8%	**83.6%**	**-7.7%**

Table 6.3: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only

Rank	Last Year Rank	Drug Description	Current Quarter 2019 Q4 Total Paid Claims	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from *Prior Quarter*	% Change Utilizing Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	QUETIAPINE FUMARATE	127,005	-1.8%	-0.9%	48,331	17.2%	-1.5%	-0.7%
2	2	ARIPIPRAZOLE	98,253	-1.2%	2.4%	42,474	15.1%	-0.7%	2.7%
3	3	RISPERIDONE	71,611	-3.2%	-1.8%	28,518	10.1%	-2.9%	-2.3%
4	4	OLANZAPINE	73,978	-2.1%	2.8%	28,221	10.0%	-1.1%	3.7%
5	5	BENZTROPINE MESYLATE	49,059	-2.8%	-2.3%	19,276	6.8%	-2.1%	-1.9%
6	6	LURASIDONE HCL	38,518	-2.1%	0.8%	16,111	5.7%	-1.2%	0.9%
7	8	BUPRENORPHINE HCL/ NALOXONE HCL	43,086	3.6%	21.0%	12,960	4.6%	4.3%	21.8%
8	13	NALOXONE HCL	12,756	-14.6%	134.7%	11,818	4.2%	-15.3%	128.4%
9	7	LITHIUM CARBONATE	26,460	-2.6%	-1.7%	10,908	3.9%	-1.9%	-1.5%
10	9	PALIPERIDONE PALMITATE	19,355	1.2%	4.1%	8,175	2.9%	0.5%	6.0%
11	17	BICTEGRAV/EMTRICIT/ TENOFOV ALA	17,862	10.2%	85.7%	7,536	2.7%	10.5%	89.3%
12	10	HALOPERIDOL	17,152	0.2%	-3.6%	6,444	2.3%	-1.7%	-5.8%
13	11	EMTRICITABINE/ TENOFOVIR (TDF)	9,894	-15.6%	-19.8%	5,530	2.0%	-10.6%	-11.5%
14	12	ZIPRASIDONE HCL	14,012	-3.3%	-8.4%	5,179	1.8%	-2.9%	-7.4%
15	18	NALTREXONE HCL	7,720	8.0%	36.6%	4,627	1.6%	7.5%	36.2%
16	14	INSULIN LISPRO	8,314	-0.4%	-11.8%	3,891	1.4%	-5.2%	-12.0%
17	16	INSULIN GLARGINE, HUM.REC.ANLOG	6,611	-2.2%	-13.6%	3,573	1.3%	-5.9%	-14.6%
18	19	CLOZAPINE	19,441	-1.0%	2.7%	3,471	1.2%	1.3%	5.4%
19	15	EMTRICITABINE/ TENOFOV ALAFENAM	7,414	3.3%	-29.1%	3,338	1.2%	11.0%	-21.1%
20	20	BUPRENORPHINE HCL	8,657	4.0%	25.1%	3,337	1.2%	3.8%	24.7%

APPENDIX B: Definition of terms.

Adjudicate: To pay or deny drug claims after evaluating the claim for coverage requirements

Beneficiary: A person who has been determined eligible for Medi-Cal, as according to the California Code of Regulations 50024

Eligible beneficiary: A Medi-Cal beneficiary that qualifies for drug benefits

Quarter: One fourth, ¼, 25% or .25 of a year measured in months.

Reimbursement: The reimbursement paid to Medi-Cal pharmacy providers for legend and nonlegend drugs dispensed to Medi-Cal Fee-for-Service (FFS) beneficiaries. Reimbursement is determined in accordance with CA Welfare and Institutions Code Section 14105.45(b)(1).

Drug therapeutic category: Drug therapeutic categories are grouping of drugs at various hierarchy levels and characteristics that may be similar in chemical structure, pharmacological effect, clinical use, indications, and/or other characteristics of drug products.

Utilizing beneficiary: A Medi-Cal beneficiary with at least one prescription filled during the measurement period

MEDI-CAL DRUG USE REVIEW (DUR) PROGRAM
QUARTERLY EVALUATION REPORT – 4th Quarter 2019

The purpose of the educational intervention component of DUR is to improve the quality and cost-effectiveness of prescribing and dispensing practices for Medi-Cal beneficiaries. Educational interventions include ongoing dissemination of clinically important information through the Medi-Cal provider bulletin process.

DUR educational articles are published in provider bulletins and posted on the DUR: Educational Articles page on the DUR website. Two years after publication, each article is reviewed again in a systematic way in order to evaluate any change over time. These evaluations are conducted quarterly and use the following template:

- Background
- Purpose
- Data Criteria and Findings
- Analysis
- Limitations
- Research/Policy Recommendations
- Clinical Recommendations
- Board Recommendations

Many factors may influence the prescribing and dispensing practices of Medi-Cal providers, making it difficult to accurately measure the full impact of the educational articles. Such factors may include, but are not limited to, the following:

- Changes and updates to treatment guidelines and recommendations
- Beneficiary expectations and requests and healthcare habits and behavior
- Direct-to-consumer advertising
- Provider training and experience
- Anecdotal experience
- Provider resistance
- Extent of readership
- Exposure to multiple sources of continuing education

The purpose of DUR educational articles is to apprise Medi-Cal providers and pharmacies of current treatment guidelines and recommendations on drugs, disease states, and medical conditions. These articles contain valuable information that is effective when used as a part of an overall campaign to disseminate timely and needed information to providers and pharmacies.

The following recommendations may help to improve accessibility, reach, and interest of educational articles to the Medi-Cal provider and pharmacy community:

- Continue to distribute articles through normal publication channels, but also send articles separate and independent from the bulletin, in order to increase visibility.
- Distribute article links to medical and pharmaceutical organizations/associations for distribution to their members or publications in journals and/or bulletins.
- Encourage prescribers and pharmacists to sign up for distribution of DUR articles via the Medi-Cal Subscription Service (MCSS).
- Facilitate continuing medical education (CME) and/or continuing education (CE) opportunities to prescribers and pharmacists related to article content
- Incorporate case studies into articles.
- Package articles with other collateral materials for distribution through various media channels such as posters, postcard mailings and flyers that highlight the recommendations of each article.
- Disseminate shorter educational alerts that highlight relevant and important topics that can be published with greater frequency.
- When appropriate, disseminate lay versions of articles to beneficiaries to promote physician uptake and set beneficiary expectations.
- Continue to support the direct link between articles and retrospective DUR educational outreach to prescribers and pharmacists.
- Increase understanding of prospective DUR alert methodology, by using articles to focus on drug therapy problems that are frequently overridden at the pharmacy level.
- Include patient-specific profiles for educational outreach where the primary objective is an improvement in the quality of care.
- Use provider-specific profiles for educational outreach where the primary objective is an improvement in the quality of prescribing.
- Use pharmacy-specific profiles for educational outreach where the primary objective is an improvement in the quality of dispensing.

This quarterly evaluation report provides a detailed evaluation of the following DUR educational article, which was published during the 1st quarter of 2017 (Q1 2017):

- Improving the Quality of Care: Risks Associated with Use of Fluoroquinolones – February 2017

Evaluation of Educational Article

Improving the Quality of Care: Risks Associated with Use of Fluoroquinolones – February 2017

- **Background:** Fluoroquinolone antibiotics are approved to treat certain serious bacterial infections and work by killing or stopping the growth of bacteria that can cause illness. Despite the many FDA-approved indications for use, the Centers for Disease Control and Prevention (CDC), the Infectious Diseases Society of America (IDSA), the American Thoracic Society (ATS), and other professional organizations all recommend fluoroquinolones not be used as first-line therapy in community settings when other treatment options are available. On July 26, 2016, the FDA approved safety labeling changes for fluoroquinolones. The labeling changes include an updated Boxed Warning and revisions to the Warnings and Precautions section to enhance warnings about the association of fluoroquinolones with disabling and potentially permanent side effects, and to limit their use in patients with less serious bacterial infections. Within the Medi-Cal fee-for-service population approximately two-thirds (n = 33,483; 68%) of fluoroquinolone use from December 1, 2015, through November 30, 2016, appeared to be potentially inappropriate based on the new FDA recommendations, with 5,102 beneficiaries (10%) having a primary or secondary diagnosis of acute bacterial exacerbation of chronic bronchitis, a total of 9,165 beneficiaries (19%) with acute sinusitis, and 19,306 beneficiaries (39%) with an uncomplicated UTI.

- **Purpose:** The purpose of this evaluation is to 1) review fluoroquinolone use in the Medi-Cal fee-for-service population and 2) review relevant safety information and clinical recommendations for fluoroquinolones in order to determine if there have been any changes in use since the original DUR bulletin was published in February 2017.

- **Data Criteria and Findings:** For the biennial review, the same inclusion/exclusion criteria as the published article were followed:
  - Inclusion criteria:
    - At least one paid claim for a fluoroquinolone through the Medi-Cal Fee-for-Service program between November 1, 2018 and October 31, 2019 (the measurement year).
  - Exclusion criteria:
    - Beneficiaries with paid medical claims within seven days prior to the index date (the date of service of the fluoroquinolone paid claim) that showed the place of service to be a long-term care facility, skilled nursing facility, or inpatient hospital.
    - Beneficiaries with any indication of penicillin or other drug allergy that would impact the use of fluoroquinolones as a first-line therapy.

Within the study population, any beneficiary with one of the following primary or secondary ICD-9-CM diagnostic codes within the seven-day window of the index date was coded as a potentially inappropriate use of fluoroquinolones:

- Acute bacterial sinusitis (461)
- Acute bacterial exacerbation of chronic bronchitis (491.21)
- Uncomplicated UTIs (595.00, 595.89, 595.90, or 599)

Potentially inappropriate fluoroquinolone use was also calculated among selected demographic groups that had significant findings in the original article.

Medi-Cal fee-for-service population	Article data: 12/01/15 – 11/30/16	Evaluation data: 11/01/18 – 10/31/19	Percent change
Beneficiaries identified with at least one paid claim for a fluoroquinolone during the measurement year that met inclusion/ exclusion criteria	***49,276***	***29,876***	***-40%***
Percentage of study population with potentially inappropriate use of fluoroquinolones during the measurement year	68%	57%	***-11%***
Percentage of female beneficiaries in the study population with potentially inappropriate use of fluoroquinolones during the measurement year	71%	61%	***-10%***
Percentage of beneficiaries in the study population younger than 18 years of age with potentially inappropriate use of fluoroquinolones during the measurement year	56%	44%	***-12%***
Percentage of beneficiaries in the study population residing in Los Angeles County with potentially inappropriate use of fluoroquinolones during the measurement year	78%	63%	***-15%***

- **Analysis:** The results from the evaluation of fluoroquinolone use show a 40% decrease in the total number of Medi-Cal fee-for-service beneficiaries identified with at least one paid claim for a fluoroquinolone during the measurement year. The eligible Medi-Cal fee-for-service population during this same time period decreased by only 10%, so the use of fluoroquinolone medications decreased beyond what would be expected from a decrease in the eligible population. In addition, there was an overall decrease in

potentially inappropriate use of fluoroquinolones among the study population by 11%.

Since the publication of this educational article, the DUR program has published two additional alerts related to FDA safety concerns regarding fluoroquinolones:

- Drug Safety Communication: Adverse Effects from Fluoroquinolone Antibiotics published in July 2018
- Drug Safety Communication: Updated Adverse Effects from Fluoroquinolones published in March 2019.

In addition, an educational outreach letter was sent on August 2, 2017, to the top 100 prescribers of fluoroquinolones in the Medi-Cal fee-for-service program. The objectives for the mailing were the following:

- To inform providers of the FDA-approved safety labeling changes for fluoroquinolones
- To decrease the number of Medi-Cal patients receiving treatment with fluoroquinolones for acute bacterial exacerbation of chronic bronchitis, acute sinusitis, and uncomplicated UTI

In the 12 months following the mailing of the letter, there was a 41% decrease in the number of paid claims for fluoroquinolone among prescribers who received the mailing (n = 85), compared with only a 16% decrease among prescribers who did not receive the mailing (n = 15) due to undeliverable mail. A similar difference was also seen among total utilizing beneficiaries, with a 39% decrease in utilizing beneficiaries with a paid claim for a fluoroquinolone observed among those providers who received the letter, compared with only a 5% decrease among providers who did not receive the letter.

- **Limitations:** Both the evaluation report and the original article used ICD9-CM diagnostic codes, as ICD10 codes were not consistently available at the time of the original article. Both datasets used the same backwards crosswalk to convert ICD10 codes into ICD9 codes. Medical claims data also were evaluated for both time periods using the original ICD10 codes, which were not consistently available at the time of the publication of the original article. Results from the ICD10 analysis showed less than 1% variation for each measurement year, so it was determined to keep the methods the same as the original article.

- **Research/Policy Recommendations:**
  1. Continue to monitor use of antibiotics in the Medi-Cal population.

- **Clinical Recommendations:**
  1. Incorporate allergy assessment into routine physical examination and evaluate patients for true penicillin allergy by conducting a history,

physical, and (where appropriate) a skin test and challenge dose.
2. Prescribe antibiotics carefully and correctly. Work with pharmacists to ensure appropriate antibiotic use, prevent resistance, and assist with early detection of adverse events.
3. Providers should not prescribe systemic fluoroquinolones to patients who have other treatment options for acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis, and uncomplicated UTIs because the risks outweigh the benefits in these patients.
4. Providers and pharmacists should discuss the signs and symptoms of adverse events associated with fluoroquinolones with patients.
5. Providers should discontinue fluoroquinolone treatment immediately if a patient reports serious side effects, and switch to a non-fluoroquinolone antibacterial drug to complete the patient's treatment course.
6. Avoid fluoroquinolones in patients who have previously experienced serious adverse reactions associated with fluoroquinolones.
7. Check formulary status of alternative antibiotics to fluoroquinolones.

- **Board Recommendations:**
  1. Consider repeat of educational outreach letter to top prescribers of fluoroquinolones, with the inclusion of the two additional safety alerts published by the DUR program.