



**MEDI-CAL DRUG USE REVIEW BOARD  
MEETING MINUTES  
Tuesday, February 13, 2007  
10:06 a.m. to 12:15**

**Location:** Department of Health Services  
1501 Capitol Avenue, Room 71.1203  
Sacramento, CA 95814

Topic	Discussion
<b>1) CALL TO ORDER</b>	Meeting was called to order by Janeen McBride Members present: Kenneth Schell, Ross Miller, Andrew Wong, Janeen McBride, Marilyn Stebbins, Robert Mowers, Patrick Finley, Tim Albertson Members absent: Stephen Stahl
<b>2) APPROVAL OF LAST MINUTES</b>	Janeen McBride moved to approve the minutes with changes from Dr. Miller and Dr. Wong. Minutes unanimously approved as amended.
<b>3) CDHS COMMENTS</b>	<p>A. Medi-Cal Medicare Emergency Drug Benefits Update</p> <ul style="list-style-type: none"> <li>• Dr. Teri Miller, California Department of Health Services (CDHS) Pharmacy Policy Unit, updated the State's Emergency Drug Benefit (EDB) stating that it ended January 31, 2007. Claims with date of service (DOS) before 1/31/07 will be paid, but claims after 1/31/07 will not be paid. Department also has seen a dramatic decrease in number of Treatment Authorization Request (TARs).</li> <li>• Dr. Kenneth Schell asked regarding for those TARs that were submitted, was there an actual percentage refused or were they all processed. Dr. Teri Miller answered that inappropriate claims were denied and the way the Department's staff are handling those, they were instructed to be as helpful as possible.</li> </ul> <p>B. Executive Order / E- Prescribing</p> <ul style="list-style-type: none"> <li>• Kim Ortiz –California Department Health Services, spoke about Electronic Health Information Exchange starting within two years and E- Prescribing in 2010. She spoke about both the Governor and the President with regards to the Healthcare Reform proposals. Another role that she has taken on is trying to help collaborate funding to accomplish E-Prescribing and Health Information Exchange across government and the private sector.</li> </ul> <p>C. Deficit Reduction Act (DRA) Grant</p> <ul style="list-style-type: none"> <li>• Dr. Lisa Ashton, California Department of Health Services (CDHS), provided information regarding the last board meeting where CDHS was preparing the grants for submittal. The state submitted three proposals for part of a \$150 million in grant money that was available through CMS as part of the Deficit Reduction Act (DRA) to be spent within a two year period.</li> <li>• The three grants submitted were as follows: <ul style="list-style-type: none"> <li>○ CALRHIO Grant supported linking Emergency Rooms and Clinics with Medi-Cal to have data available at the point of</li> </ul> </li> </ul>

service in the emergency rooms and clinics.

- Pay for Performance Grant proposal to set up structure and policy to be able to deliver on a pay for performance strategy with the Fee-for-Service (FFS) population
  - Chronic Care Model was proposed by the safety net clinics and their hospitals and it was a model in Diabetes.
- Dr. Ashton stated that California did not receive any funding. There were 27 States that received funding for a total of \$103 million. CMS has reserved \$47 million for a second round of grants. There has not been a letter requesting new proposals, but when it is received Dr. Ashton is expecting a short turnaround time of 3 to 4 weeks for submittal. She added that this is now an opportunity for the Board to put in their ideas to come up with something that will support some of the orders of the Governor on patient safety, fraud and abuse.
  - Dr. Ashton stated that she read through the grants that were funded and chose four of them that the Board may be able to assist with and modify it to fit into the DUR environment.
  - Dr. Ashton went through four of the grants that were chosen, that included Connecticut, Utah, Tennessee and New Mexico. She added that Medi-Cal was encouraged by CMS to go ahead and rewrite and revise the CALRHIO proposal.
    - Connecticut looked at building the infrastructure for Health Information Exchange and to hook the E-Prescribing onto it and maybe targeting a specific population perhaps Mental Health.
    - Tennessee model looks at E-Prescribing and to support their E-Health Advice counsel. They proposed looking at 50 providers and they will look at it by counties and the ratio of patient's to TennCare providers and measure if there is a decrease in percentage of prior authorizations.
    - New Mexico model is an E-Prescribing proposal and they also asked for money to make technical changes to their MMIS (Medicaid Management Information System) and to revise their claims system in order to support E-Prescribing. Their outcome is to report back on their accomplishments.
    - Utah received \$2.9 million and Dr. Ashton suggested that it might be something that the Board can look at that can bring some ideas to their mind. She added that Utah has an Electronic Surveillance Tool that will be developed and run out of the University of Utah pharmacy school. It is a retrospective analysis using the claim data to identify duplicate medication, potential drug disease interaction, and targets intervention and assists them to create Medicaid policy.
  - Dr. Ashton added that the Board might consider these ideas and the members that served on the Prospective DUR Improvement committee (Dr. McBride, Dr. Schell, Dr. Miller and Dr. Mowers) might want to work with her to help write the grant proposals.
  - Dr. Miller asked if there is something written from CMS with feedback as to why the grant was not funded.
  - Kim Ortiz replied that there was no specific reason and just continued that the new proposals should include giving CMS a better view of where California is going.
  - Dr. Miller asked about the vendor process. Dr. Ashton answered that in the other proposals, contractors are mentioned, and California has a

bid or procurement process. Outcomes would need to be shown within two years.

- Dr. Stebbins commented that just having implemented EMR with an E-Prescribing system within their own facility with only 160 doctors, she is not sure how Medi-Cal is going to get things done in 2 years. Medi-Cal FFS has doctors that are not in groups, they are typically single doctors out there and if they buy into an E-Prescribing system and have to turn around and buy into an EMR system because that will be mandated by CMS at some point, she is not sure how they plan to get anything done in 2 years.
- Dr. Schell asked if these are the only 4 proposals. Dr. Ashton answered, No, and they all are on the CMS Web site at [www.cms.hhs.gov](http://www.cms.hhs.gov) and all 27 grants that were funded are posted with the amount.
- Dr. Miller asked about the work that has already been done by organizations like the California Health Care Foundation related to looking at IT infrastructure within the state, is there a way we can piggyback onto other proposals? Kim Ortiz replied that there are proposals out there and they are collaborating with those organizations.
- Dr. Miller commented to take the CALRHIO proposal and resubmit it but do what we need to do to make the changes to it rather than reinventing the wheel in 6 weeks. Dr Ashton added that we can submit more than 1 proposal. Kim Ortiz talked about that the State of Alabama got funded for statewide Health Information Exchange that has a quality component. She thinks that CMS will entertain CALRHIO type proposal that contains payment for performance.
- Dr. Stebbins commented that the Utah model contains both a retro and prospective surveillance with medication therapy management.
- Dr. Wong commented about the Utah proposal and he tend to agree that it might be a good model for California. It looks as if they combined all three grants that were submitted into one idea that has multiple components with looking at chronic diseases, using HEDIS measures and disease programs. Suggested looking at different health systems within California and their electronic systems.
- Kim Ortiz stated that CMS would look very positively on our proposals if we were to start partnering with states that are doing the same. Dr. Ashton agreed and that our proposal might be to use their tools once they get theirs done to move forward in our state.
- Dr. Wong added that by the time California is started Utah is already done and Dr. Ashton added that we can contract out for theirs and everyone agreed that this is a good idea. She also mentioned that Utah has a lot of support because of the universities to do a lot of looking at interventions and data to assist in coming up with their strategies.
- Kim Ortiz mentioned that the long range goal is to end up with a National Health Information network.
- Dr. Albertson asked is there a motion for CMS to have a backbone that is uniform across electronic delivery systems? To have a common nomenclature between programs.
- Dr. McBride stated that all Board Members are in agreement as to fixing the CALRHIO proposal and going toward the direction that Utah went for a new proposal.
- Dr. Ashton stated that she will send the proposals to the whole group and will wait for the news to come from CMS for the new set of grants.

	<p>D. Medicare Part D Emergency Drug Benefit Update</p> <ul style="list-style-type: none"> <li>• Dr. Teri Miller described the Medicare Part D Emergency Benefit bulletin that came out in January 2007. The emergency benefit ended on January 31, 2007. On this bulletin there is some helpful contact information of the plans that may help the pharmacies.</li> <li>• Dr. Pilar Williams, Pharmacy Chief, California Department of Health Services, notified the attendees that starting March 1, 2007, all providers will need to use the Beneficiary Identification Card (BIC) and not Social Security Numbers (SSN). Dr. Mowers inquired if the Pharmacists can still call and obtain the numbers from the Internet if they have the beneficiaries SSN.</li> </ul>
<p><b>4) ONGOING PROJECTS</b></p>	<p>A. Acetaminophen Toxicity Analysis</p> <ul style="list-style-type: none"> <li>• Dr. Ashton gave a brief history of Acetaminophen usage in the state that goes over the recommended four grams per day and that they have access to more than 4 grams for more than 100 consecutive days. CDHS tried to figure out ways within our system to prevent this over usage and nothing exists that we can turn on or modify. There was discussion of sending letters to the 57 patients with known liver toxicity who were continuing to receive the high dosage of acetaminophen. We are unable to correctly identify the prescribers in the majority of those cases and since the original data was obtained, Medicare Part D has been initiated. What we did find that was at the request of the board is to look at what the OTC (Over the Counter) contribution was to the over 4 grams/day for over 100 day people. The results showed that in 50% of the cases, there was 1 OTC medication that was contributing to that over 4 grams of the high doses.</li> <li>• Dr. Ashton stated that what she needs is to get together with Dr. Albertson and Dr. Schell to do the following: <ul style="list-style-type: none"> <li>○ Go back and rerun the data with current patients and see where we're at.</li> <li>○ Check to see that in the first cut of data if they were Medicare or not. If we find that there were a great number of them from Medicare, they may be continuing to get their OTC from Medi-Cal because we pay for the excluded medication and their prescription acetaminophen from the Part D primary payer. It is noted that 85% of the time it was Vicodin that the patients were also taking that attributed to the high acetaminophen dosage. This may be an opportunity to work with Part D PDP, because we each have a piece of the data to look at cumulative dose.</li> </ul> </li> <li>• Dr. Ashton mentioned that this is an opportunity to go back and look and bring them back by if they are Part B or not and also look at the FFS (Fee for Service) and continue to do the surveillance of how many people are receiving more than 4 grams/day. Jim Klein and Dr. Ashton will get back with Dr. Albertson &amp; Dr. Schell to see how we want to proceed with the new set of analysis and to look at the Part D component.</li> <li>• Dr. Ross Miller asked when was the last time the data was run. Jim Klein responded that it was in the first half of 2005. Dr. Ashton stated that some Medicare beneficiaries left in 2006. Dr. Albertson requested CDHS to look back at the 2005 data and pull their Medicare information so the data can be looked at pre and post Medicare Part D.</li> <li>• Ron Sanui, California Department of Health Services, stated that CDHS</li> </ul>

is contracting with the Part D plans on sharing data. CMS will not share information with the states, but will share with the PDP and University settings. Dr. Ashton asked that CDHS receive the data in the Prescription Data Element (PDE) format and is working on agreements with the PDPs.

- Dr. McBride asked if there was a way to make Early Refill or Duplicate Therapy a hard edit past 4 grams or require a TAR for anything higher. Dr. Ashton replied that not without a System Development Notice (SDN) which requires a system change. CDHS is not doing any more SDN's at this time.

#### B. Antidepressants in Children and Adolescents Study

- Dr. Patrick Finley shared some background of what he has been doing on the study for the last year. They looked at the impact of the FDA black box warning on antidepressants in children and adolescents. Their study was looking to see if there is decreased prescriptions for antidepressants in these age categories, and were there increases in psychiatric visits for these patients. The Committee for Protection of Human Subjects (CPHS) approval was granted two months ago. Jim Klein is working on the methodology including diagnosis, prescriptions, emergency room and psychiatric visits. No specific data is ready right now.
- Dr. Finley mentioned that there is a large quantity of data with many things to look at. Dr. Ashton stated that the data is mapping to NCPDP-35 file.

#### C. Asthma Study

- Dr. Ashton gave background on phase one of the Asthma study using HEDIS® measures and applying to FFS population. Since the last DUR Board Meeting, the data has been refined so take out patients over 40 years of age that may be emphysema or COPD patients. A random cut of 40 patients were taken and all of their utilization data were looked at. The data was rerun from January – June 2006 to include all asthmatics, with FFS and continuous eligibility with an ICD-9 of 493. At this point the beneficiaries with age over 40 years were taken out of the data.
- Analysis of the 2006 data showed a lot of conflicting figures. A notable item from the data is that the chronic asthma patients have a lot of atypical antipsychotic prescriptions. The data needs to be analyzed to see what is really going on with this group. Dr. Ashton was asked to do more cuts of the data.
- Dr. Albertson noted that Medicaid is a difficult group to manage with the co-morbidities that can occur. Medicaid overall is a group with multiple utilizations of healthcare resources that include diabetes, asthma, heart disease and others.
- Dr. Wong suggested that medical records may need to be reviewed for this study to see what is going on with the mental illness. Dr. Stebbins stated that this may be hard to do.
- Dr. Miller asked why they are not coding for mental illness when large amounts of money are being spent on prescription antipsychotics.
  - Dr. Ashton mentioned that a lot of the beneficiaries with psychiatric claims are in the SHORT DOYLE county system. Medi-Cal has the drug claims for the children with psychiatric disorder. Atypical antipsychotics are a carve-out from the managed care plans. Only drugs are carved out to Medi-Cal, not the medical claims.
  - Bob Umeda said the psychiatrics use DSM-IV diagnosis not ICD-

9 codes for diagnosis. This data would not come to Medi-Cal FFS. Medi-Cal does get short Doyle claims.

D. Rheumatoid Arthritis Study

- Dr. Wong reported that the Committee for Protection of Human Subjects has been renewed the RA study until 2008. Data has been collected and will be analyzed and can be presented at the next meeting. He stated that rheumatoid arthritis is a complex disease and articles have been published that describe the complexity of care. Kahn KL, MacLean CH, Liu H, Rubenstein LZ, Wong AL, et al: The Complexity of Care for Patients with Rheumatoid Arthritis: Metrics for Better Understanding Chronic Disease Care. Medical Care 2007, and the other is Kahn KL, MacLean CH, Liu H, Rubenstein LZ, Wong AL, et al: Application of Explicit Process of Care Measurement to Rheumatoid Arthritis: Moving from Evidence to Practice. Arthritis & Rheumatism (Arthritis Care & Research) 2006.

E. California Mental Health Disease Management Program (CalMEND)

- Dr. Teri Miller stated that CalMEND has changed the word “disease” to “care” to more closely match the patient centered nature of the program. Into the end of the first year of three years to develop this program. Still in the strategic planning and development phase of the program.
- Dr. Teri Miller went on to explain that it is a consumer focused, evidence driven effort to develop a statewide mental health care management program to promote shared decision making with consumers, family members and providers to support a wellness and recovery journey.
- It is a multi-disciplinary program. There are four sub-committees.
  - One of the sub-committees is looking at treatment guidelines for schizophrenia. Antipsychotics are being looked at for their appropriate use.
  - A data sub-committee that is looking at different data sets and how they can work better to share data among departments.
  - A client-family sub-committee that is looking at educational materials.
  - A finance and infrastructure sub-committee is looking at how mental health care service get funded in California
- Dr. Finley has been attending the CalMEND clinical practice subcommittee meetings and is concerned with how they are going to get providers to stick to treatment guidelines. There have been counties that came up with treatment guidelines and providers did not follow them. Dr. McBride suggested that counties can put step-therapy in place to have the providers follow in order to get payment.

**5) DUR BOARD MEMBER COMMENTS ON ONGOING PROJECTS**

- A. Dr. Stebbins announced that on Medicare Part D outreach all the Pharmacy schools signed on and the training program will commence in July.
- B. Dr. McBride announced that Dr. Art Whitney has resigned from the DUR Board and thanked him for his service to the Board. It was also mentioned that the DUR Board is looking for a Pharmacist Board member.
- C. Dr. Wong shared two articles that have been published: The Complexity of Care for Patients with Rheumatoid Arthritis: Metrics for Better Understanding Chronic Disease Care in Medical Care 2007, and the other is Application of Explicit Process of Care Measurement to

Rheumatoid Arthritis: Moving from Evidence to Practice in Arthritis & Rheumatism (Arthritis Care & Research) 2006.

**6) UTILIZATION REPORTS**

A. Dr. Tina Wills, Electronic Data Systems (EDS), introduced the information from the Quarterly Report dated October through December 2006.

- Prospective DUR:
  - The prospective DUR data has stayed fairly constant with the percent of alerts and drug make-up are constant. Table 3 shows the generic drug names of the drugs in each of the top four alerts.
  - Dr. Schell asked to clarify if a drug is turned on or off, then the whole alert is turned off. Dr. Wills and Dr. Ashton clarified that each drug can have its own alerts set, but as a whole if you turn on/off a single alert then all of the interactions within that alert are on/off.
  - Dr. Albertson asked for clarification of the layout of Table 1, and was answered by Dr. Wills. Dr. Albertson asked if the data for the last year could be included. Eric King, Electronic Data Systems, stated that it will be included.
  - Dr. Albertson asked about the Prospective DUR system and if there have been any changes in the past 13 years and its usefulness. Dr. Ashton replied that the system is required and the data is what is reported. Changes cannot be made due to system limitations.
  
- Retrospective DUR:
  - Dr. Wills explained that FPACT and CCS/GHPP have now been taken out of the Quarterly report to better show what FFS is paying for. Also a standardized reporting timeframe of 28 days has been included to show a direct correlation from time period to time period. Dr. McBride asked if the Average Cost per Rx does not include any rebates. Dr. Wills answered it does not.
  - Dr. Schell asked about the bell shaped curve pattern in 2006 and was that same pattern apparent in 2005. Mr. King responded that in a past Board meeting, it was requested to minimize the data to a rolling 18 month window.
  - The other measures of retrospective DUR have stayed fairly constant including PMPM, Utilization and Total Paid by Month. The amount of TAR1 claims have dropped less than 1%, but increases in amount paid for TAR claims and average cost per claim. This assumes there are less claims but for more expensive drugs.
  - Dr. Stebbins asked if there is data on the percent of TAR claims denied. Dr. Wills and Mr. King replied that this data is not reported, but in theory could be pulled. Mr. King will look into the SURGE system to see if he can pull that data. Dr. Wong stated that it would be interesting to see what percentage of TARs are being denied.
  - Dr. McBride asked about the Code 1 restrictions and if there is a way to know if the person has met that requirement. Dr. Wills replied only under an audit can that be shown. It is an honor system for the pharmacy provider.
  - Dr. Wills explained Table 6 – Pharmacy Utilization by Age has

	<p>stayed fairly constant. The percent of recipient for the 65+ has dropped since the implementation of Medicare Part D. The 40-64 year olds have the largest amount of dollars paid, total recipients and highest dollars/per age group of any of the groups.</p> <ul style="list-style-type: none"> <li>○ Dr. Stebbins and Dr. Finley inquired in the 0-12 age groups why glucocorticoids and beta-adrenergic agents have such a high increase in claims from third quarter 2006 to fourth quarter 2006. Dr. Wills replied that it may be due to seasonal variations. Dr. Stebbins asked to see a rolling five quarters for these two categories to see if this is typical of these drugs in this season.</li> <li>○ Dr. Wills requested a vote of the Board members to decide which format of Utilization tables 7, 7A or 7B, 7C also the same for tables 8, 8A or 8B, 8C. They present the same information but in different formats. One showing a rolling 5 quarters and the other showing current compared to past quarter and past year. <ul style="list-style-type: none"> <li>▪ Dr. McBride called for a motion. Dr. Schell motioned for 7B, 7C and 8B, 8C to be chosen because it shows previous quarter and previous year.</li> <li>▪ Dr. Stebbins would like a more clear labeling of the tables for 7B &amp; 7C.</li> <li>▪ Dr. McBride called for a vote, and was passed unanimously.</li> </ul> </li> </ul> <p>B. Early Refill (ER) Alerts</p> <ul style="list-style-type: none"> <li>• Dr. Ashton stated that a letter was drafted to the top 25 pharmacies that have large amounts of ER overrides as an action item. The data was run again to see what is happening to the ER Alerts. There has been a 56% decrease in the number of ER alerts that are being overridden. The list of pharmacies were pulled and type of medications looked at. This showed that the mix of medications do not include pain medications, but include aspirin, folic acid and calcium. Long term care facilities seem to be the pharmacies that have the most overrides. It was determined that a letter may not need to be sent out to the top pharmacies, but maybe a letter to a few of them based on the types of medications (i.e., aspirin).</li> <li>• Dr. Mowers asked if this would be worthwhile to spend time and resources on this problem. Dr. Mowers recommends not sending out the letter. Dr. Ashton asked if EDS should monitor for one more quarter. Dr. Mowers agreed to this.</li> </ul>
<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 May 8, 2007, in room 71.1203 at 1501 Capitol Avenue.
<b>9) ADJOURNMENT</b>	The meeting adjourned at 12:15 p.m.

**Summary of Action Items:**

- 1. Amend 09/12/06 meeting minutes as requested.**
- 2. Deficit Reduction Act (DRA) Grant Opportunities**
  - a) Dr. Ashton will meet with the DUR Board members to discuss options for a new proposal for CMS.
- 3. Acetaminophen Toxicity Analysis**
  - a) Dr. Ashton and Jim Klein will rerun the acetaminophen toxicity with 2006 data and send the results to the DUR Board members electronically.
  - b) Dr. Ashton will re-run the 2005 data and separate out the Medicare Part D from FFS.
- 4. Asthma Study**
  - a) Dr. Ashton will do more cuts on the asthma study data and write a high-level overview of the steps taken to obtain and analyze the data.
  - b) Dr. Ashton will pull short Doyle eligibility and cross the beneficiaries for mental health claims on the asthmatic patients.
- 5. Quarterly Report**
  - a) EDS will add into Table 1, the data for the previous year/quarter.
  - b) EDS will look into the SURGE system and see if data for denied TAR claims can be pulled.
  - c) EDS will pull rolling five quarters of data on Glucocorticoids and Beta-adrenergic agents for the 0-12 year age group for the next DUR Board Meeting.
- 6. Early Refill Alert**
  - a) EDS to monitor ER drug alerts for one additional quarter of time and report at the next DUR Board Meeting.