



**MEDI-CAL DRUG USE REVIEW BOARD  
MEETING MINUTES  
Tuesday, September 12, 2006  
10:00 a.m. to Noon**

**Location:** Department of Health Services  
1500 Capitol Avenue, Training Rooms A & B  
Sacramento, CA 95814

Topic	Discussion
<b>1) CALL TO ORDER</b>	Meeting was called to order by Dr. Albertson Members present: Tim Albertson, Andrew Wong, Ross Miller, Marilyn Stebbins, Robert Mowers, Janeen McBride Members absent: Stephen Stahl, Kenneth Schell, Art Whitney, Patrick Finley
<b>2) APPROVAL OF LAST MINUTES</b>	Dr. Albertson moved to approve the minutes from the May 9, 2006 board meeting. Dr. Miller requested a change in section 6.A.3 to show a combination of the first two sentences into one sentence. Dr. Miller also requested a grammatical change in section 6.B.4 to add an apostrophe "s" to the word "it" in the last sentence of the section. Dr. Miller made a motion, Dr. Stebbins seconded the motion and a unanimous vote was made to approve to send a letter to the pharmacy providers with high ER Alert that we will be monitoring their rate of ER Alerts that are issued in their pharmacies (as stated in section 6.B.3). Minutes unanimously approved as amended.
<b>3) CDHS COMMENTS – MEDI-CAL MEDICARE EMERGENCY DRUG BENEFIT UPDATES &amp; DEFICIT REDUCTION ACT GRANT OPPORTUNITIES</b>	<p>A. Medi-Cal Medicare Emergency Drug Benefits Update</p> <ol style="list-style-type: none"> <li>1. Dr. Teri Miller, California Department of Health Services (CDHS) Pharmacy Policy Unit, updated the State's Emergency Drug Benefit (EDB) and presented some upcoming items to look for.               <ol style="list-style-type: none"> <li>i. The State of California has had a plan in place to provide medications for dual eligibles who are unable to obtain them from Medicare Part D. The EDB Program began January 12, 2006, and has had a number of modifications since. The first change, beginning May 17, 2006, required that providers have an approved <i>Treatment Authorization Request</i> (TAR) before the State's EDB Program could be used to pay the drug claim. Certain criteria were satisfied in order to obtain TAR approval. This change resulted in a dramatic decrease in the number of claims submitted to the EDB Program and the decreased numbers continue today.</li> <li>ii. CDHS sent staff to review pharmacy claims submitted under the EDB Program prior to May 17. The review found that some claims were submitted for the co-pays and this was not the intent of the EDB Program. Providers found to be billing the co-pays were asked to reverse those claims and CDHS continues to monitor those claims.</li> <li>iii. The Legislature put into place the current EDB Program that runs through January 31, 2007. For dual eligibles who may be able to obtain the needed medication through the Part D Plan after utilizing the "exceptions" or "prior authorization request" process and the Plan fails to respond in a timely manner. Initially, from May 17, until September 1, that clock started ticking when the pharmacy contacted the physician and documented that contact. Emergency medications, if the Plan failed to respond within 24 hours, qualified for the EDB Program. If non-emergency medication and the Plan failed to respond within 72 hours, that qualified for the EBD Program. Effective September 1, that clock changes to when the physician contacts the Plan, not when the pharmacy contacts the physician. This change was required by the Legislature. This information is posted on the Medi-Cal Web site and the provider bulletin initially</li> </ol> </li> </ol>

announcing the EDB Program has been updated to reflect this change. Initially, CDHS required that the pharmacy attach a copy of the physician's request to the Part D Plan to the TAR since that was the only way to document the requirement. Since that time, concerns have been raised and discussions held concerning satisfying the intent of this Legislation while allowing dual eligibles to obtain needed medications because they are unable to obtain them from the Part D Plan. It has been decided that CDHS will allow pharmacists to document that the physician "said" that they contacted the Part D Plan at a certain point in time with the understanding that the pharmacy is putting themselves at risk if the physician later states they did not do that.

- iv. Because some providers continue to bill co-pays, CDHS made the decision that effective September 15, 2006 CDHS will no longer pay for claims that are billed for the Emergency Drug Benefit claims that have dates of service prior to May 17. Providers were provided with 30-day notice of this change as a courtesy.
  - v. Providers were notified of these changes via a Medi-Cal Bulletin on August 10, 2006. These changes were also listed on the Medi-Cal Web site.
2. Dr. Teri Miller also stated that CMS has released the Benchmark numbers for 2007. It is \$24 nationwide, and around \$21 premium in California.
- i. A question has come up that what will happen with the dual eligibles if their previous plan has a different benchmark and the premium is above the benchmark, do they lose that plan and have to enroll in another plan. The answer is yes they will be reassigned if their plan premium is more than \$2 more than what the California benchmark is.
  - ii. CMS is predicting that over 90% of dual eligibles will be able to stay in their current plan.
3. CMS released end of year timelines of Beneficiary Communications and Enrollment. This showed when they were going to release information on the various plans, the plan finder tool.
4. Dr. Mowers asked if CDHS is tracking the type of medications that the providers are requesting under the Emergency Plan because the pharmacies can't get a hold of the Part D Plans. Dr. Teri Miller answered that they have not looked at it since May or June but there were basically two reasons for using the Emergency Drug Benefit.
- i. The Part D Plan prior authorization process is not working and this tends to be for the higher cost drugs
  - ii. Beneficiaries not showing up on the system when they go to have a prescription filled. CMS has said that they intend that the Wellpoint system be used for that process if they know that the person is a dual eligible. Medi-Cal has posted this process on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).
- B. Deficit Reduction Act (DRA) Grant Opportunities
1. Dr. Lisa Ashton, California Department of Health Services (CDHS) Pharmacy Policy Unit, provided information regarding the DRA providing funding to the state to transform the care that is provided to the Medicaid patient in an effort to increase quality and lower cost. Announcement of this went out at the end of July announcing the availability of \$150 million of grant money over a 2-year period for 2007 and 2008. This is for a proposal to transform the Medicaid population.
- i. Areas that were to be looked at were implementation of Medication Management Programs as part of the Drug Use Review program. CDHS is submitting three proposals for this grant money. The public was notified and given five days notice if they wanted to submit a proposal. The deadline was September 15, 2006, but there has been an extension granted to October 2, 2006. In the grant proposals we are looking for technology and improving the connectivity and availability of data that can look at increasing quality of care and DUR issues such as duplicate therapy and fraud and abuse.

	<ul style="list-style-type: none"> <li>ii. Dr. Albertson asked if there was a chance for the DUR board to get more information about the proposal. Dr. Kevin Gorospe, California Department of Health Services (CDHS), stated that there is no information that can be given at this point.</li> <li>iii. Dr. Ross Miller asked if there would be a role for the DUR board to comment on any of the proposals before they are submitted. Dr. Ashton answered that there would probably not be time before they are submitted. Dr. Ross Miller also suggested looking at TennCare program in Tennessee. They have an electronic interconnectivity program to monitor patient safety, medication errors and drug interactions. TennCare has a private vendor for the IT portion.</li> </ul> <ol style="list-style-type: none"> <li>2. Dr. Ashton also mentioned that there was a description of the Medication Risk Management Program Definition for CMS activities.</li> <li>3. Dr. Ross Miller asked if the proposals would be an “a la carte” menu or be combined to a three-prong strategy to maximize our successes. Dr. Gorospe answered that information regarding this cannot be shared at this point.</li> <li>4. Dr. Wong asked if in these proposals for the grant money, if there will be money for DUR Board activities. Dr. Gorospe answered that there would be nothing right now.</li> </ol>
<p><b>4) ONGOING PROJECTS</b></p>	<p>A. Acetaminophen Toxicity Analysis</p> <ol style="list-style-type: none"> <li>1. Dr. Ashton addressed several follow up items from the previous meeting. To recap, the data was pulled from 1/05 through 6/05 and looked at the users of over the maximum recommended daily dose of 4 grams. <ul style="list-style-type: none"> <li>i. There were 1500 beneficiaries who had access to over 4 grams per day for over 100 consecutive days; 132 who had access to over 6 grams per day for over 100 days; and 3 had access to over 12 grams per day for the same time period. Looking at the over 4 grams per day, 3.7% had documented renal disease and 0.5% had documented liver disease.</li> <li>ii. The previous action item was to determine if there was a way to identify the prescribers who are prescribing for the high dose acetaminophen and liver disease. Jim Klein looked at the data and could not identify over 60% of providers with any accuracy. We can look at the top 10 pharmacies that dispensed the high dose acetaminophen.</li> <li>iii. 78.3% of the high dose acetaminophen was from a single prescription that was dispensed. 80% of the time, the NDC was Vicodin® that caused the high dose. Vicodin® is not a target drug, so we cannot apply edits to the drug that might be useful.</li> <li>iv. A max dose can be put on the drug, but it is often overridden. There is currently a frequency limitation on Vicodin® and found that the prescriptions for twelve grams and more are being obtained with a TAR. Dr. Ashton suggested that education be done at the TAR Field Offices on high dose acetaminophen. Dr. Wong asked who is reviewing the TAR forms.</li> <li>v. Dr. Ross Miller asked about the 57 patients with liver disease and if we can send a letter to the 57 patients and the pharmacies and to the forty percent of providers that we know of with the warning of the high dose of acetaminophen.</li> <li>vi. Dr. Stebbins had concerns about the TAR field offices that are approving the TARs. Dr. Kevin Gorospe, CDHS, Policy Pharmacy Unit, replied that in the TAR offices there are protocols and in some instances there is sufficient medical documentation that the provider knows of the dose. Due diligence is followed by the TAR field office.</li> <li>vii. Dr. Gorospe suggested that the DUR Board put together an educational document to disseminate to providers at meetings, presentations or CPhA Outlook. CDHS has a table at Outlook and can put out the information there.</li> <li>viii. Dr. Wong asked if there was a way that the DUR Board could view the TAR forms of the high dose acetaminophen. Dr. Gorospe answered that is not an option.</li> </ul> </li> </ol>

2. Dr. Albertson asked if over-the-counter (OTC) acetaminophen is a contributor to any of the high dose acetaminophen. Dr. Ashton stated that she did not think so. Dr. Ashton stated that CDHS could go back and take a look to see if there were any substantial amount of OTC acetaminophen.
3. Dr. Gorospe reminded the Board that Medicare Part D now takes over for the prescription claims, where Medi-Cal still does the OTC claims. Medi-Cal may not know what prescription claims they are getting through Medicare. Medi-Cal is hoping to exchange the information with Medicare and that is being worked on so a clearer picture of what medications the beneficiaries are using can be tracked.
4. Dr. Ashton stated that a proposal to write up the high dose acetaminophen was submitted to the Committee for Protection of Human Subjects, California IRB. This is to hopefully publish the results to a larger audience.
5. Dr. Wong requested that the TAR field office respond to the Boards concerns. Dr. Gorospe stated that the Policy Division will deal with the TAR field office.

B. Antidepressants in Children and Adolescents Study

1. Dr. Ashton stated that Dr. Finley has completed a study protocol that will be sent to the Committee for Protection of Human Subjects. The study is to look at the impact of the 2004 FDA warning of increased suicidality of antidepressants on Medi-Cal data. Looking at the risk of suicidality in that population. We are going to look at the impact of that warning and see if the utilization of antidepressants has changed. The recommendations stated that there should be follow-up on patients with a dosage change or medication change, and we will take a look at this and see if it has occurred. Looking at the outcome in our population.

C. Asthma Study

1. Dr. Ashton stated that the data has been cut for the first round of studies. Dr. Albertson and Dr. Stebbins are the principal investigators.
2. In the first round, the design mirrors HEDIS® measures in order to have national comparators as well as our own state managed care plans to see how we are performing in fee-for-service.
  - i. Medi-Cal is at 55%, which is below the commercial plans at 75% and Medi-Cal managed care plans at 62%. CDHS needs to understand why there is a difference and how are they being served differently.
3. Another measure looked at is beta-agonist over usage. Medi-Cal had a 35% rate of over usage. This is defined as greater than 8 canisters per year. There is no comparator for this measure because of the inconsistencies in the reporting of what is over usage. There will be a comparator next year. Dr. Stebbins asked if CDHS has taken a California subset of data to look at a difference of prescribers nationwide versus California. There is a lot of discussion available due to pay for performance of the private plans.
4. Dr. Ashton said that they were looking at other ways of cutting the data, such as taking out the over 40-year-olds because they may be misdiagnosed as having asthma.

D. Rheumatoid Arthritis Study

1. Dr. Wong stated there was a teleconference on August 21, 2006 with Dr. Mike Nichols, Chair of Pharmacoeconomics and Policy Dept at USC, along with Jim Klein, California Department of Health Services (CDHS), to come up with how they want the data run. Dr. Nichols gave a review of the database. Preliminary data should be ready in mid-October. Want to look at practice patterns and how some of the different medications are being used. Correlate the Disease Modifying Antirheumatic Drugs (DMARD) to Biologic Response Modifiers (BRM).

E. Prospective Drug Use Review (ProDUR) Impact Improvement Project

1. Dr. Ross Miller, Dr. McBride, Dr. Schell and Dr. Ashton worked together to try to clean-up the ProDUR system. There are a lot of alerts being sent out. The pharmacies are overriding the alerts about an 80% of the alerts.
2. The high volume alerts were looked at to determine which alerts are inappropriate. They would like to be turned off. An example of this is the therapeutic duplication alert of short and long acting beta-agonists, which is an appropriate dosing regimen, both drugs would have to be turned off in their entirety so there are no alerts that would come up. The group does not want to

	<p>turn off the drugs completely.</p> <ol style="list-style-type: none"> <li>3. Dr. Ashton would like the Board to realize that the current system cannot do what they want it to do. Look toward re-designing the system with what the DUR board would like it to do.</li> <li>4. Federal Regulations require that there is a prospective DUR system at our point of sale in the State Plan. A State Plan would also need to be rewritten that stated what we wanted the prospective DUR program to do. This would include what we would like it to do and what we are trying to do to fix it.</li> <li>5. Dr. Ross Miller asked if there is a price fixed system. Dr. Ashton explained that an SDN would be required to fix any one thing in the system. Dr. Stebbins commented that any PBM has the ability to do the prospective DUR that the board would like to see in place. Dr. Stebbins is also concerned that not fixing the prospective DUR system is a possible safety issue. <ol style="list-style-type: none"> <li>i. Dr. Gorospe answered that the process is controlled by the Payment System Division (PSD) and fiscal intermediary. There is recognition that other changes need to be made at the end of the three option years ending in 2010. PSD is analyzing this now.</li> <li>ii. Anything that would be fixed now would have to be a budgetary legislative issue.</li> </ol> </li> <li>6. Dr. McBride asked if there is something that can be done now that may lose some of the good stuff but can help overall. Dr. Ashton answered that the Late Refill has been cleaned up so it is not alerting for drugs that are refilled late. Early Refill (ER) is on for all drugs, but can be overridden. The drugs can be looked at to see which drugs are a real problem with ER and clean up those drugs. All drugs go through an ER edit.</li> <li>7. Dr. Mowers asked for clarification on alerts with the example of beta-agonists, stating that if you turned off a therapeutic duplication alert, the early refill alert could still be turned on. Dr. Ashton agreed that they are all separate alerts, and that you cannot turn off specific interactions between drugs.</li> <li>8. Dr. McBride questioned the target drug list, and why there are not alerts for all drugs, and not just the target drug. Mr. Vic Walker answered that the target drugs list was to reduce the amount of inappropriate alerts that were being sent out to pharmacists and to look at the high dollar products.</li> <li>9. Dr. McBride stated that the committee on this topic will reconvene.</li> <li>10. Dr. Gorospe stated that the CDHS will be split into Public Health and Department of Health Services.</li> </ol>
<p><b>5) DUR BOARD MEMBER COMMENTS ON ONGOING PROJECTS</b></p>	<ol style="list-style-type: none"> <li>A. Dr. McBride stated that this is new to the agenda for the Board members to present projects that are pertinent to the board but not part of what the board is specifically doing. These items can be referred to in our Annual Report.</li> <li>B. Dr. Wong mentioned that UCLA Rheumatology is looking at quality of care measures. These quality measures have been recently approved by the American College of Rheumatology for different rheumatic diseases. <ol style="list-style-type: none"> <li>1. Different insurance plans and medical groups are applying the quality measures and most likely will be adopted by HEDIS.</li> </ol> </li> <li>C. Dr. Stebbins shared that a project that is a statewide Medicare Part D outreach project that is a 3½ yr grant. This will look at outreach to underserved population in California. Looking to run it through the pharmacy schools. Training pharmacy students about Medicare Part D with annual updates to go out into underserved communities and incorporating it into the community pharmacy rotations.</li> </ol>
<p><b>6) UTILIZATION REPORTS</b></p>	<ol style="list-style-type: none"> <li>A. Dr. Ashton had a follow up with Dr. Stahl on Antidepressant Use. Dr. Stahl noted that the cost associated with antidepressants was high given that there were generic equivalents available. Dr. Ashton looked at generic utilization of the SSRI class of medication. The first six months of 2006 were analyzed excluding Medicare beneficiaries and looking only at paid claims. The generic substitution rate is looked at as antidepressants as a whole, which is 87%. <ol style="list-style-type: none"> <li>1. Dr. Ross Miller requested clarification of single source prescribing rate and generic utilization rate. Dr. Ashton gave clarification to Dr. Miller's question.</li> <li>2. The Board members asked to have Dr. Ashton recalculate the percentage and clarify the numbers.</li> </ol> </li> <li>B. Quarterly Report (April - June 2006)</li> </ol>

	<ol style="list-style-type: none"> <li>1. Dr. Tina Wills, Electronic Data Systems, reviewed the Quarterly report.</li> <li>2. Prospective DUR: <ol style="list-style-type: none"> <li>i. Changes were made to the emergency provisions on May 17, 2006 with respect to requiring a TAR for all drugs billed for Medicare Part D patients. Statewide drug claims decreased 13%, and this is attributed to the change in emergency provisions.</li> <li>ii. The alerts generated during this time frame stayed fairly constant with what type of medications that are included on the alert lists.</li> </ol> </li> <li>3. Retrospective DUR: <ol style="list-style-type: none"> <li>i. No significant changes in utilization numbers compared to January through March 2006. Current numbers are very similar.</li> <li>ii. New section that calculates what percentage of claims are for multi-source drugs to compare to Medicaid average. Medi-Cal is at 54% of claims are billed for generics in the second quarter. The Generic Price indicator (GPI) is used to determine this.</li> <li>iii. The DUR Board had requested in a previous meeting to add a section to the tables in the quarterly report to show the percent change for the last four quarters compared to an anchor quarter. The anchor quarter was the second quarter 2005. <ol style="list-style-type: none"> <li>1. Tables 7, 7A, 8 &amp; 8A – each quarter was compared to the second quarter 2005. The first and second quarter 2006 showed a significant drop in utilization due to Medicare Part D. There was one drug that increased, Oral Contraceptives that would not normally be utilized by Medicare Part D beneficiaries. Dr. Ross Miller asked if there was one quarter missing from report. Board wants 5 rolling quarters, with the first quarter (2<sup>nd</sup> quarter 2005) being the anchor quarter and that quarter being reported so it can be compared to the next four quarters.</li> <li>2. It is noted that the data will be skewed due to the implementation of Medicare Part D.</li> </ol> </li> <li>iv. Dr. Albertson questioned that the average cost of prescriptions went down with Medicare Part D. Dr. Stebbins stated that Medicare Part D plans are paying for these medications due to the disabled status of certain patients.</li> <li>v. Dr. Stebbins asked about the first quarter data and the emergency coverage has affected the data. No real data can be evaluated until the emergency provision has been completely eliminated. Dr. Gorospe stated that as we send people to Medicare, we also get new beneficiaries into the Medi-Cal system.</li> </ol> </li> </ol>
<b>7) PUBLIC OR DUR BOARD COMMENTS</b>	There was no public or DUR Board comments.
<b>8) DATE OF NEXT DUR BOARD MEETING</b>	The next DUR Board Meeting is scheduled for November 7, 2006, in training rooms A & B, at 1500 Capitol Avenue.
<b>9) ADJOURNMENT</b>	The meeting adjourned at 11:35 AM

**Summary of Action Items:**

1. **Amend 05/09/06 meeting minutes as requested.**
2. **Early Refill Alerts**
  - a) Dr. Ashton to draft a letter to pharmacies with excessive amounts of early refills.
  - b) EDS will run the data for the last three months to rank the data by number of early refills and overrides.
3. **Deficit Reduction Act (DRA) Grant Opportunities**
  - a) Dr. Ashton will look at TennCare and their connectivity project.
4. **Acetaminophen Toxicity Analysis**
  - a) Dr. Ashton will look at the OTC contribution to the Acetaminophen study.
5. **Board Member Ongoing Projects**
  - a) Dr. Ashton will coordinate with Dr. Stebbins on her Medicare Part D outreach program to include Medi-Cal.
6. **Utilization Reports**
  - a) Dr. Ashton will recalculate the percentage on the Antidepressant use data. This will be provided at the next DUR Board Meeting.
7. **Quarterly Report**

- a) Adjust Quarterly Report Tables 7 & 8 to include percent change of current quarter plus last four quarters. Show an anchor quarter (3<sup>rd</sup> quarter 2005) along with the next four quarters to compare it to for the next quarterly report.