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, September 13, 2022,** at the following location:

Department of Health Care Services
1500 Capitol Avenue
1st Floor Training Rooms A and B
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	Yana Paulson, PharmD	940-945
R/A/D	**3.** Review and Approval of Previous Minutes from May 17, 2022	Yana Paulson, PharmD	945-950
	4. Old Business		
R/A/I/D	**a.** DHCS Update **b.** Recommended MCP Action Items from May 17, 2022 **c.** Review of Board Action Items from May 17, 2022	Pharmacy Benefits Division Pauline Chan, RPh, MBA Andrew Wong, MD, Randall Stafford, MD, PhD, and Stan Leung, PharmD	950-1030
	5. New Business		
R/A/I/D	**a.** Global DUR Board Activities i. FFY 2021 DUR Annual Report: MCO Summary ii. DUR Bylaws iii. DUR Board Vice Chair Elections	Pauline Chan, RPh, MBA	1030-1055
Morning Break			1055-1100
R/I/D	**b.** Health Plan Presentation by CalOptima: Retrospective DUR 2021 Highlights	Nicki Ghazanfarpour, PharmD	1100-1130

Report Type*	Agenda Item	Presenter	Time
R/I/D	**c.** Health Plan Presentation by CalViva, California Health & Wellness, HealthNet Medi-Cal: HEDIS Medi-Cal Clinical Pharmacy Adherence Program	Flora Siao, PharmD and La Kesha Farmer, PharmD	1130-1200
	Lunch Break		1200-100
R/D	**d.** Recap of morning action items	Hannah Orozco, PharmD	100-105
R/I/D	**e.** Health Plan Presentation by San Francisco Health Plan: Identifying and Informing High Risk Members Prior to the Medi-Cal Rx Transition	Jessica Shost, PharmD	105-125
R/A/D	**f.** UCSF Update i. Review of DUR Publications ii. DUR Educational Outreach to Providers iii. Retrospective DUR iv. Prospective DUR	Shalini Lynch, PharmD, Ally Diiorio, PharmD, and Amanda Fingado, MPH	125-245
R/D	**g.** Looking ahead: Call for future meeting agenda topics i. Innovative Practices Presentations by Blue Shield, CenCal, and Community Health	Pauline Chan, RPh, MBA	245-250
C	**6.** Public Comments **		250-300
I	**7.** Consent Agenda		
	a. Meeting feedback **b.** Next meeting: Tuesday, November 15, 2022 1700 K Street 1st Floor Conference Room Sacramento, CA 95814 **c.** Proposed DUR Board Meeting Dates for 2023: Tuesday, February 28, 2023 Tuesday, May 16, 2023 Tuesday, September 19, 2023 Tuesday, November 28, 2023		
A	**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
September 13, 2022

- **Suggested Sections to Review Prior to Meeting:**
  - FFY 2021 DUR Annual Report to CMS: MCO Summary (**Pages 34 – 59)**
    - These slides provide a summary of the responses by all 26 MCOs to the FFY 2021 DUR annual report to CMS. There will not be time at the meeting to go through each slide in detail, so please review prior to the Board meeting.

  - DUR Board Vice Chair Elections (**Pages 63 – 64**)
    - Elections for Vice Chair take place at each September Board meeting. Please review Dr. Blatt's candidate statement for the 2023 Vice Chair in advance of the Board meeting.

  - Opioid Dashboard (**Pages 85 – 93**)
    - The DUR Program (via DHCS) now has access to the opioid dashboard for the Medi-Cal Rx program. The packet contains a summary of what is available on the dashboard. Please review the slides in advance of the Board meeting.

- **Important Reminders:**
  - The following date has posted for the remaining DUR Board meeting for 2022:
    - Tuesday, November 15, 2022

  - The following tentative dates have been proposed for the 2023 DUR Board meetings:
    - Tuesday, February 28, 2023
    - Tuesday, May 16, 2023
    - Tuesday, September 19, 2023
    - Tuesday, November 28, 2023

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 in advance
- The meeting will not be cancelled if there are unforeseen technical difficulties or limitations with the webcast
- For those viewing the meeting via webcast, please use the chat feature to ask questions

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 move that…..". Motion is 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, May 17, 2022

9:30 a.m. – 2:00 p.m.

Location: Department of Health Care Services
1700 K Street, 1st Floor Conference Room
Sacramento, California

Topic	Discussion
1) WELCOME/ INTRODUCTIONS/ ROLL CALL/ ANNOUNCEMENTS	• Board members present included Drs. Timothy Albertson, Michael Blatt, Lakshmi Dhanvanthari, Stan Leung, Johanna Liu, Janeen McBride, Robert Mowers, Yana Paulson, Marilyn Stebbins, and Andrew Wong. • Board members present on the webinar included Dr. Randall Stafford and Mr. Vic Walker. • Board members absent: Dr. Jose Dryjanski. • Department of Health Care Services (DHCS) Pharmacy Benefits Division (PBD) employees present included: Samira Ahantab, PharmD, Pauline Chan, RPh, MBA, Cassie McCrary, PharmD, Katherine Nguyen, PharmD, Paul Nguyen, PharmD, Paul Pontrelli, PharmD, Emily Schulz, PharmD, and Victoria Tereschenko, PharmD. Harry Hendrix, Chief of Pharmacy Benefits Division, Chris Amaral, PharmD, Ivana Thompson, PharmD, and Mike Wofford, PharmD were present on the webinar. • Representative from Medi-Cal managed care plans (MCPs) present included Helen Lee, PharmD (Alameda Alliance for Health). MCP representatives present on the webinar included Clarence Chung, PharmD, MBA (Kaiser), Anthony Dao (AIDS Healthcare Foundation), Michael Hammoud, PharmD (Aetna), Adam Horn, PharmD (CenCal Health), Evangelina Hurtado, PharmD (Anthem), Dang Huynh, PharmD (Health Plan of San Mateo), Susan Nakahiro, PharmD (Blue Shield of California Promise Health Plan), Brian Nguyen, PharmD (Blue Shield of California Promise Health Plan), Duyen Nguyen, PharmD (Santa Clara Family Health Plan), Navneet Sachdeva, PharmD (Central California Alliance for Health), Ming Shen, PharmD (Health Plan of San Mateo), Jessica Shost, PharmD (San Francisco Health Plan), Caroline Tambe, PharmD (Santa Clara Family Health Plan), Ashley Teijelo, PharmD (Community Health Group), Timothy Tong, PharmD (Alameda Alliance for Health), and Bruce Wearda, RPh (Kern Family Heath Care). • Ms. Chan established there was a quorum for this meeting. • Ms. Chan announced that Dr. Stebbins is retiring from UCSF and has resigned from the Board effective June 1, 2022, after 14 years of service. On behalf of DHCS, Ms. Chan expressed gratitude to Dr. Stebbins for her contributions to the Board and noted this would be Dr. Stebbins' last meeting as a Board member.
2) CALL TO ORDER/ GUIDELINES/ ROBERT'S RULES	The Chair of the Board, Dr. Yana Paulson, called the meeting to order. Dr. Paulson thanked Dr. Stebbins for her service, and the other Board members shared their sentiments. Dr. Stebbins expressed her gratitude and excitement for the Board's future. Dr. Paulson reviewed the meeting guidelines and stated that everyone is expected to be courteous, respectful, and open-minded. Dr. Paulson then provided a summary of Robert's Rules of Order.

3) REVIEW AND APPROVAL OF PREVIOUS MINUTES FROM FEBRUARY 15, 2022	The Board reviewed the minutes from the Board meeting held on February 15, 2022. Dr. Wong suggested several minor corrections to the minutes. Dr. Paulson motioned the minutes be approved with Dr. Wong's edits incorporated. Dr. Liu seconded the motion. There was no discussion. The Board voted to approve the minutes. **AYE:** Albertson, Blatt, Dhanvanthari, Leung, Liu, McBride, Mowers, Paulson, Stebbins, and Wong. **NAY:** None **ABSTAIN:** None **ABSENT:** Dryjanski, Stafford, and Walker **ACTION ITEM:** Incorporate Dr. Wong's edits and post the February 15, 2022, minutes to the DUR website.
4) OLD BUSINESS	**a.** DHCS Update – Mr. Hendrix first thanked Dr. Stebbins for her 14 years of service. For the Medi-Cal Rx transition update, he reported that as of May 9th, a team of call center representative liaisons dedicated to support special populations (Children's Care Services (CCS), Genetically Handicapped Persons Program (GHPP) and behavioral health) was formulated. Managed Care Plan (MCP) liaisons are already in place. Mr. Hendrix stated the Special Populations Liaisons are comprised of technicians, pharmacists, and supervisors who are equipped to resolve inquiries and issues around prior authorizations (PAs) and claims, when initiated by beneficiaries and county users. He added the team is not permitted to approve PAs but will work towards resolving the issue. Next, Mr. Hendrix announced that DHCS will utilize a phased approach for reinstatement of PA and claim edits to alleviate backlog. He stated that specifics with details and timeline would be shared in the next few weeks. Mr. Hendrix added that the reinstatement would be based on a methodical, data driven approach that consists of different phases with multiple stages. He shared that with the roll-out of each stage, there would be an assessment to determine if the processes and staffing are sufficient to introduce the next stage. Mr. Hendrix stated that while the original communication indicated the transition policy would expire at the end of June 2022, this will not be the case and that the transition policy will continue to extend all PAs, with no end date announced at this time. He further explained that prior to the retirement of the transition policy, stakeholders will receive a 90-day notice to ensure there is appropriate communication, support, training, and education. Mr. Hendrix added that for high impact items, such as the transition policy, stakeholders will have a 90-day notice, but for changes with smaller impact, 30- to 60-day notices can be expected. Lastly, Mr. Hendrix stated that clinical DUR edits are not being reinstated this month, and there would be education and outreach conducted prior to their reinstatement. Dr. Mowers commended the work associated with Medi-Cal Rx and asked if DHCS is looking into the necessity of reinstating all DUR alerts and considering which ones to phase in appropriately. Dr. Mowers added that this is a good time to review which alerts are most necessary. Mr. Hendrix indicated that the department is reviewing which alerts are necessary, and there is no guarantee that all DUR alerts will be turned back on. Dr. Mowers added he felt that some alerts could be removed. Dr. Paulson asked how many Special Populations Liaisons would be available for the program. Mr. Hendrix estimated it was between 10-20 people and stated that an analysis was conducted to determine an appropriate number. Dr. Paulson asked Mr. Hendrix to repeat which special populations would be served under this team. Mr. Hendrix stated they would serve CCS, GHPP, and the Behavioral Health Program. Mr. Walker asked which alerts Dr. Mowers would suggest modifying or removing. Dr. Mowers indicated he did not have specific alerts in mind but wanted to determine which alerts from Medi-Cal Rx might be redundant with alerts pharmacies are already sending through their systems. He added that if DHCS needs a volunteer to help review the alerts, he would be happy to assist because this is a great time to re-evaluate the alerts. Mr. Walker concurred and indicated he would like to review the alerts further as well. Dr.

Paulson stated she would like an analysis to determine which alerts are largely overridden without any changes to the claim as those might be candidates to remove.

b. Review of Board Action Items:

- Medication Therapy Management (MTM) Program Updates – Dr. Wofford provided an update on the MTM program, reminding the Board that MTMquestions@dhcs.gov was developed by DHCS as a portal for communication specific to MTM. He indicated that Dr. Ahantab is the MTM pharmacist and that she would be able to provide any application information. Dr. Wofford indicated that DHCS is seeing slow and steady growth, with 69 applications approved, 12 denied, and 4 under review. He reiterated that the MTM claims are medical claims and not submitted as NCPDP pharmacy claims; therefore, they take longer to submit and pay. Dr. Wofford stated that DHCS has started developing criteria for how they will assess providers enrolled in the MTM program. He added that providers must submit quarterly and annual updates of their progress on measures such as adherence, compliance, and medications in the beneficiary's profile. Dr. Wofford also stated DHCS would be looking at additional measures, such as if the beneficiary is on a more appropriate therapy than prior to the MTM intervention, improved safety measures, the number of comprehensive reviews, and total provider encounters. He stated this information will be used to assess provider progress with the MTM program.

  Dr. Leung asked if there is education and outreach to pharmacies with regards to therapy gaps. He provided an example of a patient on suboptimal statin therapy, asking if a pharmacy would be notified of the suboptimal therapy. Dr. Leung suggested that since DHCS has all the pharmacy-related data, DHCS could leverage the information to send an alert to the pharmacies. Dr. Wofford replied that they would review and assess once more data becomes available.

  Dr. Wong shared that in Los Angeles County, there are plans to expand the scope of clinical pharmacists integrated in the heart failure clinic to include rheumatoid arthritis and lupus. Dr. Wong then asked for a status update on adding diagnosis such as autoimmune-related diseases as part of expanded categories of drugs in the MTM service. Dr. Wofford stated no additional categories will be added at this time as there is not enough activity yet to assess the initial categories. Dr. Wong asked about the expected time frame for further assessment. Dr. Wofford indicated that DHCS is hoping for further assessment within the next quarter.

  Dr. Stebbins indicated that she was pleased with the increased enrollment but asked Dr. Wofford if he had an explanation for the absence of claims submitted. Dr. Wofford shared that while medical claims do take longer to process, he is unaware of feedback indicating issues with submission. He stated that there has been indication of delays due to providers establishing requirements associated with a new MTM program, in addition to other factors such as COVID-19 related burdens.

  Dr. Sachdeva asked if Dr. Wofford could provide a description on how MTM is initiated and how beneficiaries are referred to the program. Dr. Wofford stated that there is no formal referral program, but that physicians can refer beneficiaries. He shared that there is a section in the enrollment packet on how to identify beneficiaries at risk, which includes factors such as multiple providers, multiple medications, abnormal lab values, etc. Dr. Blatt asked if a health plan can make recommendations if they have supporting data. Dr. Wofford confirmed this is permissible.

  Dr. Paulson stated that health plans have MTM programs for specialty drugs and asked if any of the pharmacies enrolled are specialty pharmacies. Dr. Wofford stated that many of the pharmacies classify themselves as specialty but stated that DHCS does not have criteria to identify a pharmacy as such. Dr. Paulson

	asked if DHCS is monitoring specialty drug adherence outside of the MTM program and recommended there should be adherence monitoring if it is not taking place. Dr. Wofford confirmed there is quarterly MTM monitoring for all drugs and not only specialty drugs, since identification of drugs as specialty drugs has legal limitations. He added that DHCS could monitor certain drugs of interest. Dr. Paulson suggested referencing the list provided by CMS. Dr. Blatt asked if the MTM services must be in person or if they could be via video. Additionally, he asked if a pharmacy can contract with pharmacists who conduct the MTM services remotely or if the pharmacist must be on site. Dr. Wofford stated the only requirement is the pharmacy or pharmacists who are providing the services must be who is identified on the application. Dr. Leung asked if the Board could make recommendations for measures to use when evaluating MTM activities. Dr. Wofford replied that it would be purview of the Board, and DHCS would be happy to review anything that would enhance the monitoring. Dr. Leung then indicated there are four Healthcare Effectiveness Data and Information Set (HEDIS) measures he can think of to start with. Dr. Wofford noted that they plan to incorporate HEDIS measures. Dr. Leung motioned to add Managed Care Accountability Set (MCAS) measures to evaluate the MTM program. He added that MCPs play an important role in identifying gaps and forward the information to pharmacies. Dr. Mowers seconded the motion. Dr. Dhanvanthari asked if DHCS is doing anything to identify the gaps with the abundant data they have. Dr. Leung noted they aren't but the MCPs can and that Magellan and DHCS own the data. Dr. Dhanvanthari suggested to amend the motion and add that the Board members can recommend additional classes, such as drugs for the treatment of hepatitis C virus infection. Dr. Paulson noted the Board currently has that ability. Dr. Thompson reminded all that the plans still need to perform DUR related functions, including retrospective DUR. Dr. Blatt stated that according to All Plan Letter (APL) 20-020, the health plans still have the responsibility for monitoring, but that the MCPs need more guidance. He stated he wasn't sure if there was a universal documentation tool but suggested a universal platform would be beneficial. Dr. Paulson questioned how long it takes to process an MTM claim. Dr. Wofford indicated it was normally around 30 days. Dr. Blatt urged that following such measures isn't easy for larger plans and asked if there are practices or results to review from other states with successful programs. Dr. Wofford stated DHCS did review other states, but the other states were more focused on specific disease states. He added that they could not find a comparable state as they didn't fit the legislative requirements of California. Dr. Blatt expressed that the broad scope was a struggle and Dr. Wofford acknowledged the challenge. Dr. Paulson asked if there was information about which pharmacies have signed up for MTM services so they could be used for referrals. Dr. Wofford indicated they could provide a list. Dr. Paulson suggested to invite plans to share best practices in streamlining the services for the Board to review and formulate recommendations. She stated the amended motion is to add MCAS measurements to evaluate the MTM programs and allow the Board to recommend other diagnoses or conditions for monitoring at a future date. Dr. Stebbins seconded the motion. Dr. Wofford noted the program is to look at more broad disease states, even those for which there are not monitoring programs. He stated that providers must have the ability to focus their program on mental health or hemophilia; therefore, it cannot be too limiting or too focused on measurements. Dr. Mowers indicated the recommendation is not to adjust, rather it is to consider MCAS measurements and additional medications for DHCS to incorporate in the future. Dr. Wofford understood and encouraged the recommendation as long as it was not too limiting. Dr. Mowers stated his interpretation is to expand and highlight the specific measures as opportunities to be involved with MTM.

The Board approved the motion to add MCAS measurements to the evaluation of the MTM program and to allow additional diagnosis and conditions to be recommended at a future date.

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

ACTION ITEM: The DUR Board recommendations to 1) add MCAS measurements to evaluate the MTM program and 2) allow for the Board to recommend other diagnoses or conditions for monitoring in the future will be submitted to DHCS.

Dr. Blatt then motioned to have DHCS clearly define both the role of health plans in recommending patient populations to MTM pharmacies and the data requirements for transmission to the pharmacies. Dr. Mowers seconded the motion. Dr. Paulson suggested instead of DHCS defining these parameters, the plans should initiate what makes sense for the plan and have the plans come to the Board and share for best practice considerations. Dr. Stebbins concurred with this suggestion as it allows for more flexibility. Dr. Blatt disagreed and stated the flexibility is detrimental to the beneficiary. Dr. McBride stated the plans are too different and supported the suggestion to allow the plans to initiate their own plans. Dr. Albertson advised DHCS to review the plans and determine if their approaches are appropriate for the populations they serve. Dr. Blatt indicated at a minimum, the plans should be held to the MCAS measures and that DHCS was too far removed from the population specifics. He added that the plans have the necessary data to feed to the MTM pharmacies. Dr. Liu supported the idea of plans having the autonomy to decide what is appropriate for their quality and clinical programs. Dr. Wofford reminded the Board that each pharmacy has the liberty to decide which diagnoses they want to focus their MTM efforts on, and those may differ from minimum requirements.

The Board did not approve the motion.

AYE: Blatt
NAY: Albertson, Dhanvanthari, Leung, Liu, McBride, Mowers, Paulson, and Stebbins
ABSTAIN: Wong
ABSENT: Dryjanski, Stafford, and Walker

Ms. Chan requested an update from Dr. Amaral on the Medi-Cal Drug Advisory Committee (MCDAC). Dr. Amaral stated monthly Contract Drugs List (CDL) updates continue and can be found in the bulletin on the Medi-Cal Rx website. He added that DHCS is working with Magellan to look at lifting PA requirements on some drugs, as well as investigating CDL discrepancies. Regarding MCDAC, Dr. Amaral noted that nine new members have joined the committee and provided helpful input for the most recent quarter.

- The Board recommends expanding the description of the Vital Directions framework to include the four essential infrastructure needs – Further discussion held under New Business.

c. Recommended Action Items for MCPs from February 15, 2022 – Ms. Chan presented the recommended action items for MCPs from the Board meeting held on February 15, 2022. Recommendations are separated into two categories: required action items and suggested action items.

5) NEW BUSINESS	**a.** Health Plan Presentation by Alameda Alliance for Health: Pharmacy Programs presented by Helen Lee, PharmD, MBA (Alameda Alliance for Health) – Dr. Lee provided an overview of the Alameda Alliance for Health membership distribution by city, noting that their membership has increased during the pandemic. She highlighted the initiatives of Alliance and the rollout of CalAIM enhanced Care Management and In Lieu of Services, Pharmacy, and Major Organ Transplants programs on January 1, 2022. She added that these programs are expected to alleviate social disparities. Dr. Lee shared the approach for reducing gaps in care for asthma patients and noted that Alliance was one of nine programs nationwide selected by the Centers for Medicare & Medicaid Services (CMS) for inclusion in their asthma affinity workgroup. She stated the pilot study focused on African Americans with non-compliant asthma medication ratios (AMRs). Dr. Lee shared strategies used to identify and support non-compliant members. She indicated the outcomes measured in the program were the AMR compliance rate improvement (goal ratio ≥ 0.5) and asthma-related emergency room (ER) visits (decrease visits by 50% or more). Dr. Leung asked what the baseline values for these measures were, and Dr. Lee indicated she would have to validate. Dr. Blatt asked how the goal was decided upon. Dr. Lee stated they worked with a HEDIS coordinator to define the goals. Dr. Lee shared that the program consisted of two groups and explained the results of the program which showed that most of the members did not experience an ER visit 3 months after the intervention, half of the members for the first group achieved a goal AMR score 3 months after the intervention, and all but one reached goal within 2 months in the second group. Dr. Paulson noted the high touch effort associated with the program and asked how many resources were exerted for the groups. Dr. Lee replied that while the supporting team was large, each intervention consisted of one pharmacist, two case managers, and one health educator. Dr. Leung asked how many members were contacted to enroll the number they did. Dr. Lee stated they contacted 12 members and enrolled six for the first group and contacted 15 and enrolled five for the second group. Dr. Leung then asked how Alliance augmented member engagement as it was high. Dr. Lee explained how they utilized pharmacy claims data to obtain more accurate mailing addresses and that each member also received at least two follow up calls if there was no response. She added that to engage providers, they found most success when either case managers or pharmacists called them. Dr. Stebbins also acknowledged the high engagement, especially for an African American population. She stated that typically there is mistrust with this community due to negative interactions with the healthcare system. She shared that in her experience, using navigators, pharmacists, and primary care doctors of the same race helped to increase engagement. Dr. Lee then discussed the biosimilar optimization program, noting that per APLs 20-020 and 21-018, physician administered drugs are still each health plan's responsibility. She explained that biosimilars are largely utilized in Europe, but there is hesitancy for use in the United States. Therefore, she stated the aim of this program was to educate providers and increase their comfort with using biosimilars. Dr. Blatt asked how they shifted provider behavior to increase the use of biosimilars. Dr. Lee stated they communicated with their delegate partners and provided evidence-based cost and clinical data from Europe. Dr. Wong asked which provider groups most used the specialty drugs. Dr. Lee stated it was typically gastroenterologists, rheumatologists, and oncologists that were targeted, and these targeted providers often influenced their peers. Dr. Wong then asked which providers made the biggest influence. Dr. Lee stated it was oncologists and immunologists. Lastly, Dr. Lee highlighted both their Shotproof Program that aimed to maximize incentives for COVID-19 vaccines in vulnerable populations, and their substance use program, a multidisciplinary effort to utilize medication-assisted treatment to taper opioid use safely. c

b. Global DUR Board Activities

i. Vital Directions Framework: 2021 Update – Dr. Paulson stated the Board uses the framework developed by the National Academy of Medicine (NAM) as a guide for developing their own vital directions. She noted that both Dr. Wong and Dr. Stafford would provide further input on the integration of the vital directions framework into the work conducted by the Board. Dr. Wong shared that they intended to maintain the four goals identified but wanted to create subgoals that addressed the changing needs of the Board. He stated the idea was to expand the measures as follows:

- What matters most: utilize core measures
- Modernize skills: utilize academic detailing
- Accelerate real-world evidence: utilize clinical guidelines and evidence-based guidance
- Advance science: forward clinical collaboration

Dr. Wong suggested for the next Board meeting the Board could define the specific actionable items for each of the expanded goals. Dr. Leung agreed that those additions would help add more direction, but also suggested ensuring there is a way to measure and track the impact of each action.

Dr. Stafford reinforced the importance of social determinants of health and the importance of integrating clinical care with public health efforts. He pointed out an assumption with the Vital Directions document was to treat the individual as a complete person,. Dr. Stafford stressed the idea that pharmacy issues are integral to a whole range of other efforts and encouraged the movement to recognize that while the Boards focus is pharmacy, a much broader perspective is required. Ms. Chan added that the whole person care approach is in the bylaws, along with both social and environmental determinants of health. Dr. Paulson commended Dr. Lee and stated that her presentation used 3 of the 4 goals which were 1) measure what matters most, 2) utilizing real world-evidence, and 3) academic detailing. Regarding the framework, Dr. Wong motioned to expand the vital directions with the subgoals previously mentioned. Dr. Albertson seconded the motion. There was no further discussion and the motion passed.

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

ACTION ITEM: The DUR Board recommendation to expand the vital directions to incorporate the following sub-goals will be submitted to DHCS:

- Measure what matters most - utilize consistent core measures
- Modernize skills – via academic detailing
- Accelerate real-world evidence – leverage clinical guidelines and social determinants
- Advance science – drive clinical collaboration

c. Recap of the morning action items – Hannah Orozco, PharmD (Magellan) read the Board action items from the morning session. There was no discussion, and no edits were made to the listed action items.

d. UCSF Update

i. Review of DUR Publications by Shalini Lynch, PharmD (UCSF)

- Dr. Lynch shared with the Board that a DUR educational alert entitled, "Professional Organizations Push for Recall of Buprenorphine Dental Warning," was published in February 2022. This alert summarized a letter to the U.S. Food and Drug Administration (FDA) from the American Society of Addiction Medicine (ASAM) and ten other health professional associations, requesting the FDA retract a Drug Safety Communication issued in January regarding possible dental problems associated with transmucosal buprenorphine.

- Discussion/Recommendations for Future Educational Bulletins – The calendar for future DUR educational bulletins was reviewed. There was no discussion, and no edits or additions were made.

ii. DUR Educational Outreach to Providers

- Final Outcomes: Dental Pain Letter – Amanda Fingado, MPH (UCSF) presented final outcomes from the 2021 mailing that aimed to inform dentists about the updated American Dental Association (ADA) and the American Academy of Pediatric Dentistry (AAPD) recommendations for the management of acute dental pain). The top 153 prescribers were identified with total paid claims for opioid medication exceeding 3 days' supply between March 1, 2019, and February 29, 2020. Educational outreach letters were mailed in February of 2021 and included the Medi-Cal DUR bulletin on dental prescribing and a provider survey. Ms. Fingado reported that within 12 months following the mailing, among the 153 prescribers there was a 44% decrease in paid claims for opioids among these prescribers (3,474 paid claims for opioids prescribed after mailing vs. 6,162 before the mailing), including a 50% decrease in paid claims for oxycodone. In addition, the average days' supply decreased from 4.9 to 4.4 days, the average number of tablets decreased from 20.3 to 18.8 tablets, and eleven prescribers had no paid claims for opioids during this time. Regarding secondary outcomes, in the 12-month period following the mailing, 32% of paid claims for opioids had days' supply < 3 (vs. 15% of paid claims prior to the mailing). Ms. Fingado reported that among those paid claims with days' supply < 3, the average number of tablets also decreased from 15.2 to 13.0 tablets. In addition, these 153 prescribers had a 19% increase after the mailing in paid claims for non-opioid pain medications, including ibuprofen and acetaminophen and the overall proportion of opioid claims among all paid claims by these prescribers went from 10.0% to 5.2%. The response rate (within 90 days) was 18% and the returned mail rate was 6%. Dr. Mowers asked if the letters also target oral surgeons or only dentists. Ms. Fingado stated it was primarily dentists and endodontists. Dr. Stebbins asked if there were plans to review the data again to determine if the rate of opioid prescribing will increase in conjunction with more offices opening back up with the reduced COVID-19 restrictions. Ms. Fingado stated the follow-up data used was from the last 12 months (March 1, 2021, through February 28, 2022).

- Retrospective Naloxone Study – Ally Diiorio, PharmD (UCSF) provided an update on a retrospective naloxone study, which was based on research completed for a DUR educational article published in December 2021. Dr. Diiorio shared that IRB approval was received from both UCSF and DHCS, and the virtual poster would be presented at both the 24th Annual UCSF Department of Clinical Pharmacy Spring Research Symposium and the 2022 American College of Clinical Pharmacy Virtual Poster Symposium.

- Prospective Naloxone Study – Dr. Diiorio stated that death due to overdose is on the rise and based on research conducted by James Gasper, PharmD, BCPP (DHCS), less than 50% of community pharmacies in California had naloxone in stock during 2020. Dr. Diiorio indicated that pharmacies in rural communities were even less likely to furnish and stock naloxone. As a result, the prospective study will focus on Lake County and Nevada County, which had two of the highest rates of death due to opioid overdose during 2020. Dr. Diiorio shared this prospective study would be a sequential, mixed-methods approach with both quantitative and qualitative assessments. The study aims include the following:
  - Identify unique barriers and facilitators to furnish naloxone from community pharmacies in Lake County and Nevada County.
  - Understand prior naloxone distribution initiatives by local community organizations.

- Assess attitudes and beliefs held by pharmacy staff regarding the use of naloxone.

Dr. Paulson asked if there was feedback on the current attitude of pharmacist towards furnishing naloxone. Dr. Diiorio stated there was still a stigma associated with furnishing naloxone and that pharmacies have expressed concern about attracting unwanted clientele. Dr. Diiorio provided a general outline of the study timeline and noted that updates will be shared at future Board meetings.

iii. Prospective DUR: Fee-for-Service

- Review of DUR Alerts for New Generic Code Numbers (GCNs) in 1Q2022 (January – March 2022): 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:
  - CABOTEGRAVIR – Ingredient Duplication (ID)
  - CELECOXIB/TRAMADOL – Drug Disease (MC), Therapeutic Duplication (TD), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - RILPIVIRINE – Ingredient Duplication (ID)

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

iv. Retrospective DUR

- Annual Report to CMS: FFY 2021 – Ms. Fingado reported that CMS only wants the PDMP data tables completed with data from the PDMP (not from pharmacy claims). Mandatory reporting of these data will be required starting in FFY 2023. Ms. Fingado also shared that the CMS survey added three additional classes to the psychotropic medication section: antidepressants, mood stabilizers, and antianxiety/sedatives. Ms. Fingado noted that MCO reports are due to DHCS by June 1, 2022. Ms. Chan noted there have already been two office hour sessions and three plans have already submitted their reports.

- Global Quarterly: 4Q2022 (October 2021 – December 2021) – Ms. Fingado presented the Global Quarterly Medi-Cal DUR report for 4Q2021. 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 this would be the final report that includes only pharmacy claims data prior to the implementation of Medi-Cal Rx. The Board had no questions and there was no discussion.

- Global Annual Report: Calendar Year 2021 – Ms. Fingado presented the Global Annual Report for calendar year 2021, noting that only 21% of eligible FFS enrollees had a paid pharmacy claim compared with 56% of eligible MCP enrollees. Ms. Fingado stated that FFS enrollees were 23% of eligible beneficiaries, 9% of utilizing beneficiaries, and 6% of total paid claims. Overall, she reported a 12% increase in utilizing beneficiaries and a 4% increase in total paid claims from 2020, driven primarily by COVID-19 vaccines. Dr. Dhanvanthari asked what the number of utilizing beneficiaries was prior to COVID. Ms. Fingado indicated she would have to refer to prior reports to validate the number.

- Quarterly Report: 1Q2022 (January 2022 – March 2022) – Ms. Fingado presented the Medi-Cal quarterly DUR report for the 1st quarter of 2022, which includes both prospective and retrospective DUR data. She indicated that this

report was generated using Magellan data, and as more data are available it would be added to future reports. Ms. Fingado shared summary data, including the total volume of Medi-Cal Rx claims submitted for processing in 1Q2022 (53,153,578) and that 31% of eligible Medi-Cal Rx beneficiaries had a paid claim during this quarter. Dr. Leung asked if rejected claims means that the claim stayed rejected. Ms. Fingado explained that rejected claims include scenarios such as missing beneficiary information, missing National Drug Code (NDC), or other errors that would cause a claim not to be processed. Dr. Leung asked if it would be fair to assume that in these scenarios, the claims stayed unpaid. Dr. Thompson replied that the outcome cannot be predicted because there is no way to track it and that not every claim can be fixed. She added the claim would be reflected as a paid claim if fixed, but it could not be tracked. Ms. Fingado stated that previous quarterly reports only included data on paid claims as there was never the capability to report on the other categories, such as overall submitted claims. Ms. Fingado noted that the total paid claims data fell within about 200 claims in comparison with the total paid claims reported in the prior quarter (4Q2021). Dr. Mowers asked if there were data available for denied and rejected claims for each month of the quarter. Ms. Fingado stated there was a promising trend seen in both denials and rejections decreasing from February to March and that the data has begun to normalize since the first 12 days in January. Dr. Thompson stated that in January especially, there was a high volume of submitted, paid, then reversed claims, which is potentially explained by providers testing the systems to verify connections were working appropriately. Ms. Fingado reminded the Board that the report formats are still evolving and for the previous quarterly reports, prospective DUR data had only been available for FFS claims so it may take some time to have appropriate comparative data.

- Quarterly Evaluation Report: 1Q2022 (January 2022 – March 2022) – Ms. Fingado presented a summary of the report published in the 1st quarter of 2022, which covered the following educational article published during the 1st quarter of 2020:
  - Drug Safety Communication: Mental Health Side Effects from Montelukast – January 2020

  Ms. Fingado noted that there had not been any additional FDA safety communications on montelukast since the publication of the original article, however the guideline recommendations for both allergic rhinitis and asthma have been updated since the original article was published, in order to incorporate the FDA's warning for mental health side effects from montelukast.

  Rhinitis 2020: A practice parameter update now recommends that clinicians 1) avoid leukotriene receptor antagonist (LTRAs), for treatment of nonallergic rhinitis and 2) reserve LRTAs for treatment of allergic rhinitis with inadequate response or intolerance to alternative therapies. The 2021 update of the Global Strategy for Asthma Management and Prevention list LRTAs as an alternative option for asthma management and encourage providers to weigh the risks of montelukast due to the FDA's *Boxed Warning*. Ms. Fingado recommended continued monitoring of research and FDA communications regarding montelukast and continue monitoring of the appropriate use of montelukast in the Medi-Cal population. Final outcomes of the 2020 montelukast mailing will be presented at a future Board meeting.

- Core Set Measures: Care of Acute and Chronic Conditions – Ms. Fingado presented a summary of the FFY 2020 data from Medi-Cal that published in December 2021, which covered the following four measures:
  - Asthma Medication Ratio: Ages 19 to 64 (AMR-AD): The percentage of adults ages 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year was 55.1% in California, which was

	slightly higher than the median of 53.7% (higher rates are better on this measure). o Asthma Medication Ratio: Ages 5–18 (AMR-CH): The percentage of children and adolescents ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year was 67.8% in California, which was slightly lower than the median of 68.5% (higher rates are better on this measure). o Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (HPC-AD): The percentage of adults ages 18 to 75 with Type 1 or Type 2 diabetes who had HbA1c in poor control (>9.0%) during the measurement year was 36.5% in California, which was slightly lower than the median of 39.0% (lower rates are better on this measure). This measure did not include FFS data from California, due to a lack of clinical data available. o Controlling High Blood Pressure: Ages 18 to 85 (CBP-AD): the percentage of adults ages 18 to 85 diagnosed with hypertension with adequately controlled blood pressure (less than 140/90 mm Hg) during the measurement year was 61.1% in California, which was slightly higher than the median of 59.2% (higher rates are better on this measure). This measure excluded data from dual-eligibles. Ms. Fingado briefly discussed selected recommendations for improving each measure. She also suggested that any health plans who have developed successful interventions targeting any of these measures should contact Ms. Chan for presentation at future Board meetings. Finally, the calendar for upcoming retrospective reviews was reviewed, with the upcoming meeting scheduled to have a focus on behavioral health. **e.** Looking Ahead: Ms. Chan called for any future meeting agenda topics or potential health plan presentations to be sent to DHCS.
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 September 13, 2022, in the DHCS 1st Floor Conference Room located at 1700 K Street, Sacramento, CA 95814.
8) ADJOURNMENT	• The meeting was adjourned at 2:00 pm.

Action Items	**Ownership**
Incorporate edits from Dr. Wong into the February 15, 2022, Board meeting minutes and post to the DUR website.	Amanda
The DUR Board recommendations to 1) add MCAS measurements to evaluate the MTM program and 2) allow for the Board to recommend other diagnoses or conditions for monitoring in the future will be submitted to DHCS.	Board/DHCS
The DUR Board recommendation to expand the vital directions to incorporate the following sub-goals will be submitted to DHCS: • Measure what matters most - utilize consistent core measures • Modernize skills – via academic detailing • Accelerate real-world evidence – leverage clinical guidelines and social determinants • Advance science – drive clinical collaboration	Board/DHCS

DHCS Update: Medi-Cal Rx

Pharmacy Benefits Division
September 13, 2022

GLOBAL MEDI-CAL DRUG USE REVIEW BOARD
MAY 17, 2022, BOARD MEETING MCP ACTIONS

MCP: _____

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

Reminders

MCP DUR Requirements:
With the implementation of Medi-Cal Rx on January 1, 2022, the following outlines DUR related responsibilities and supports for MCPs.

- **Prospective DUR** – This is not required of MCPs as of January 1, 2022. MCPs can review pro DUR alerts and overrides for their Members and use this information for provider (prescriber) education and interventions, which is a part of retrospective DUR.
- **Retrospective DUR** – This is still required of MCPs January 1, 2022, and forward. MCPs will receive comprehensive claims and PA history for their Members and can use claims data for their own quality improvement and retrospective DUR activities. In addition to that, as part of Global Medi-Cal DUR program, administered by DHCS in collaboration with Magellan and the University of California, San Francisco (UCSF), retrospective DUR analyses will be conducted for the entire Medi-Cal population, and results shared in aggregate, with the DUR Board, and by MCP, via the Medi-Cal Rx MCP secure portal, for their populations only.

  Any provider outreach needed as part of retrospective DUR interventions, are recommended to MCPs for their Members. UCSF is responsible for FFS-enrolled beneficiaries, and MCPs are able to use FFS developed communications (e.g., provider letter templates) or use their preferred method of provider communication.

  MCPs must continue to provide retrospective DUR (Retro DUR) activities designed to manage care including but not limited to identifying patterns of:

  - Therapeutic appropriateness
  - Adverse events
  - Incorrect duration of treatment
  - Over or under utilization
  - Inappropriate or medically unnecessary prescribing
  - Gross overprescribing and use
  - Fraud, waste, or abuse
  - Assessing medication adherence and identifying opportunities for care management interventions/outreach

- **Educational Outreach** – This is still required of MCPs January 1, 2022, and forward. UCSF will develop and publish educational bulletins and alerts throughout each year on a variety of topics. MCPs are currently required to disseminate DUR educational articles via their preferred method of provider communication, which may include posting them on their provider web page.

  MCPs must provide active and ongoing outreach to educate providers on common drug therapy problems (e.g., asthma medication ratio monitoring, opioid and naloxone co-prescribing, new prescribing guidelines and advisories) with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all beneficiary health.

- **Annual DUR Report** – This is still required of MCPs January 1, 2022, and forward. MCPs must annually submit the modified annual report and must include descriptions of any retrospective DUR activities and any innovative practices implemented by the MCP in the prior federal Fiscal Year.

- **Global Medi-Cal DUR Board Participation** – This is still required of MCPs January 1, 2022, and forward. MCPs must participate in the activities of the Global Medi-Cal DUR Board, including but not limited to:
  - Providing advice and feedback related to the nature and scope of the prospective and retrospective DUR programs.
  - Recommendations for DUR interventions.
  - Input regarding innovative DUR practices.
  - Board meeting attendance and Board membership.

-

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**
Alert (February 2022): Professional Organizations Push for Recall of Buprenorphine Dental Warning		

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

1. **Discuss the best practices presented by Alameda Alliance for Health on asthma medication ratio (AMR), biosimilar optimization, COVID-19 vaccine incentives, and the use of medication-assisted treatment to taper opioid use safely.**

   Actions:
   a. Review at MCP's P&T/DUR Committee
   b. Review MCP data for ideas and possible opportunities for change.

2. **Review the summary of the Core Set Measures data for Medi-Cal, which for this meeting focused on measures related to the Care of Acute and Chronic Conditions.**

   Actions:
   a. Review at MCP's P&T/DUR Committee
   b. Review MCP data for ideas and possible opportunities for change.

3. **Review list of approved topics for retrospective DUR reviews, educational bulletins and alerts, and educational outreach letters to providers/pharmacies**

   Actions:
   a. Discuss and prioritize topics at MCP's P&T/DUR Committee
   b. Share information at next board meetings

4. **Review Board Actions and Recommendations from the May 17, 2022 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. Consider offering feedback at future DUR board meetings

Old Business

Action Items from May 17, 2022

- The Board recommends DHCS:
  - Add MCAS measurements to evaluate the MTM program
  - Allow for the Board to recommend other diagnoses or conditions for monitoring in the future
- The Board recommends expanding the description of the Vital Directions to incorporate the following sub-goals:
  - Measure what matters most: utilize consistent core measures
  - Modernize skills: via academic detailing
  - Accelerate real-world evidence: leverage clinical guidelines and social determinants
  - Advance science: drive clinical collaboration

Medi-Cal DUR

California Department of Health Care Services

Medi-Cal Managed Care Accountability Set (MCAS) for Managed Care Health Plans (MCPs)

Updated December 31, 2021

Measurement Year 2022 | Reporting Year 2023

Total Number of Measures = 39 (8 Hybrid/Administrative and 31 Administrative)

MPL means Minimum Performance Level

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL
1	Breast Cancer Screening	BCS	NCQA	Administrative	Yes
2	Cervical Cancer Screening	CCS	NCQA	Hybrid/Admin**	Yes
3	Child and Adolescent Well-Care Visits*	WCV	NCQA	Administrative	Yes
4	Childhood Immunization Status: Combination 10*	CIS-10	NCQA	Hybrid/Admin**	Yes
5	Chlamydia Screening in Women	CHL	NCQA	Administrative	Yes [i]
6	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	NCQA	Administrative	Yes
7	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	NCQA	Administrative	Yes
8	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (> 9%)*	HBD	NCQA	Hybrid/Admin**	Yes
9	Controlling High Blood Pressure*	CBP	NCQA	Hybrid/Admin**	Yes

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL
10	Immunizations for Adolescents: Combination 2*	IMA-2	NCQA	Hybrid/Admin**	Yes
11	Lead Screening in Children	LSC	NCQA	Hybrid/Admin**	Yes
12	Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	NCQA	Hybrid/Admin**	Yes
13	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	NCQA	Hybrid/Admin**	Yes
14	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits	W30-6+	NCQA	Administrative	Yes
15	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits	W30-2+	NCQA	Administrative	Yes
16	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED [ii]	NCQA	Administrative	No
17	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	Administrative	No
18	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	Administrative	No
19	Asthma Medication Ratio	AMR	NCQA	Administrative	No
20	Adults' Access to Preventive/Ambulatory Health Services	AAP	NCQA	Administrative	No
21	Colorectal Cancer Screening*	COL	NCQA	Administrative	No

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL
22	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	CMS	Administrative	No
23	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	CMS	Administrative	No
24	Topical Fluoride for Children	TFL-CH	DQA	Administrative	No
25	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	ECDS	No
26	Developmental Screening in the First Three Years of Life	DEV	CMS	Administrative	No
27	Diabetes Screening for People w/ Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	NCQA	Administrative	No
28	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	NCQA	Administrative	No
29	Follow-Up After ED Visit for Substance Use – 7 days*	FUA	NCQA	Administrative	No
30	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-C&M	NCQA	Administrative	No
31	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-Init	NCQA	Administrative	No

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL
32	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	NCQA	Administrative	No
33	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	NTSV CB	TJC	Administrative	No
34	Pharmacotherapy for Opioid Use Disorder	POD	NCQA	Administrative	No
35	Plan All-Cause Readmissions	PCR [ii]	NCQA	Administrative	No
36	Postpartum Depression Screening and Follow Up*	PDS-E	NCQA	ECDS	No
37	Prenatal Depression Screening and Follow Up*	PND-E	NCQA	ECDS	No
38	Prenatal Immunization Status	PRS-E	NCQA	ECDS	No
39	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	ECDS	No

MCAS for Population-Specific Health Plans (PSPs)

Measurement Year 2022 | Reporting Year 2023

PSPs:

- AIDS Healthcare Foundation (AHF)
- SCAN Health Plan (SCAN)

#	MEASURE REQUIRED OF PSP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	PSP	HELD TO MPL
1	Breast Cancer Screening	BCS	NCQA	Administrative	SCAN	Yes
2	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control (>9.0%)*	HBD	NCQA	Hybrid/Admin**	AHF, SCAN	Yes
3	Controlling High Blood Pressure*	CBP	NCQA	Hybrid/Admin**	AHF, SCAN	Yes
4	Follow-Up After ED Visit for Mental Illness – 30 days*	FUM	NCQA	Administrative	AHF, SCAN	Yes
5	Follow-Up After ED Visit for Substance Abuse – 30 days*	FUA	NCQA	Administrative	AHF, SCAN	Yes
6	Adults' Access to Preventive/Ambulatory Health Services	AAP	NCQA	Administrative	AHF, SCAN	No
7	Colorectal Cancer Screening*	COL	NCQA	Hybrid/Admin**	AHF, SCAN	No
8	Contraceptive Care—All Women: Most or Moderately Effective Contraception	CCW-MMEC	CMS	Administrative	AHF	No
9	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	ECDS	AHF, SCAN	No

10	Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	NCQA	Administrative	AHF, SCAN	No
11	Follow-Up After ED Visit for Substance Abuse – 7 days*	FUA	NCQA	Administrative	AHF, SCAN	No
12	Pharmacotherapy for Opioid Use Disorder	POD	NCQA	Administrative	AHF, SCAN	No
13	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	ECDS	AHF, SCAN	No

MCAS for Managed Long-Term Services and Supports Plans (MLTSSPs)

Measurement Year 2022 | Reporting Year 2023

#	MEASURE REQUIRED OF MLTSSP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL
1	Ambulatory Care: ED Visits	AMB-ED	NCQA	Administrative	No
2	Plan All-Cause Readmissions	PCR	NCQA	Administrative	No

[i] MCPs held to the MPL on the total rate only

[ii] Stratified by Seniors and Persons with Disabilities (SPDs)

ECDS: Electronic Clinical Data Systems (electronic reporting method for certain HEDIS measures)

* Measures must be stratified by race/ethnicity. DHCS to provide further direction.

** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates

Measure Steward Key:
CMS - Centers for Medicare & Medicaid Services
DQA – Dental Quality Alliance
NCQA – National Committee for Quality Assurance
TJC - The Joint Commission

Vital Directions Infrastructure Needs & DUR Board Goals, Strategies & Actions

Andrew Wong, M.D.
Randy Stafford, M.D., Ph.D.
Global Medi-Cal DUR Board Meeting
September 13, 2022

Developing DUR Board Goals 2022

- Initial presentation at the February 2022 Board Meeting with a primary set of goals.
- Board Action at the February 2022 meeting:
  - Furthering, to incorporate Vital Directions' four infrastructure needs into the Board goals:
    1. Measure what matters most
    2. Modernize skills
    3. Accelerate real world evidence
    4. Advance science
  - Vital Direction update in 2021 (Health Affairs, 2021)
    - Address health equity
    - Lesson learned from COVID-19 –preventive care/public health

Key Thoughts in Developing Goals, Strategies and Tactics/Specific Actions:

- Board Action at May 2022 meeting:
  - The infrastructure needs are broad main goals. These will likely remain applicable over time.
  - The more specific strategies and tactics/specific actions change and evolve over time.
  - Further discussion to identify specific board actions at the September 2022 meeting.

Discussion One

- For each of the four infrastructure needs, board to further discuss strategies and tactics/specific actions on how to achieve:

Infrastructure Needs	Strategies	Tactics/Specific Actions
Measure What Matters Most	Utilizing consistent core measures/metrics that are actionable	Identify/prioritize existing measures MCAS, HEDIS Explore use of ED visits, hospitalizations as outcome measures ??

Discussion Two

Infrastructure Needs	Strategies	Tactics/Specific Actions
Modernize Skills:		
A. Providers	Education/Training skills:	Academic Detailing Identify resources and training materials (NaRCAD) DUR residency projects
B. Medi-Cal	Data Management Skills	Identify expertise MMA/UCSF

Discussion Three

Infrastructure Needs	Strategies	Tactics/Specific Action
Accelerate Real World Evidence	Apply Clinical Guidelines & Evidence-based Practice Prioritize and focus on chronic conditions, e.g. diabetes, asthma, hypertension, chronic pain, etc.	Document and share best practices of retrospective DUR interventions Identify opportunity to implement best practices

Discussion Four

Infrastructure Needs	Strategies	Tactics/Specific Actions
Advance Science	Clinical research collaboration Public-private partnership	Collaborations (e.g. UCSF, LAC DHCS, etc.) Participate in CMS workgroups Submit to peer-review journals for publications

Next Steps

FFY 2021 DUR Annual Report: Medi-Cal Managed Care Plan Summary

Pauline Chan, R.Ph., MBA
September 13, 2022

Average Monthly Medi-Cal Enrollment

- 26 plans completed annual report
  - 16 identified as comprehensive MCO
  - 10 identified as comprehensive MCO + Managed Long-Term Services and Supports (MLTSS)
- Range: 363 – 1,472,507 beneficiaries
- Mean: 367,665 beneficiaries

Prospective DUR Criteria

- Most common pharmacy POS vendors:
  - MedImpact Healthcare Services, Inc. (n = 9)
  - CVS/Caremark (n = 6)
- Most common ProDUR criteria sources:
  - First Data Bank (n = 17)
  - Medi-Span (n = 9)

3

Prospective DUR Criteria

- 17 plans receive periodic reports with pharmacy override activity (ranges from daily to every 6 months)
- 7 plans follow up with providers who routinely override alerts

4

Early Refill: Threshold for Edits

Non-controlled drugs

	Plans (n)
70%	2
75%	14
76%	1
80%	5
85%	2
90%	2

Mean: 78%

Schedule II drugs

	Plans (n)
75%	7
80%	4
85%	2
90%	13

Mean: 84%

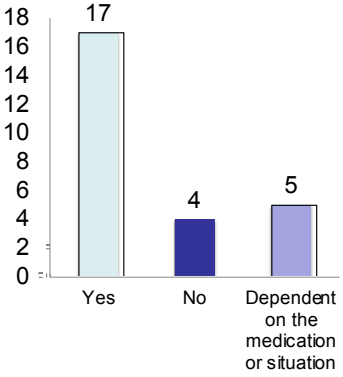
Schedule III-V drugs

	Plans (n)
75%	7
80%	4
85%	1
90%	14

Mean 84%

Early Refill: Non-Controlled Drugs

When an early refill message occurs, does your MCO require prior authorization?



IF YES: who obtains authorization?

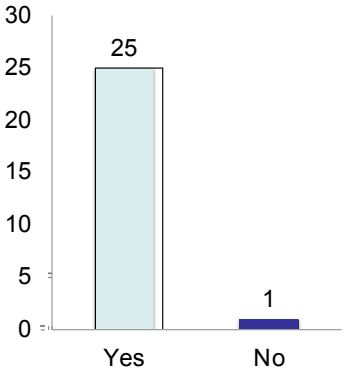
- Prescriber = 4
- Pharmacist or Prescriber = 18

IF NO: can the pharmacist override at the point of service?

- Yes = 3
- No = 1

Early Refill: Controlled Drugs

When an early refill message occurs, does your MCO require prior authorization?



IF YES: who obtains authorization?

- Prescriber = 9
- Pharmacist or Prescriber = 16

IF NO: can the pharmacist override at the point of service?

- Yes = 1

7

Early Refill

- Pharmacist override of ER alert without PA
  - 12 plans allow for lost/stolen Rx
  - 12 plans allow for vacation
- 6 plans have accumulation edit
- 10 plans have policy prohibiting auto-refill

8

Top 10 Prior Authorization Requests by Drug Name

- 94 drugs in the Top 10
- Most frequent drugs recorded:

- TRETINOIN (n = 13)
- OXYCODONE (n = 11)
- ADALIMUMAB (n = 11)
- HYDROCODONE/ ACETAMINOPHEN (n = 10)
- NUTRITIONAL SUPPLEMENTS (n = 10)
- INSULIN GLARGINE/INSULIN LISPRO (n = 9)
- SEMIGLUTIDE (n = 9)
- RIFAXIMIN (n = 8)
- DEXTROAMPHETAMINE/ AMPHETAMINE (n = 8)
- LIDOCAINE (n = 8)
- EMPAGLIFLOZIN (n = 8)
- TACROLIMUS (n = 7)
- DULAGLUTIDE (n = 7)

Highlighted = Not on the most frequent list in FFY2020

9

Top 10 Prior Authorization Requests by Drug Class

- 77 drug classes in the Top 10
- Most frequent drug classes recorded:

- ANALGESICS, NARCOTIC AGENTS (n = 25)
- ANTICONVULSANT AGENTS (n = 17)
- ONCOLOGY AGENTS (n =16)
- NUTRITIONAL SUPPLEMENTS (n = 11)
- ACNE AGENTS (n = 10)
- ANTIMIGRAINE AGENTS (n = 9)
- GLP-1 AGONISTS (n = 9)
- ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS (n = 8)
- SGLT-2 INHIBITORS (n = 8)
- IMMUNOMODULATORS (n = 8)

Highlighted = Not on the most frequent list in FFY2020

10

Top 5 Claim Reason Denials

- 21 denial reasons in the Top 5
- Most frequent reasons recorded:
  - REFILL TOO SOON (n = 25)
  - PLAN LIMITATIONS EXCEEDED (n = 23)
  - PRODUCT/SERVICE NOT COVERED – PLAN/BENEFIT EXCLUSION (n = 14)
  - PRIOR AUTHORIZATION REQUIRED (n = 13)
  - PRODUCT NOT ON FORMULARY (n = 13)
  - PATIENT IS NOT COVERED (n = 10)
  - SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYOR (n = 10)
  - DUR REJECT ERROR (n = 7)
  - NDC NOT COVERED (n = 6)

11

Top 10 Drug Names by Amount Paid

- 71 drugs in the Top 10
- Most frequent drugs recorded:
  - INSULIN GLARGINE (n = 22)
  - ADALIMUMAB (n = 21)
  - ETANERCEPT (n = 18)
  - DULAGLUTIDE (n = 15)
  - EMPAGLIFLOZIN (n = 13)
  - INSULIN LISPRO (n = 11)
  - FLUTICASONE (n = 10)
  - SITAGLIPTIN (n = 10)
  - SOFOSBUVIR/VELPATASVIR (n = 10)
  - APIXABAN (n = 10)
  - USTEKINUMAB (n =10)
  - ALBUTEROL SULFATE (n = 8)
  - SEMIGLUTIDE (n = 7)

Highlighted = Not on the most frequent list in FFY2020

12

Top 10 Drug Names by Claim Count

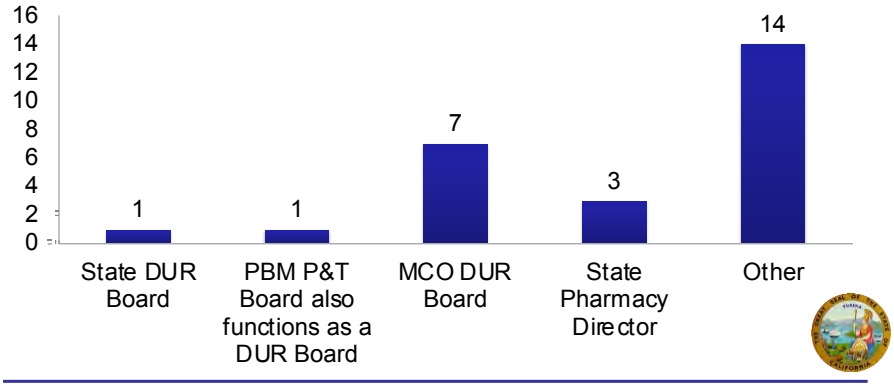
- 35 drugs in the Top 10
- Most frequent drugs recorded:

- ALBUTEROL (n = 25)
- IBUPROFEN (n = 25)
- ATORVASTATIN (n = 25)
- METFORMIN HCL (n = 23)
- GABAPENTIN (n = 21)
- CHOLECALCIFEROL (n = 18)
- OMEPRAZOLE (n = 17)
- LISINOPRIL (n = 15)
- ASPIRIN (n = 13)
- AMLODIPINE (n = 13)
- FLUTICASONE (n = 12)
- LORATADINE (n = 10)

13

Retrospective DUR Criteria

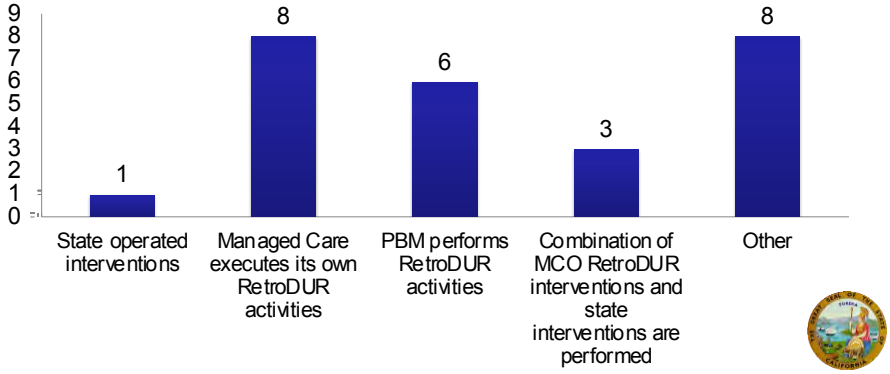
Who reviews and approves the RetroDUR criteria?



14

Retrospective DUR Operations

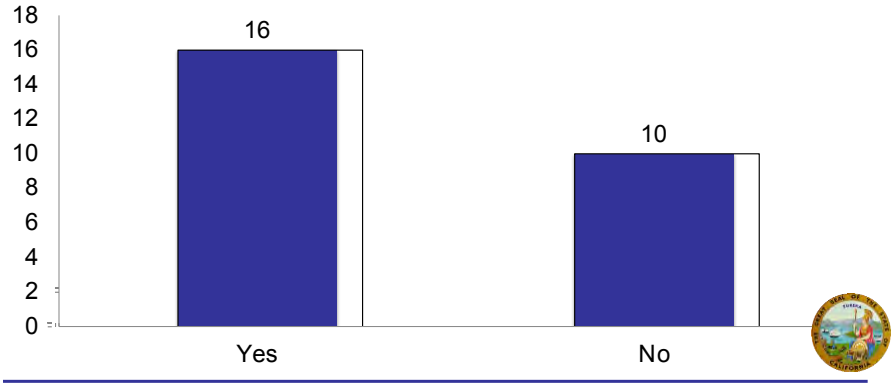
Please indicate how your program operates and oversees RetroDUR reviews.



15

Retrospective DUR Board

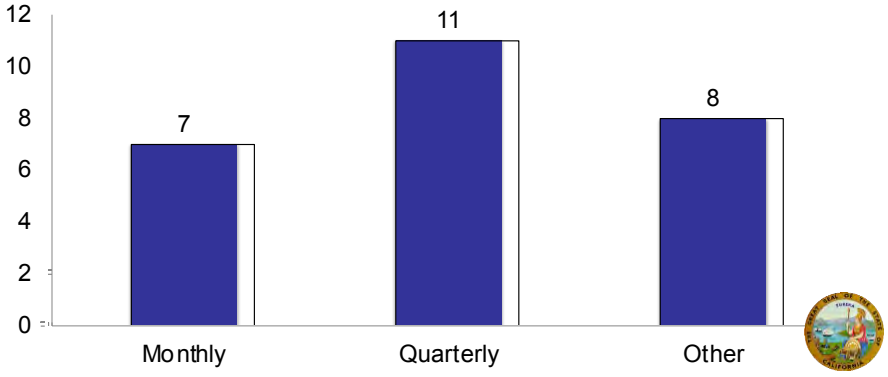
Is the RetroDUR vendor the developer/supplier of your retrospective DUR criteria?



16

Retrospective DUR Education

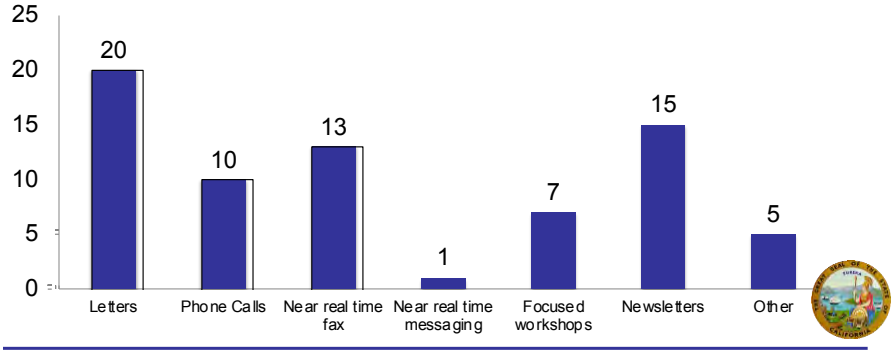
How often does your MCO perform retrospective practitioner-based education?



17

Retrospective DUR Education (cont.)

What is the preferred mode of communication when performing RetroDUR initiatives? Check all that apply:



18

DUR Board Activity

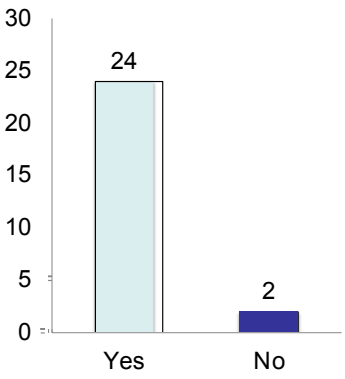
- 7 plans have a Medication Therapy Management Program

Physician Administered Drugs (PADs)

- 2 plans incorporate PADs into ProDUR
  - 2 planning to include in future
- 5 plans incorporate PADs into RetroDUR
  - 3 planning to include in future

Generic Policy

Does your MCO have a more restrictive brand drug policy?



- Prior authorization is required = 23
- Require that a MedWatch Form be submitted = 10
- Require the medical reason(s) for override accompany the prescription = 6
- Try and fail with at least 2 generics = 4
- Try and fail with or have documented allergies to at least 1 generic = 1

21

Generic Utilization Percentage

- Overall MCO generic utilization percentage (total generic claims/total claims): 89.5%
- Mean generic utilization percentage (across plans): 87.2%
  - Range: 53.5% - 94.5%
  - 5 plans were greater than or equal to 90%

22

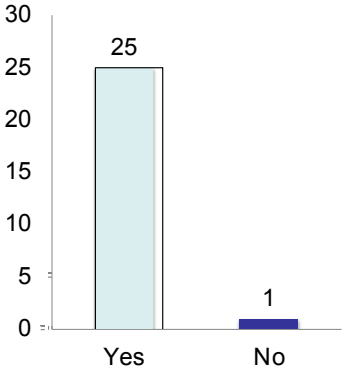
Generic Expenditure Percentage

- Overall MCO generic expenditure percentage (total generic dollars/total dollars): 22.0%
- Mean generic expenditure percentage (across plans): 20.9%
  - Range: 2.4% - 77.1%
  - Only 5 plans were greater than 22.0%

23

Lock-In or Patient Review and Restriction Programs

Does your MCO have a documented process in place that identifies potential fraud or abuse of controlled drugs by beneficiaries?

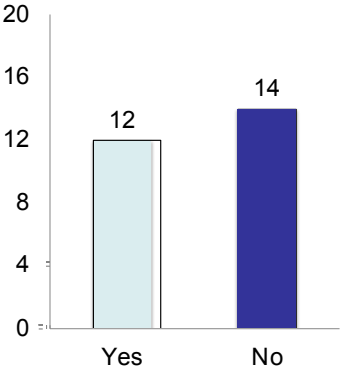


- Refer to Program Integrity Unit/ Surveillance Utilization Review = 15
- Refer to Lock-In Program = 13
- Deny claims = 12
- Require prior authorization = 12
- Refer to Office of Inspector General = 5
- Other = 10

24

Lock-In or Patient Review and Restriction Programs (cont.)

Does your MCO have a Lock-In program for beneficiaries with potential misuse or abuse of controlled substances (CS)?



Criteria used to identify candidates:

- Different prescribers of CS = 12
- Multiple pharmacies = 11
- Number of CS = 10
- Multiple ER visits = 4
- PDMP data = 4
- Days' supply of CS = 3
- Exclusivity of short-acting opioids =1
- Other = 4

25

Lock-In Program

Of the 12 plans with Lock-In Programs:

- 10 can restrict beneficiary to prescriber
- 11 can restrict beneficiary to pharmacy
- 11 can restrict to prescriber and pharmacy

26

Lock-In Program (cont.)

Of the 12 plans with Lock-In Programs:

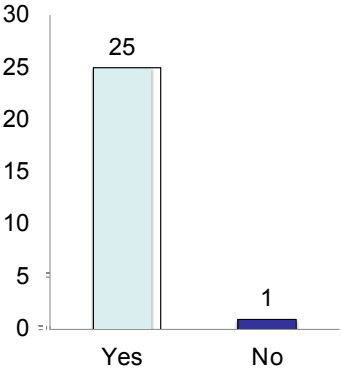
- 8 have a 12 month Lock-In period
- 1 has a 24 month Lock-In period
- 3 determine the time period on a case-by-case basis

Population in Lock-In ranged from 0 - 0.1%

27

Process to Identify Fraud or Abuse: Prescribers

Does your MCO have a documented process in place that identifies possible fraud or abuse of controlled drugs by prescribers?

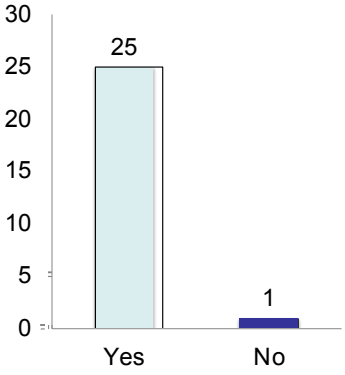


- Refer to Program Integrity Unit/ Surveillance Utilization Review = 20
- Refer to the appropriate Medical Board = 8
- Deny claims written by prescriber = 7
- Other = 15

28

Process to Identify Fraud or Abuse: Pharmacy Providers

Does your MCO have a documented process in place that identifies possible fraud or abuse of controlled drugs by pharmacy providers?

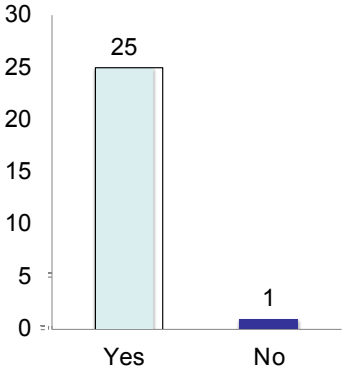


- Refer to Program Integrity Unit/ Surveillance Utilization Review = 22
- Deny claims = 12
- Refer to Board of Pharmacy = 11
- Other = 11

29

Process to Identify Fraud or Abuse: Beneficiaries

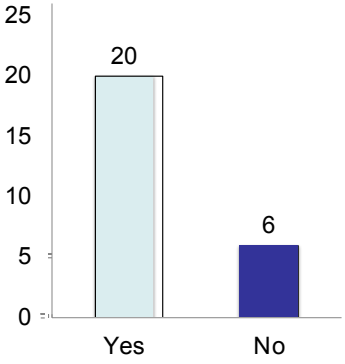
Does your MCO have a documented process in place that identifies and/or prevents potential fraud or abuse of non-controlled drugs by beneficiaries?



30

Prescription Drug Monitoring Program (PDMP)

Does your MCO require prescribers (in your provider agreement) to access the PDMP patient history before prescribing controlled substances?

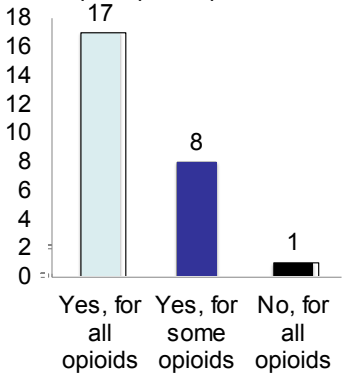


- 2 plans have access to Border States' PDMP data
- 6 plans require pharmacists to query the state's PDMP before dispensing
- 5 plans indicated there are protocols for pharmacists checking the PDMP
- 13 plans noted barriers that exist regarding the PDMP
- 7 plans completed the PDMP tables (optional for FFY2021)

31

Opioids: Initial Prescriptions

Do you currently have a POS edit in place to limit the quantity dispensed of an initial opioid prescription?



- Maximum days for initial opioid prescriptions:
  - 7 days (n = 18)
  - 14 days (n = 1)
  - 30 days (n = 6)

32

Opioids: Subsequent Prescriptions

- 26 plans have POS edits in place to limit the quantity dispensed of short-acting opioids
- 25 plans have POS edits in place to limit the quantity dispensed of long-acting opioids
  - 1 plan requires PA on all long-acting opioids

Opioids: Other Measures to Monitor/Manage Prescribing

- Deny claim and require PA (n = 23)
- Morphine Milligram Equivalent (MME) daily dose program (n = 26)
- Step therapy or clinical criteria (n = 23)
- Require diagnosis (n = 13)
- Intervention letters (n = 12)
- Requirement that prescriber has an opioid treatment plan for patients (n = 12)
- Workgroups to address opioids (n = 13)
- Requirement that patient has a pain management contract or Patient-Provider agreement (n = 12)
- Require PDMP checks (n = 11)
- Pharmacist override (n = 16)
- Require documentation of urine drug screening results (n = 5)

Opioids: Other Prescribing Controls Described by Plans

- Lock-in programs limit coverage of frequently abused medications
- Counseling requirements for females of reproductive age about opioid use during pregnancy and neonatal abstinence syndrome
- POS edits that identify high MME for both single claims and across claims, prevent duplicative long-acting opioid therapy, identify opioid-buprenorphine concurrent use, and a more restrictive refill too soon parameter for opioids
- Require medical records document clinical rationale for high dose of opioids and a titration of medication up to current dose
- Documentation of an oncologist, palliative care specialist, or pain specialist recommending the requested dose
- Conduct prescriber outreach based on a member's opioid utilization profile
- Review of the member's controlled-substance history prior to prescribing opioids for the first time and at least once every 4 months thereafter
- Case management for high-risk beneficiaries
- Concurrent prescribing of naloxone requirements
- Quarterly report cards for top opioid prescribers

35

Opioids: Other Interventions

- 21 plans have POS edits to monitor **duplicate therapy** of opioid prescriptions
- 25 plans have POS edits to monitor **early refills** of opioid prescriptions
- 17 plans have an automated retrospective claims review process to monitor opioid prescriptions **exceeding limitations**
- 20 plans have POS edits to monitor **opioids and benzodiazepines** used concurrently
- 17 plans have automated retrospective claims review processes to monitor **opioids and benzodiazepines** used concurrently
- 12 plans have POS edits to monitor **opioids and sedatives** used concurrently
- 16 plans have automated retrospective claims review processes to monitor **opioids and sedatives** used concurrently

36

Opioids: Other Interventions (cont.)

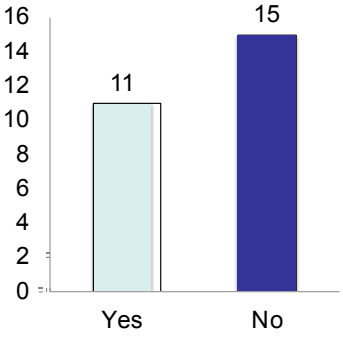
- 6 plans have POS edits to monitor **opioids and antipsychotics** used concurrently
- 13 plans have automated retrospective claims review processes to monitor **opioids and antipsychotics** used concurrently
- For beneficiaries with a diagnosis or history of opioid use disorder (OUD) or opioid poisoning diagnosis:
  - 2 plans have POS safety edits
  - 11 plans perform automated retrospective claims review
  - 11 plans initiate provider education

Opioids: Prescribing Guidelines

- 25 plans refer prescribers to CDC's Guideline for Prescribing Opioids for Chronic Pain
- 6 plans refer to other guidelines, including:
  - MCO-developed prescribing guidelines
  - Practice/Specialty/Society developed guidelines

Opioids: Abuse Deterrent Opioid Policy

Does your MCO 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)?



39

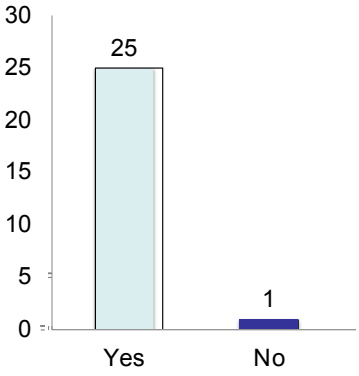
Morphine Milligram Equivalent (MME) Daily Dose

- All 26 plans have set recommended maximum MME daily dose measures
- Maximum MME limit:
  - 50 (n = 1)
  - 90 (n = 11)
  - 120 (n = 3)
  - 200 (n = 8)
  - 300 (n = 1)
  - 500 (n = 2)

40

Morphine Milligram Equivalent (MME) Daily Dose (cont.)

Does your MCO have an edit in your POS system that alerts the pharmacy provider that the MME daily dose prescribed has been exceeded?

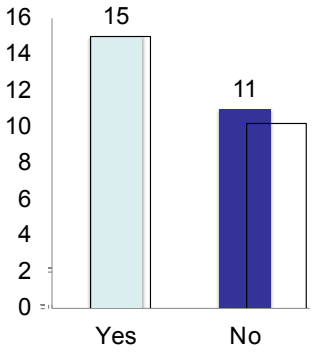


- 22 plans require PA if MME limit is exceeded
- 22 plans have automated retrospective claim reviews to monitor the MME total daily dose of opioid prescriptions dispensed

41

MME Daily Dose: Calculation

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



Calculator developers:

- CDC (n = 11)
- Other (n = 4)

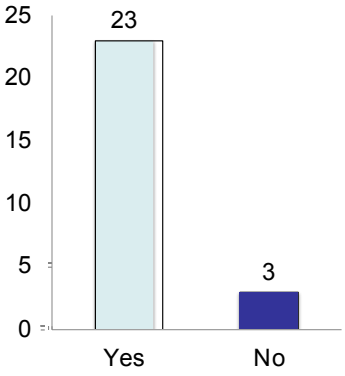
Disseminate by:

- Provider notice (n = 10)
- Website (n = 9)
- Educational seminar (n = 3)
- Integrated into EMR (n = 2)

42

Stimulants

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

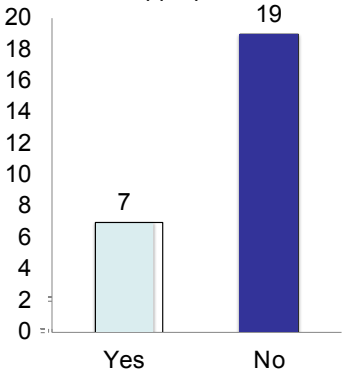


- 18 plans have documented programs to manage/monitor use of stimulants in children
  - Plans have edits in place to monitor:
    - Child's age (n = 11)
    - Dosage (n = 175
    - Indication (n = 5)
    - Polypharmacy (n = 7)

43

Antidepressants

Does your MCO have a documented program in place to either manage or monitor the appropriate use of antidepressant drugs in children?

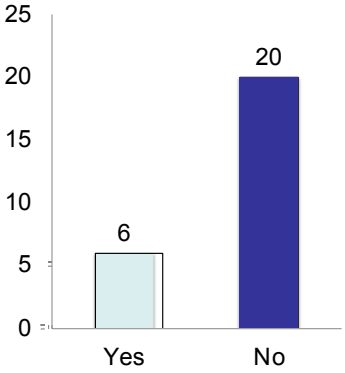


- Plans have edits in place to monitor:
  - Child's age (n = 4)
  - Dosage (n = 7)
  - Indication (n = 2)
  - Polypharmacy (n = 4)

44

Mood Stabilizing Drugs

Does your MCO have a documented program in place to either manage or monitor the appropriate use of mood stabilizing drugs in children?

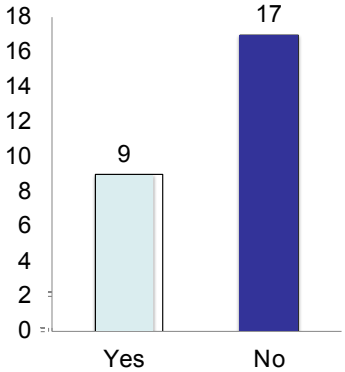


- Plans have edits in place to monitor:
  - Child's age (n = 3)
  - Dosage (n = 6)
  - Indication (n = 2)
  - Polypharmacy (n = 2)

45

Anxiety/Sedative Drugs

Does your MCO have a documented program in place to either manage or monitor the appropriate use of anxiety/sedative drugs in children?



- Plans have edits in place to monitor:
  - Child's age (n = 4)
  - Dosage (n = 9)
  - Indication (n = 2)
  - Polypharmacy (n = 5)

46

COVID-19

- 12 plans noted COVID-19 ramifications on edits and reviews on controlled substances during the public health emergency, including:
  - Temporary modifications that allowed for 90-day supplies and early refills on all medications, including controlled substances
  - Early refill thresholds were changed from 80% to 75%
  - Pharmacies were allowed to use their discretion to override for refill-too-soon or utilization management restrictions
  - Dispensing pharmacists could provide emergency refills
  - Converted MME hard edit to a soft DUR edit

47

Innovative Practices

- All 26 health plans submitted at least one innovative practice to improve quality of care; many submitted more than one practice
- Total number of practices submitted: 83
- All plans have programs to monitor and improve medication adherence
  - Use of Medication Possession Ratio (MPR)
- Increased direct involvement of pharmacy services in care coordination and transition of care
  - Post discharge medication consultation/management
  - Medication review and consultation at change of therapy
- More plans are deploying pharmacists to participate in Interdisciplinary Care Team (ICT), and case management
- High degree of collaboration, forming coalitions with other local health agencies and organizations, including FQHCs

48

Innovative Practices (cont.)

- Population health data to identify high risk beneficiaries for more targeted interventions
- Practice models:
  - Medication Therapy Management (MTM)
  - Comprehensive Medication Management (CMM)
  - Medication Reconciliation (Med Rec)
  - Targeted Medication Reviews (TMRs)
- Academic detailing for education outreach
- Process improvements, including automation of prior authorization and audits of high-volume providers
- Improve program integrity, reduce fraud, waste and abuse
- New drugs pipeline monitoring

49

Innovative Practice Focus Areas

- Opioids (use of dashboards, focus on high risk, concurrent therapy with benzodiazepines, psychotropic medications)
- Treatment of chronic conditions (diabetes, hypertension, asthma, COPD)
- Treatment of hepatitis C virus infection (pharmacist co-manage with ID and GI specialists)
- Antibiotics stewardship (Latent Tuberculosis Infection)
- ADHD medications for children
- Psychotropic drugs (antipsychotics, antidepressants)
- Physician administered drugs (PADs)
- Biosimilars (in combination with PAD reviews for optimal care)

50

Major Initiatives of FFY2021

- Responding to COVID-19:
  - Work swiftly in response to beneficiaries needs, focusing on access of care and continuation of services
  - Increase number of network pharmacies
  - Promote mail order prescription services
  - Initiate telepharmacy service to provide clinical services and other care needs when face to face consultation is not feasible
  - Remove barriers to care
- Medi-Cal Rx Transition:
  - Collaborate and work closely with DHCS on Medi-Cal Rx Transitions
  - Participate in workgroups and meetings
  - Share information and expertise

Questions?

Conflict of Interest

Conflicts of Interest are those circumstances in which the personal interests of a person may potentially or actually conflict with the interests of or may be perceived as potentially conflicting with the interests of an organization; personal interests include not only the person's own interest but also include those of the individual's household members.

No DUR Board Member shall make, participate in making or in any way attempt to use their official position to influence a decision in which the Board Member knows or has reason to know they have financial interest or that would enhance the Board Member's status or professional standing or benefit their current or previous employer. Financial interest has the same meaning as that term is defined in Government Code sections 87102.5 and 87103.

To ensure that a conflict of interest does not exist, DUR Board Members shall execute an annual Conflict of Interest (COI) statement. Board Members shall disclose in the COI any financial interest, including current employer or any previous employer in which they have a continued financial interest.

DUR Board Members shall disclose all interactions with pharmaceutical manufacturers within the previous 12 months, for which the Board Member has a contractual arrangement, has received a grant, is seeking a grant or has received other remuneration. Other remuneration includes but is not limited to honoraria, stipends and travel expenses.

DUR Board Members shall also disclose any financial interests or interactions with pharmaceutical manufacturers that occur after the annual COI filing. This disclosure may be in the form of a letter or electronic note to the Department and must occur prior to the next scheduled DUR Board Meeting.

NOTE: DUR BOARD MAY WANT TO ADOPT A SECTION THAT ALSO REQUIRES MEMBERS OR POTENTIAL MEMBERS TO DISCLOSE IF THEY ARE CURRENTLY UNDER A SANCTION (I.E. CANNOT PARTICIPATE IN A FEDERALLY FUNDED PROGRAM)

MEDI-CAL DRUG UTILIZATION REVIEW BOARD

CONFLICT OF INTEREST ATTESTATION

Please check all statements that apply in either section I or II and then sign below.

I. Applies if You Are Free of Any Conflict of Interest

____I, hereby, certify that I have reviewed the Medi-Cal DUR Board Conflict of Interest Policy.

____I, hereby, certify that I am free of any conflict of interest in participating in the Medi-Cal DUR Board.

OR

II. Applies if Your May have a Conflict of Interest

____I, hereby, certify that I have reviewed the Medi-Cal DUR Board Conflict of Interest Policy.

____I, hereby, certify that I have disclosed any potential conflicts of interest that I may have in participating in the Medi-Cal DUR Board (Attachment).

To the best of my knowledge and belief, the information contained in this response is true and accurate.

_____/_____

Signature/Date

_____

Print Name

Attachment to Conflict of Interest Form

Name: _____
Date: _____

1. Please list the names of all companies that are sponsoring research you are currently involved in or were involved in during the past 12 months.

PHARMACEUTICAL COMPANY	NAME OF PROJECT	AMOUNT OF GRANT (Direct Cost $)
a.		
b.		
c.		
d.		

2. Please list the names of all companies you are currently pursuing or you anticipate will sponsor research you will be involved in during the next 12 months.

PHARMACEUTICAL COMPANY	NAME OF PROJECT	ANTICIPATED AMOUNT (Direct Cost $)
a.		
b.		
c.		
d.		

3. Please list the names of all companies from whom you received honoraria over $250 during the past 12 months.

PHARMACEUTICAL COMPANY	TITLE OF SUBJECT	TOTAL AMOUNT $
a.		
b.		
c.		
d.		

4. Please list other income or gifts received from companies during the past 12 months (over $250 only).

PHARMACEUTICAL COMPANY	NATURE OF INCOME/GIFT	TOTAL AMOUNT $
a.		
b.		
c.		
d.		

5. Please list any financial interest you may have in pharmaceutical companies (stocks, shares, investments, etc)

PHARMACEUTICAL COMPANY	NATURE OF FINANCIAL INTEREST	TOTAL AMOUNT $
a.		
b.		
c.		
d.		

6. Please provide any additional information you feel should be disclosed at this time. Use additional sheets if needed.

2023 Vice Chair Election Eligible Board Members

- Timothy E. Albertson, MD, MPH, PhD
- Michael Blatt, PharmD
- Lakshmi Dhanvanthari, MD
- José Dryjanski, MD
- Johanna Liu, PharmD, MBA, FCPhA
- Janeen McBride, PharmD
- Robert Mowers, PharmD
- Yana Paulson, PharmD
- Randall Stafford, MD, PhD
- Vic Walker, RPh
- Andrew L. Wong, MD

Medi-Cal DUR

Dear MediCal DUR Board,

I am submitting the candidate statement for the election for the position of Vice Chair of California DHCS's Global DUR Board. I am excited about the possibility to serve as Vice Chair of the DUR Board because we are at such a critical juncture when it comes to pharmaceutical care for Medi-Cal beneficiaries. As of July 2022, we have been half a year into Medi-Cal Rx on the heels of DUR edits and prior being phased back in, we are half a year into CalAim, and the new Population Health Management programs will launch in the coming months. Additionally, it is looking like a recession is inevitable which would cause unemployment which would call on Medi-Cal to take care of more Californians in need. All of these changes around us pose significant challenges and opportunities for the DUR Board to advise DHCS on.

If elected as Vice Chair of the DUR Board, my goal is to facilitate our discussions regarding major regulatory changes in Medi-Cal that lead to reasonable and actionable recommendations for DHCS. To summarize my vision:

1. **Support Medi-Cal Rx success:** Continue to advise DHCS on real-world impact of Medi-Cal Rx
2. **Advise DHCS Managed Care Pharmacists' role in Medi-Cal Rx:** Work with the board to develop more clear definitions of "medication adherence" and "medication management" so that all Californians receive high quality medication management care regardless of which geography they live in.
3. **Promote Managed Care Pharmacists' role in Population Health Management:** make recommendations to DHCS on how MCP pharmacists and pharmacy technicians will be involved in helping PHM successful, specifically in areas of medication reconciliation and disease management.

Being elected as Vice Chair of the DUR Board would be an amazing honor. I would work with each member of the Board as well as intake thoughts and concerns from the public, in ensuring the most impactful topics of interest are discussed. We will work together to improve pharmaceutical care for all Medi-Cal beneficiaries.

Sincerely,

Dr. Michael Blatt

Digitally signed by Dr. Michael Blatt
DN: cn=Dr. Michael Blatt, o=IEHP, ou=Pharmaceutical Services, email=blatt-m@iehp.org, c=US
Date: 2022.08.11 14:16:27 -07'00'

Michael Blatt

Topics for Discussion

- Publications
  - May 2022: California Immunization Registry (CAIR 2)
- Educational Outreach
  - Update: Naloxone Prospective Study
  - Mailing Update: Bosentan Letter
  - Mailing Update: Buprenorphine Letter
  - Mailing Update: Naloxone Provider Letter
  - Mailing Update: Naloxone Pharmacy Letter

Topics for Discussion (cont.)

- Retrospective DUR
  - Quarterly DUR Report: 2Q2022 (April – June 2022)
  - FFS PAD Annual Report: 2021 (January – December 2021)
  - Evaluation Report: 2Q2022 (April – June 2022)
  - Opioid Dashboard: 2Q2022 (April – June 2022)
  - Hepatitis C Virus (HCV) Drugs: Calendar Year 2021
  - Core Set Measures: Behavioral Health
- Prospective DUR
  - New GCNs Q2 2022
  - Alert Review/Next Steps

DUR Publications

- May 2022: Alert
  - Submitting Quality Data to the California Immunization Registry (CAIR2)

Future Topics

Bulletins:

- Latent tuberculosis infection (submitted for September publication)
- Annual immunization update (submitted for September publication)
- Management of acute postpartum pain (submitted for September publication)
- Updated Pharmacist furnishing of hormonal contraception
- Managing pain in population with comorbid mental health conditions
- Hypertension medication adherence

Alerts:

- Updated NAMS guidelines for hormone replacement therapy
- Updated USPTF aspirin guidelines

Board questions/recommendations?

Update: Prospective Naloxone Study

- Study Objectives include:
  - Identify unique barriers and facilitators to furnish naloxone from community pharmacies in Lake County and Nevada County
  - Assess attitudes and beliefs held by pharmacy staff regarding naloxone use
- Survey questions assess 1) attitudes held by pharmacy staff towards naloxone use, 2) perceived barriers to furnishing naloxone at the pharmacy, and 3) need for additional naloxone training

Timeline: Prospective Naloxone Study

- Completed interviews with key stakeholders to identify barriers and understand past initiatives
- On-site visits to community pharmacies in Lake and Nevada County began August 26th
- August 27th attended the 2nd Annual International Overdose Awareness Day event in Lake County
- Fall/Winter 2022 – Data analysis/preparation of final report
- Will provide updates to the Board at future meetings

Board questions/recommendations?

Mailing Update: Bosentan Letter

- The REMS database is monitored weekly for critical updates
- On April 29, 2022, the FDA approved a modification to the Bosentan REMS Program that changed the pre-dispense authorization process for pharmacies
- Letters were mailed on June 13, 2022, to all 11 pharmacies who had dispensed bosentan to at least one Medi-Cal patient during the previous 180 days
- Letters included a fact sheet, patient list, and a pharmacy survey

Board questions/recommendations?

Mailing Update: Buprenorphine Letter

- Letters were mailed on August 10, 2022, to 1,116 prescribers of transmucosal buprenorphine to Medi-Cal FFS beneficiaries during 2022
- Letters included the Medi-Cal DUR alert on buprenorphine and a provider survey

Outcomes: Buprenorphine Letter

- Primary Outcome (to be presented at the January 2023 meeting):
  - Total paid claims for transmucosal buprenorphine prescribed within 6 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: Naloxone Provider Letter

- Letters were mailed in September to 1,021 prescribers of opioids to at least four FFS beneficiaries with:
  - > 90 days' supply of opioids in the last year (excluding buprenorphine)
  - No paid claims for naloxone in the last year
  - History of substance abuse disorder excluding nicotine OR opioid overdose OR at ≥ 1 paid claim for a benzodiazepine in last year
- Letters included the updated Medi-Cal DUR bulletin on naloxone and a provider survey

Outcomes: Naloxone Provider Letter

- Primary Outcome (to be presented at the May 2023 meeting):
  - Total paid claims for naloxone prescribed within 6 months following the mailing
- Provider response rate and returned mail rate (within 90 days of the mailing) will also be reported

Mailing Update: Naloxone Pharmacy Letter

- Letters were mailed in September to the top pharmacies that dispensed opioids to at FFS beneficiaries who had:
  - > 90 days' supply of opioids in the last year (excluding buprenorphine)
  - No paid claims for naloxone in the last year
  - History of substance abuse disorder excluding nicotine OR opioid overdose OR at ≥ 1 paid claim for a benzodiazepine in last year
- Letters included the Medi-Cal DUR bulletin on naloxone, the CDPH naloxone handout, and a pharmacy survey

Outcomes: Naloxone Pharmacy Letter

- Primary Outcome (to be presented at the May 2023 meeting):
  - Total paid claims for naloxone dispensed and/or furnished within 6 months following the mailing
- Provider response rate and returned mail rate (within 90 days of the mailing) will also be reported

Board questions/recommendations?

UCSF

Quarterly Report: 2Q2022

- Total of 46,002,851 Medi-Cal Rx claims were submitted for processing during Q2
  - 61% Paid (vs. 53% in Q1)
  - 9% Denied (vs.16% in Q1)
  - 23% of submitted claims had DUR messages or alerts (vs. 28% in Q1)
- 31% of eligible beneficiaries had a paid claim in Q2 (same as Q1)
- COVID-19 ANTIGEN TEST had 49% ↑ in total paid claims vs. Q1
- Significant increases noted in cold/flu medications from prior year

UCSF

High Cumulative Dose (HC) Alert: 2Q2022

- Quarterly DUR Reports now contain three new tables (Tables 3.1 – 3.3) summarizing the HC alert, which was activated on January 1, 2022
- The HC alert is generated when there is > 90 MME per day on a single claim or across multiple claims
- In 2022 Q2:
  - 90.3% of submitted opioid claims had no HC alert (↑ from 87.7% in Q1)
  - 97.4% of paid claims for opioids had no HC alert (was 97.5% in Q1)
  - 95.0% of submitted opioid claims were for ≤ 90 MME/day (↑ from 93.5%)
  - 98.5% of paid claims for opioids were for ≤ 90 MME/day (same as Q1)

HC Alert: 2Q2022 (cont.)

- 47.3% of claims with HC alert were for ≤ 90 MME/day
- 81.7% of submitted opioid claims with an HC alert had outcome denied
- 13.9% of submitted opioid claims with an HC alert had outcome paid
- Drugs with the highest % of submitted claims with an HC alert were FENTANYL CITRATE (100%), OXYMORPHONE HCL (85.8%), and FENTANYL (80.8%)
- Drugs with the highest % of outcome as paid with an HC alert were PENTAZOCINE HCL/NALOXONE HCL (30% paid) and FENTANYL CITRATE (23.3%)

Board questions/recommendations?

FFS PAD Annual Report: 2021

- 4th annual review of PADs in the Medi-Cal FFS Program
- Data includes claims during calendar year 2021
- Top 20 physician-administered drugs are presented by total utilizing beneficiaries, total reimbursement dollars paid, and reimbursement paid per utilizing beneficiary
- 8% increase in total utilizing beneficiaries and 12% increase in total paid claims from 2020
  - Most likely due to COVID-19 related physician office closures during 2020 (2021 numbers rebounded close to 2019 levels)

Board questions/recommendations?

Quarterly Evaluation Report: 2Q2022

- Three articles to evaluate from 2Q2020:
  - Drug Safety Communication: Withdrawal of All Ranitidine Products – April 2020
  - Improving Quality of Care: Update of Risks Associated with Use of Fluoroquinolones – April 2020
  - Clinical Guideline: Reproductive Health in Rheumatic and Musculoskeletal Diseases – May 2020

Ranitidine Evaluation: Purpose

- Review the FDA safety communications on ranitidine since the publication of the original article and describe any relevant updates

Ranitidine Evaluation: Updates

- After the withdrawal of ranitidine, a randomized, placebo-controlled clinical trial and an in-vitro study found ranitidine did not convert to NDMA in humans.
- Shortly thereafter, the prior clinical study that had reported a 400-fold increase in NDMA urinary excretion after ingestion of ranitidine was retracted by the authors.
- Ranitidine products are still unavailable at this time in the U.S., although a new OTC product was approved in 2021 with famotidine as the active ingredient.

Ranitidine: Select Recommendations

- Research/Policy Recommendations:
  - Continue to monitor research and FDA communications regarding ranitidine and other H2RAs.
  - Continue to periodically evaluate use of H2RAs within the Medi-Cal population.
- Board Recommendations:
  - None at this time

Board questions/recommendations?

Fluoroquinolones Evaluation: Purpose

- Review use of fluoroquinolones in the Medi-Cal population since the publication of the original article and describe any relevant updates.

Fluoroquinolones Evaluation: Results

Medi-Cal population	Article data: 11/1/18 – 10/31/19	Evaluation data: 11/1/20 – 10/31/21	Percent change
Community-dwelling Medi-Cal fee-for-service beneficiaries with at least one paid claim for a fluoroquinolone during the measurement year (excluding those with a history of penicillin or other drug allergy that would impact the use of fluoroquinolones as a first-line therapy)	**29,876**	**20,886**	***-30.1%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate based on FDA recommendations	57.0%	8.4%	***-48.6%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate for uncomplicated UTI	34.3%	6.8%	***-27.5%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate for acute sinusitis	15.7%	0.9%	***-14.8%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate for acute bacterial exacerbation of chronic bronchitis	7.0%	0.6%	***-6.4%***

Fluoroquinolones Evaluation: Updates

- No additional alerts related to FDA safety concerns
- Outreach letter to providers regarding fluoroquinolones were sent by the DUR program on July 10, 2020
- Evaluation showed a 30% decrease in community-dwelling FFS beneficiaries being prescribed a fluoroquinolone
- Potentially inappropriate use of fluoroquinolones decreased from 57% to 8%
  - Medi-Cal Rx data consistent with 8% for 2022 as well (FFS) but MCO data shows 13% for 2022

Fluoroquinolones: Select Recommendations

- Research/Policy Recommendations:
  - Continue to monitor research and FDA communications regarding antibiotic stewardship and safety of fluoroquinolones
  - Suggest MCOs review prescribing data and provide educational interventions, if indicated
- Board Recommendations:
  - Continue to monitor antibiotic use in the Medi-Cal population (both FFS and MCO populations) and provide updates to the Board

Board questions/recommendations?

Rheumatology Evaluation: Purpose

- Review the literature and the American College of Rheumatology (ACR) guidelines since the publication of the original article and to describe any relevant updates

Rheumatology Evaluation: Updates

- Patients with RMDs face unique challenges as pregnancy may be associated with serious maternal or adverse fetal outcomes
- Since the *Dobbs v. Jackson Women's Health Organization* decision, there have been reports of patients with RMDs having disrupted access to methotrexate
  - Rheumatologists have stopped renewing methotrexate prescriptions
  - Pharmacists have refused to fill methotrexate prescriptions
  - Unique to women (no reported cases of men being denied access)

Rheumatology Evaluation: Updates (cont.)

- On July 28, 2022, the ACR Statement on Access to Reproductive Healthcare was published, which asserts that:
  - Rheumatology health professionals and patients should not face legal consequences for utilizing medically necessary care
  - Patients with RMDs must be able to access reproductive healthcare that is appropriate
  - Healthcare professionals must be allowed to provide evidence-based care that is in the best interest of their patients

Rheumatology : Select Recommendations

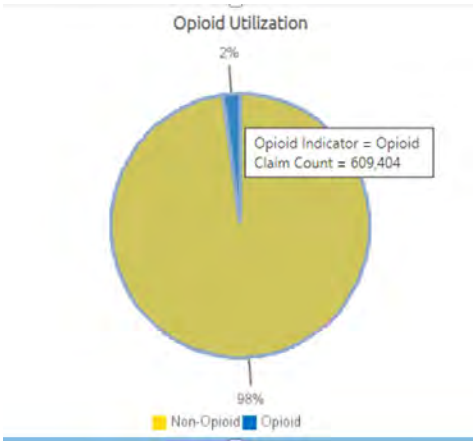
- Research/Policy Recommendations:
  - Continue to monitor clinical practice guidelines related to appropriate use of medications.
  - Research access to appropriate use of medications for treatment of RMDs among women of reproductive age in California
- Board Recommendations:
  - Evaluate the use of methotrexate in the Medi-Cal population with RMDs before and after *Dobbs vs. Jackson* and provide updates to DHCS and the Board

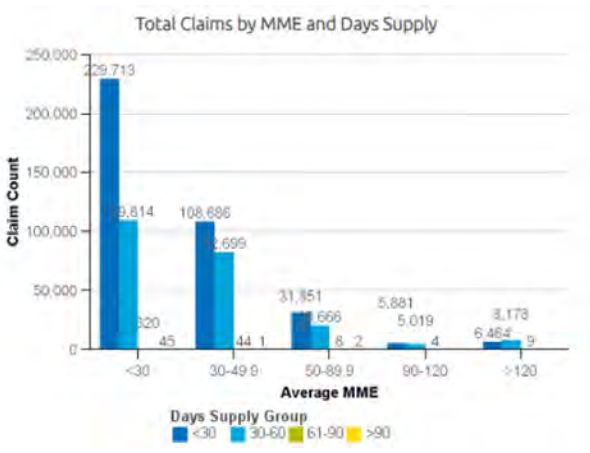
Board questions/recommendations?

Opioid Dashboard

- New resource available to DUR Program (DHCS has access now; UCSF and MCPs will have access by end of September)
- Report options include the following:
  - Overview
  - Patients
  - Concomitant Therapies
  - Opioid Titration
  - Prescriber & Pharmacy

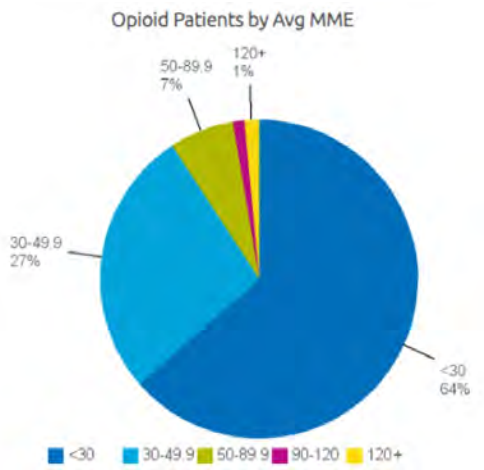
Overview: 2Q2022

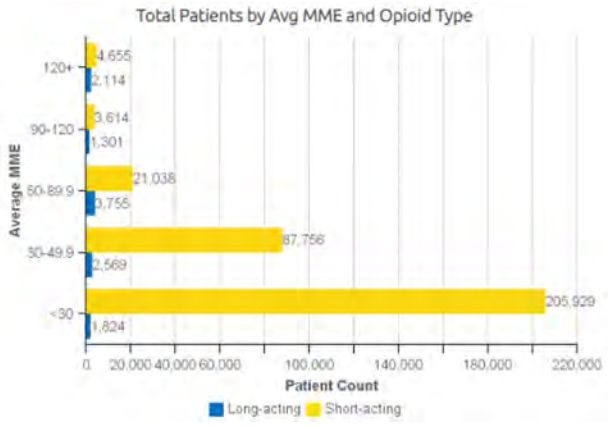




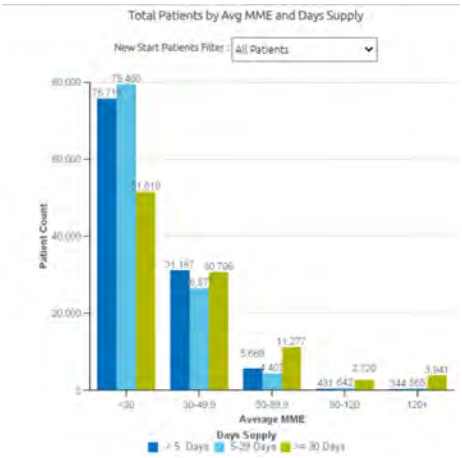
Overview: 2Q2022 (cont.)

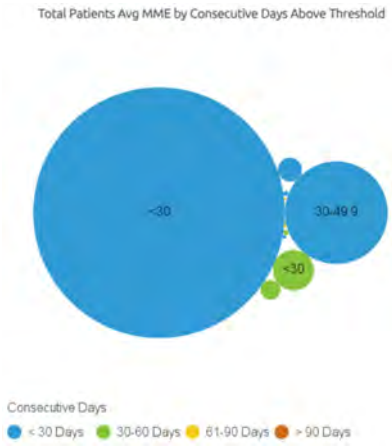
Patients: 2Q2022





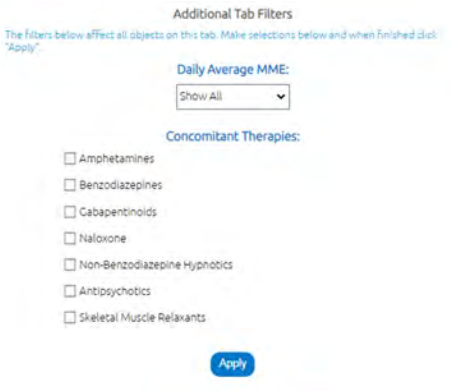
Patients: 2Q2022 (cont.)



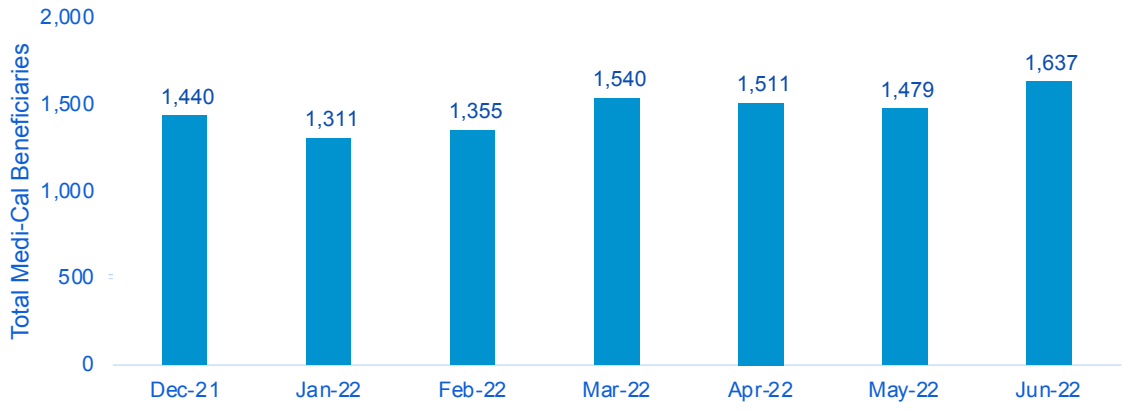


Concomitant Therapies: 12/2021 – 6/2022

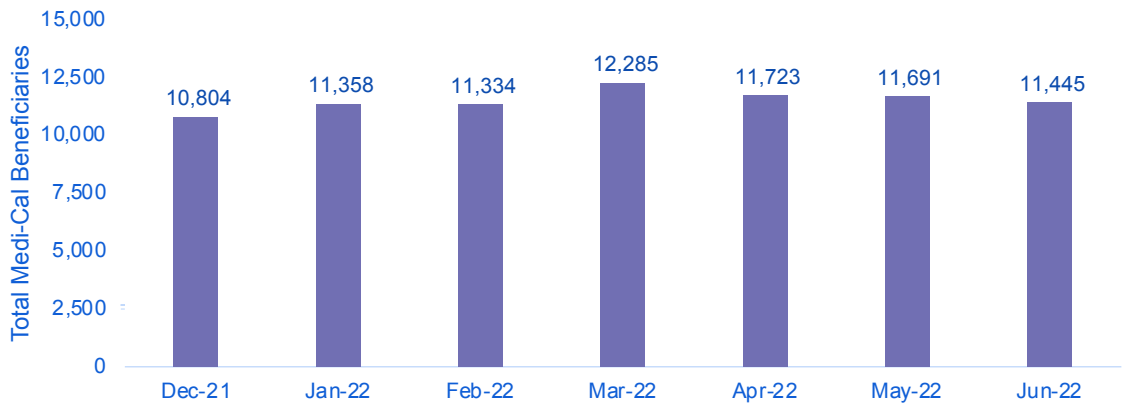
- Opioids and Amphetamines
- Opioids and Antipsychotic Medications
- Opioids and Benzodiazepines
- Opioids and Gabapentinoids
- Opioids and Naloxone
- Opioids and Skeletal Muscle Relaxants
- Opioids and Non-Benzodiazepine Hypnotics
- Opioids and Buprenorphine/Naloxone



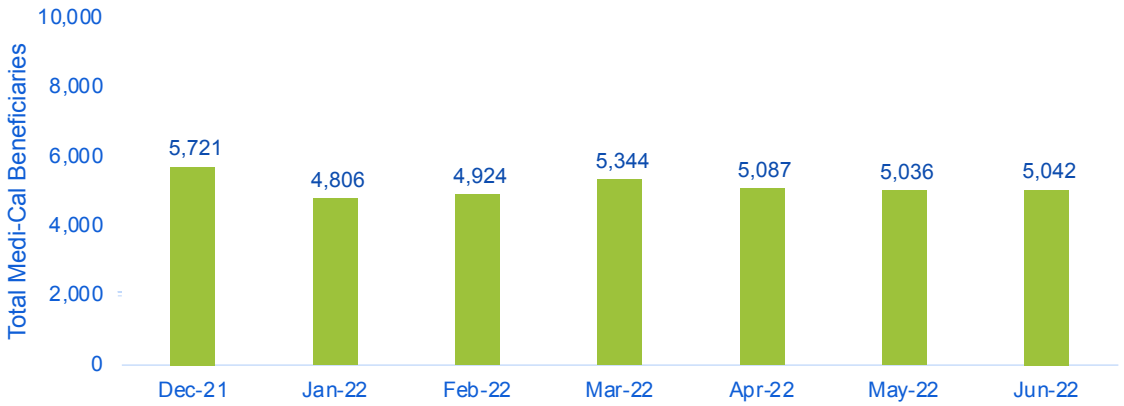
Opioids and Amphetamines



Opioids and Antipsychotic Medications

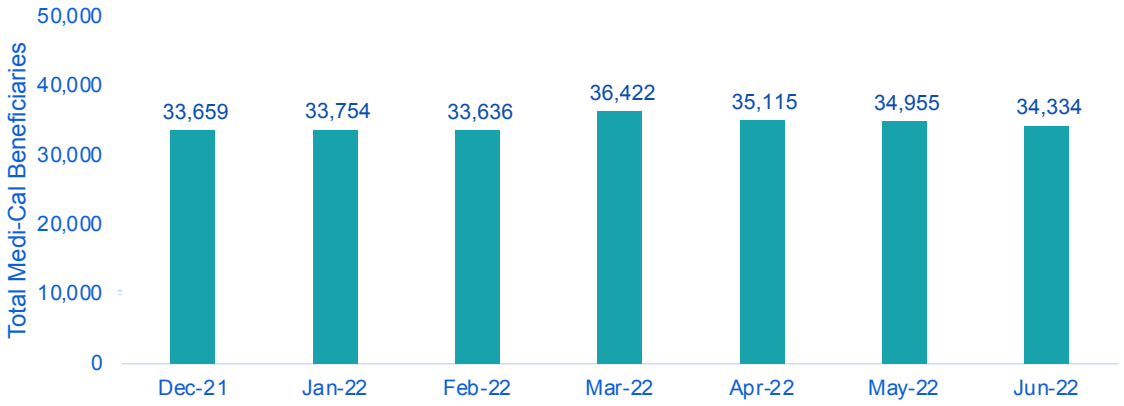


Opioids and Benzodiazepines



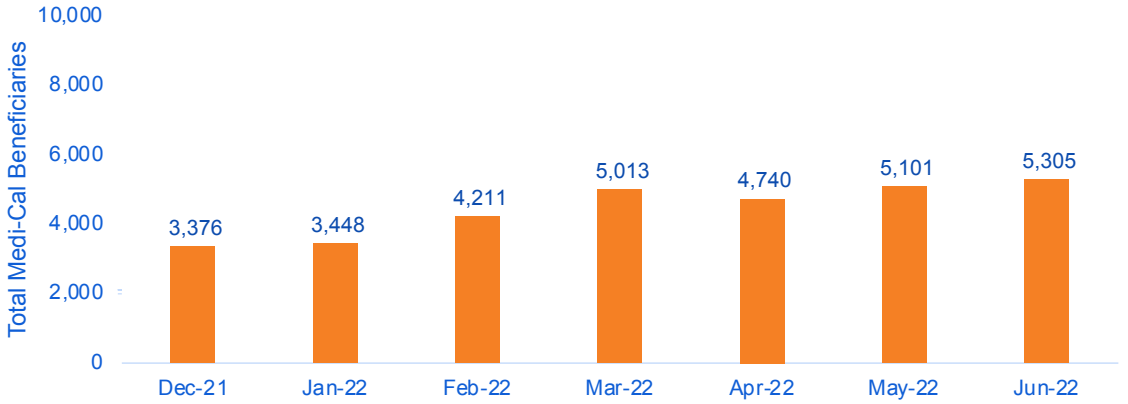
49 Prospective DUR Update – 2018Q2 (4/1/18 – 6/30/18)

Opioids and Gabapentinoids

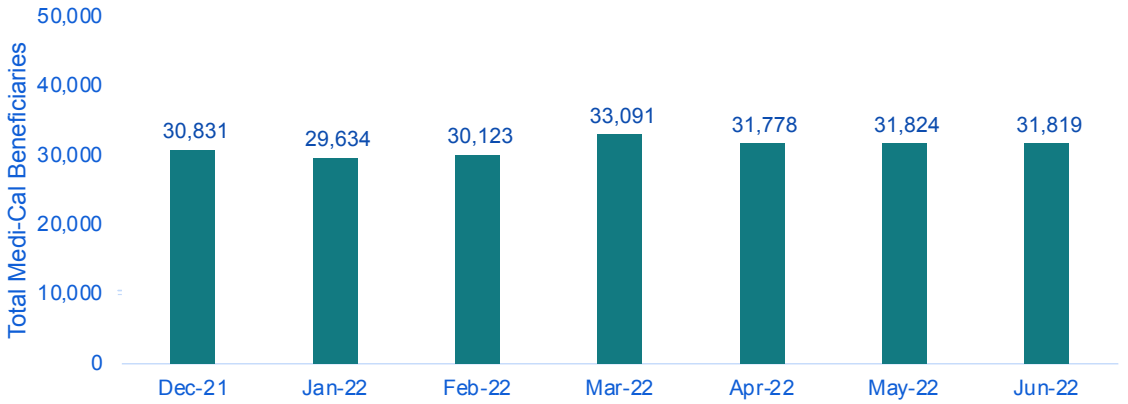


50 Prospective DUR Update – 2018Q2 (4/1/18 – 6/30/18)

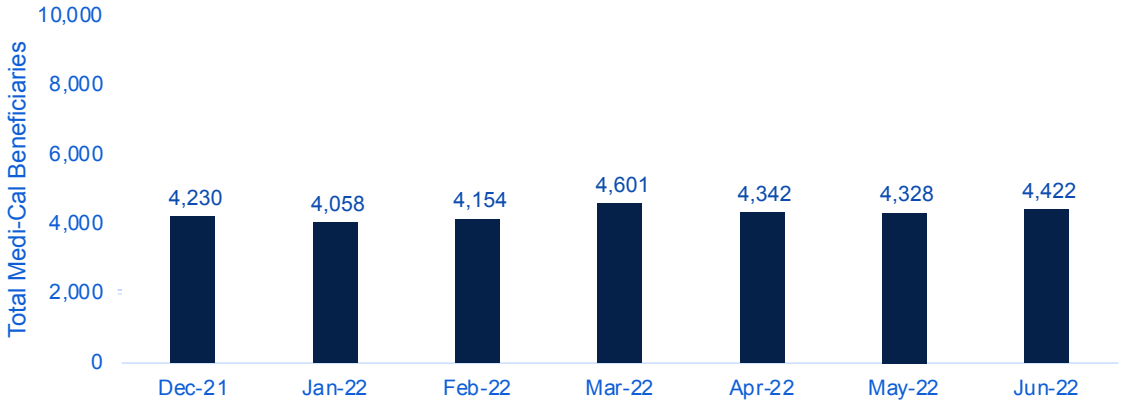
Opioids and Naloxone



Opioids and Skeletal Muscle Relaxants

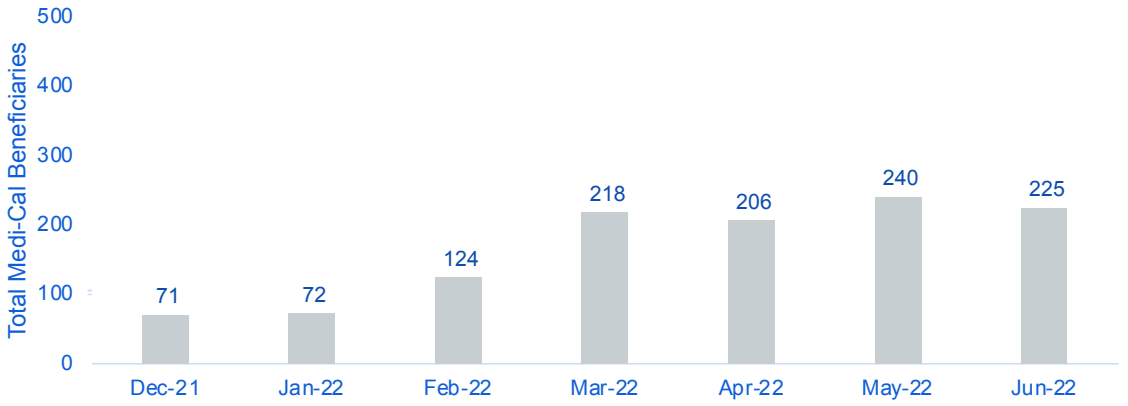


Opioids and Non-Benzodiazepine Hypnotic



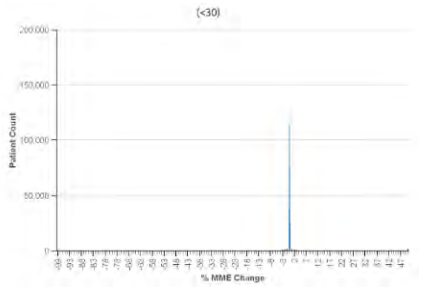
53 Prospective DUR Update – 2018Q2 (4/1/18 – 6/30/18)

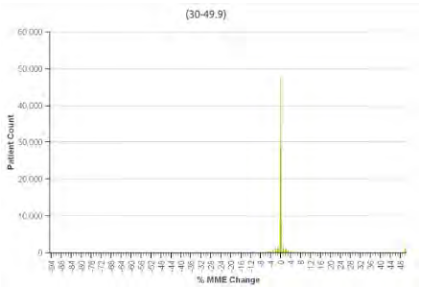
Opioids and Buprenorphine/Naloxone



54 Prospective DUR Update – 2018Q2 (4/1/18 – 6/30/18)

Opioid Titration: 2Q2022

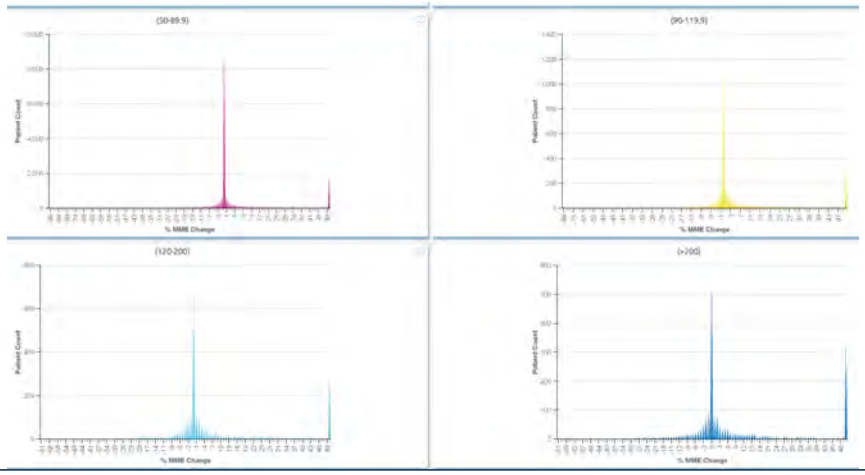




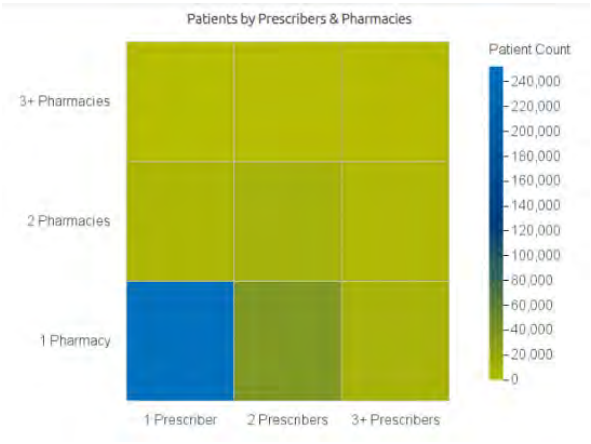
Opioid Titration - % Change in Average Daily MME

Current Average MME	% MME Change Group	Patient Count
<30	-100 to -75	900
	-74 to -50	4,289
	-49 to -25	7,734
	-24 to 0	169,669
	1 to 25	14,281
	26 to 50	9,247
	<30 - Summary	205,200
30 to 49.9	-100 to -75	41
	-74 to -50	281
	-49 to -25	1,444
	-24 to 0	67,730
	1 to 25	10,976
	26 to 50	6,311
	30 to 49.9 - Summary	86,833
50 to 89.9	-100 to -75	17
	-74 to -50	71
	-49 to -25	383
	-24 to 0	13,478
	1 to 25	4,160
	26 to 50	3,000
	50 to 89.9 - Summary	21,109

Opioid Titration: 2Q2022 (cont.)



Prescriber & Pharmacy: 2Q2022



NOTE: NPI data are used for these calculations but do not account for prescriber address.

Therefore, two prescribers within the same practice location are counted as two prescribers.

Prescriber & Pharmacy: 2Q2022 (cont.)

- Data available for prescribers and pharmacies:
  - Patient count
  - % of total patients
  - Average MME/patient
  - Total claims
  - Average number of claims/patient
  - Average MME/claim
  - Total units dispensed
  - Total units dispensed/patient
  - Average units dispensed/claim

Board questions/recommendations?

Hepatitis C Virus (HCV): Background

- National estimates suggest there are 400,700 persons with chronic hepatitis C infection in California.
- Treatment options for HCV infection have been evolving continuously since the introduction of HCV protease inhibitor therapies in 2011
  - Current treatment options available on the Medi-Cal Rx Contract Drugs List (CDL):
    - SOFOSBUVIR/VELPATASVIR
    - GLECAPREVIR/PIBRENTASVIR
    - RIBAVIRIN
    - PEGINTERFERON ALFA-2A
    - ELBASVIR/ GRAZOPREVIR
    - LEDIPASVIR/SOFOSBUVIR
    - SOFOSBUVIR
- In December 2021, DHCS revised its Treatment Policy for the Management of Chronic Hepatitis C

HCV: Background (cont.)

- In November of 2016, the Board recommended an annual evaluation of hepatitis C virus infection and treatment in the Medi-Cal population
- The 2020 evaluation was the first to include both FFS and MCP beneficiaries
- The 2021 evaluation included the following:
  - Total number of beneficiaries with a diagnosis code indicating HCV infection
  - Total number of beneficiaries initiating treatment for HCV infection
  - Regional stratification of these data to identify potential areas in the state that may benefit from additional outreach
- Board recommended repeating this evaluation one additional time

HCV: Objective

- To evaluate the prevalence of HCV infection in the Medi-Cal population and the percentage of beneficiaries with a diagnosis of HCV infection that initiate treatment, stratified by beneficiary region of residence in California.

HCV: Methods

- The study population included all Medi-Cal beneficiaries with a diagnosis code for chronic HCV with a date of service between October 1, 2020, and September 30, 2021
  - Beneficiaries were not included if only acute HCV infection diagnosis
- Within this population, the following were also reviewed:
  - Demographic data, including California region of residence
  - Paid pharmacy claims for HCV medications between October 1, 2020, and September 30, 2021 (included a 90-day lookback to account for paid claims processed prior to October 1)

HCV Drugs: Utilization Data FFY 2021

Drug	FFS Utilizing Benes	MCP Utilizing Benes
ELBASVIR/GRAZOPREVIR*	<20	279
GLECAPREVIR/PIBRENTASVIR*	190	1,002
LEDIPASVIR/SOFOSBUVIR*	< 20	39
PEGINTERFERON ALFA-2A*	< 20	< 20
RIBAVIRIN*	< 20	88
SOFOSBUVIR*	< 20	< 20
SOFOSBUVIR/VELPATASVIR*	292	3,773
SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR	< 20	123

Some beneficiaries may be on more than one medication.

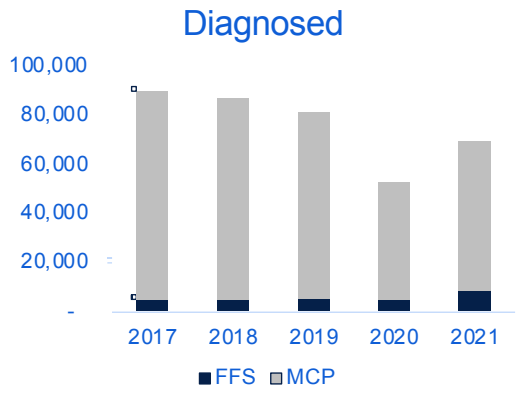
*Drug currently appears on the Medi-Cal Rx CDL

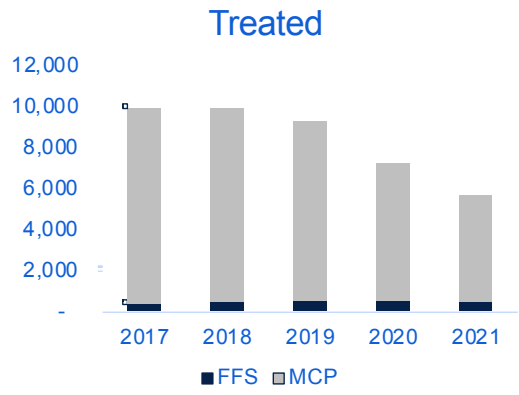
Chronic HCV Infection: FFY 2021

California Region of Residence	MCP Diagnosis	MCP % Treatment	% Change from FFY2020	FFS Diagnosis	FFS % Treatment	% Change from FFY2020
Fresno	7,073	8.6%	-5.7%	1,301	3.6%	-1.3%
Los Angeles	14,933	6.6%	-4.1%	1,663	5.4%	-2.6%
Sacramento	7,845	10.2%	-7.0%	1,563	4.4%	-5.4%
San Bernardino	11,208	7.8%	-4.4%	1,234	6.6%	-8.4%
San Diego	6,124	9.2%	-6.0%	1,022	8.7%	-8.9%
San Francisco	6,324	11.2%	-5.8%	828	9.1%	-6.6%
San Jose	7,590	8.7%	-7.8%	1,248	5.1%	-4.8%
TOTAL	***60,785***	***8.6%***	***-5.4%***	***8,835***	***5.7%***	***-5.0%***

* 2% of beneficiaries were enrolled in both MCP and FFS during FFY 2021

HCV: Trends (FFY2017 - FFY2021)





HCV: Results (Diagnosis)

- Total beneficiaries diagnosed with chronic HCV infection increased 30.6% from FFY2020
  - FFS enrollees is a 78% increase from FFY 2020 (n = 4,973)
  - MCP enrollees is a 27% increase from FFY 2020 (n = 47,927)
- Total beneficiaries diagnosed still less than 15.4% of numbers seen in FFY2019
  - Exclusive to MCP enrollees
- Data were consistent across regions

HCV: Results (Treatment)

- Glecaprevir/pibrentasvir and sofosbuvir/velpatasvir continue to be the top medications by total utilizing beneficiaries
- Total beneficiaries treated for chronic HCV infection ↓ 21.6% from FFY2020
  - FFS enrollees is a 6% decrease from FFY 2020 (n = 534)
  - MCP enrollees is a 23% decrease from FFY 2020 (n = 6,729)
- Regional variation in treatment rates similar to FFY2020
  - Low of 3.6% (FFS in Fresno Region) to 11.2% (MCP in SF Region)

HCV: Discussion

- Consistent with US data (2022, Hoenigl), which found HCV screening rates have rebounded but treatment rates have not
  - Findings similar across states and differences in COVID-19 restrictions between states did not have an impact
  - HCV linkage to care stalled during the early phase of COVID-19
  - Barriers to care, including higher frequency of active substance use and housing instability were exacerbated by COVID-19
- Similar trend of testing/screening rebounds with treatment lags has been observed with HIV and hepatitis B

HCV: Discussion (cont.)

- Last month the CDC published Vital Signs: Hepatitis C Treatment Among Insured Adults — United States, 2019–2020 in the *MMWR*
  - Similar findings
  - Treatment rates are low and vary by age and insurance payor
  - Treatment rates lowest among young adults (18–29 years of age) and Medicaid recipients
  - Timely initiation of treatment is critical to reducing viral hepatitis–related mortality, disparities, and transmission

HCV: Recommended Actions

- Suggest further review to identify treatment barriers and solutions
  - Do any plans offer telehealth visits for HCV treatment initiation?
- Suggest publication of a DUR bulletin and/or provider mailing aimed at increasing treatment rates across California
- Any educational intervention would include the AASLD-IDSA simplified HCV treatment algorithm for treatment-naive adults
  - Without cirrhosis
  - With compensated cirrhosis

Board questions/recommendations?

Core Set Measures: Behavioral Health

- CMS identified a core set of 18 behavioral health care quality measures for voluntary reporting by state Medicaid and CHIP
  - 13 measures from the Adult Core Set
  - 5 measures from the Child Core Set
- 2021 Behavioral Health Core Set Chart Pack, FFY 2020
- FFY 2020 data were published in January 2022
- California submitted 16 behavioral health measures for FFY2020
  - 13 of these were published in the core set data

Behavioral Health: Adult Core Set (n=9)

- Antidepressant Medication Management (AMM-AD)
- Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
- Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET-AD)
- Concurrent Use of Opioids and Benzodiazepines (COB-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)
- Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)
- Follow-Up After ED Visit for Mental Illness (FUM-AD)
- Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

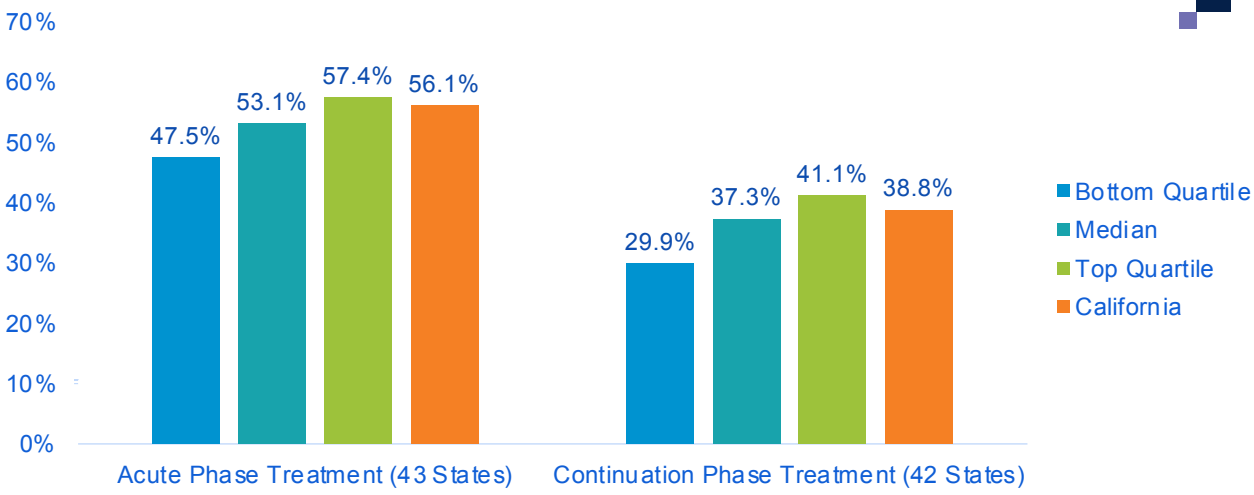
Behavioral Health: Child Core Set (n=4)

- Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)
- Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)

Antidepressant Medication Management (AMM-AD)

- Reports the percentage of adults 18 years of age or older with a diagnosis of major depression who were treated with (initial course of 12 weeks) and remained on (for at least six months) an antidepressant medication
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - Rate was validated by the state's EQRO

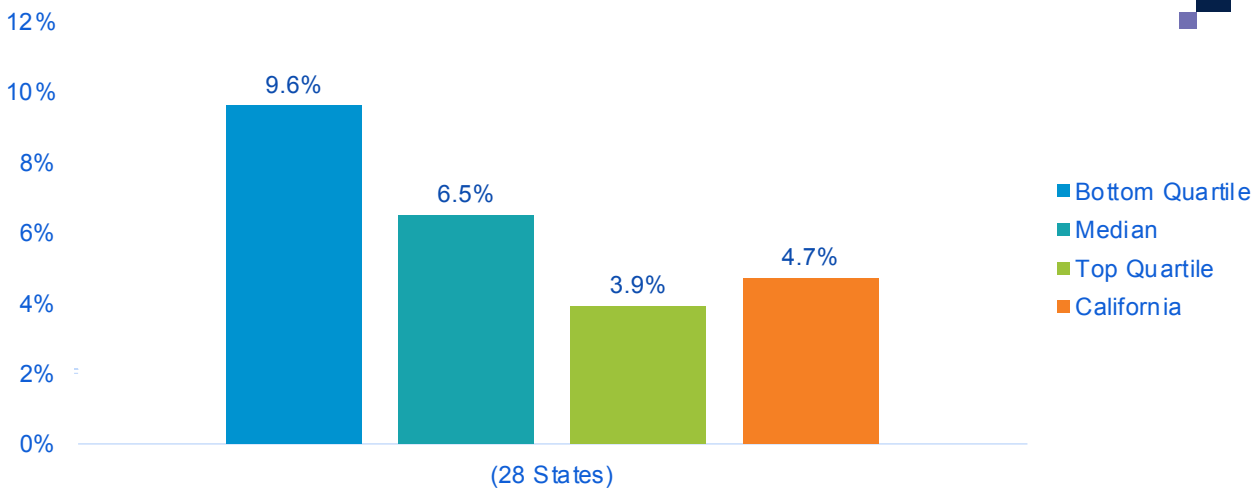
Antidepressant Medication: AMM-AD



Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

- Reports the percentage of adults 18 years of age or older without cancer who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) for a period of 90 days or more
- Lower rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was conducted

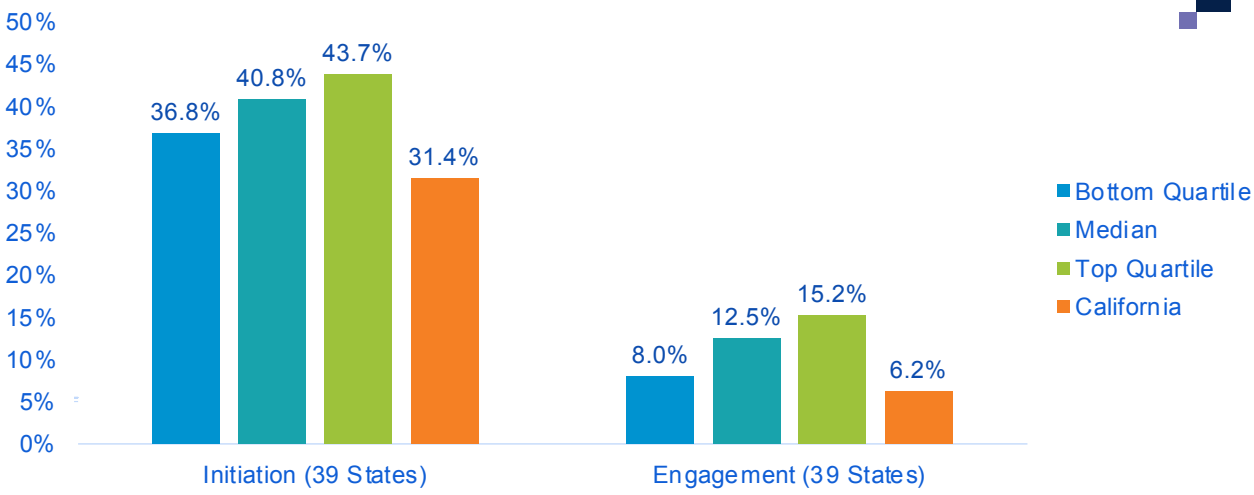
Opioids at High Dosage: OHD-AD



Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET-AD)

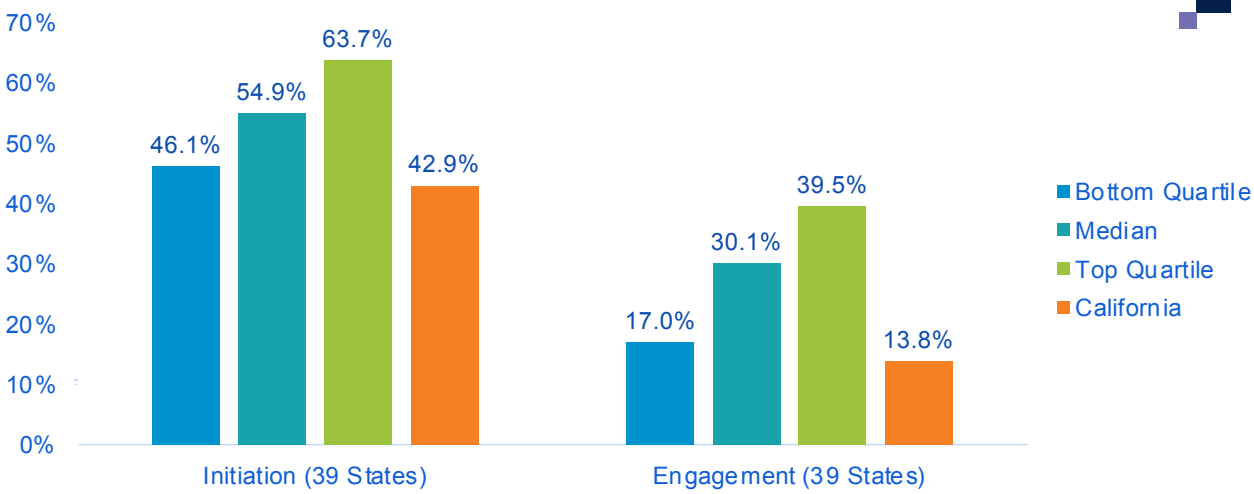
- Reports the percentage of adults 18 years of age or older with a new episode of alcohol or other drug abuse or dependence who: (1) initiated treatment within 14 days of the diagnosis, and (2) initiated treatment and were engaged in ongoing treatment within 34 days of the initiation visit
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was conducted

Alcohol Abuse or Dependence: IET-AD



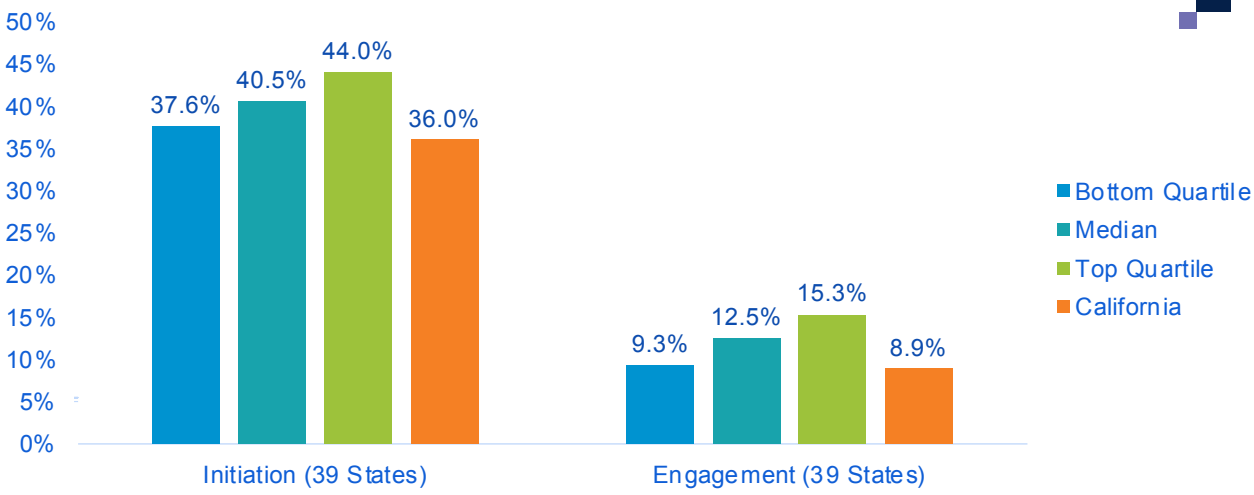
81 Retrospective DUR Updates – 2022Q2 (4/1/22 – 6/30/22)

Opioid Abuse or Dependence: IET-AD

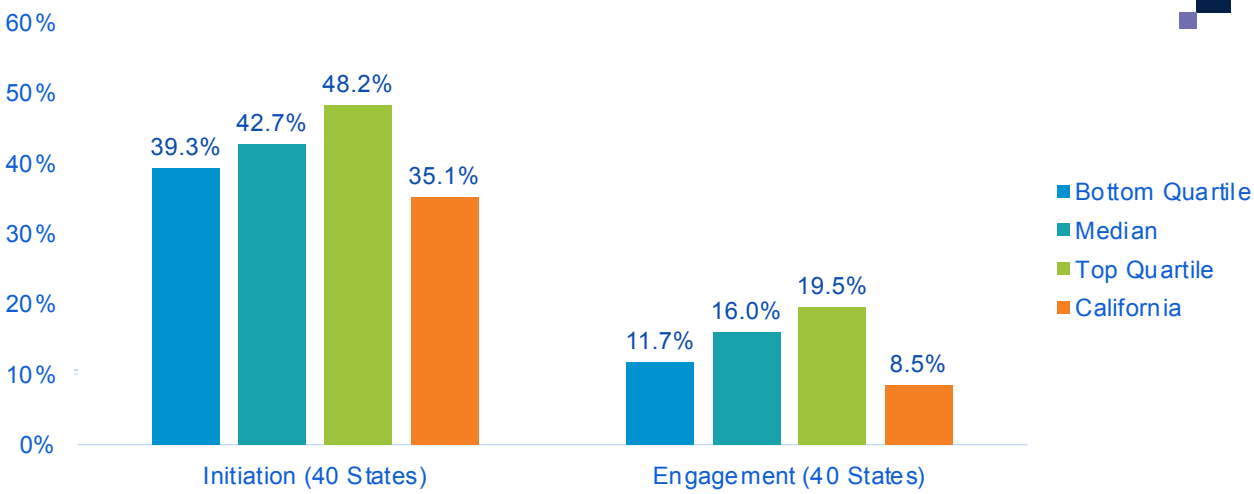


82 Retrospective DUR Updates – 2022Q2 (4/1/22 – 6/30/22)

Other Drug Abuse or Dependence: IET-AD



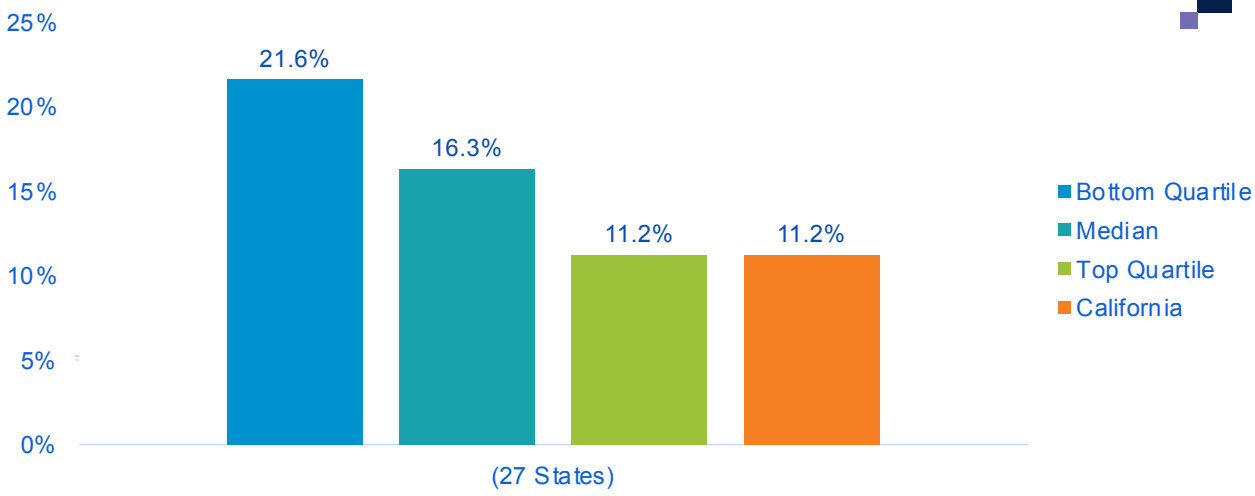
Total AOD Abuse or Dependence: IET-AD



Concurrent Use of Opioids and Benzodiazepines (COB-AD)

- Reports the percentage of adults 18 years of age or older with concurrent use of prescription opioids and benzodiazepines for 30 or more cumulative days
- Lower rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was conducted

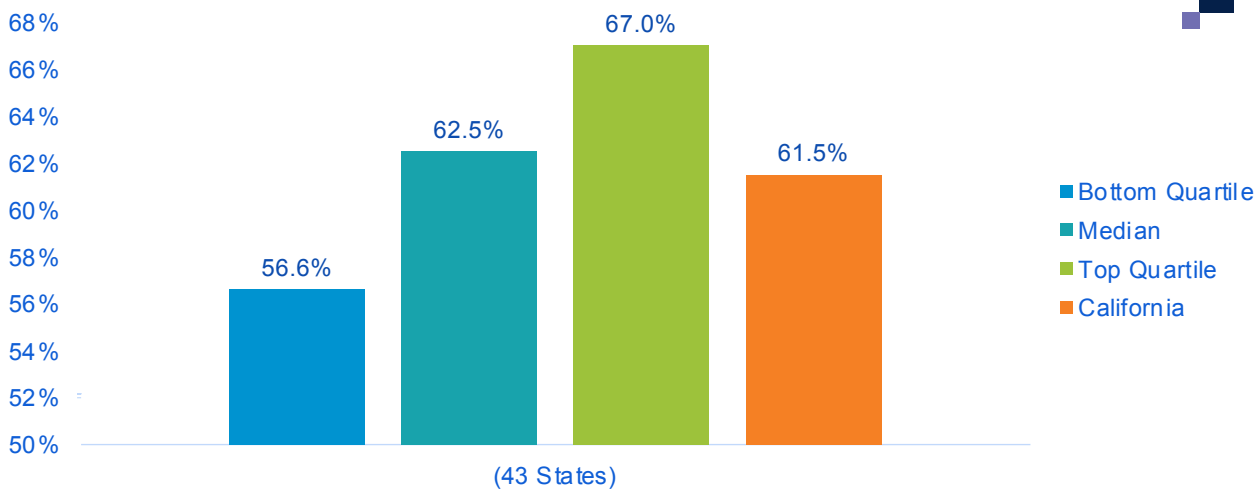
Opioids and Benzodiazepines: COB-AD



Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

- Reports the percentage of adults 18 years of age or older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was conducted

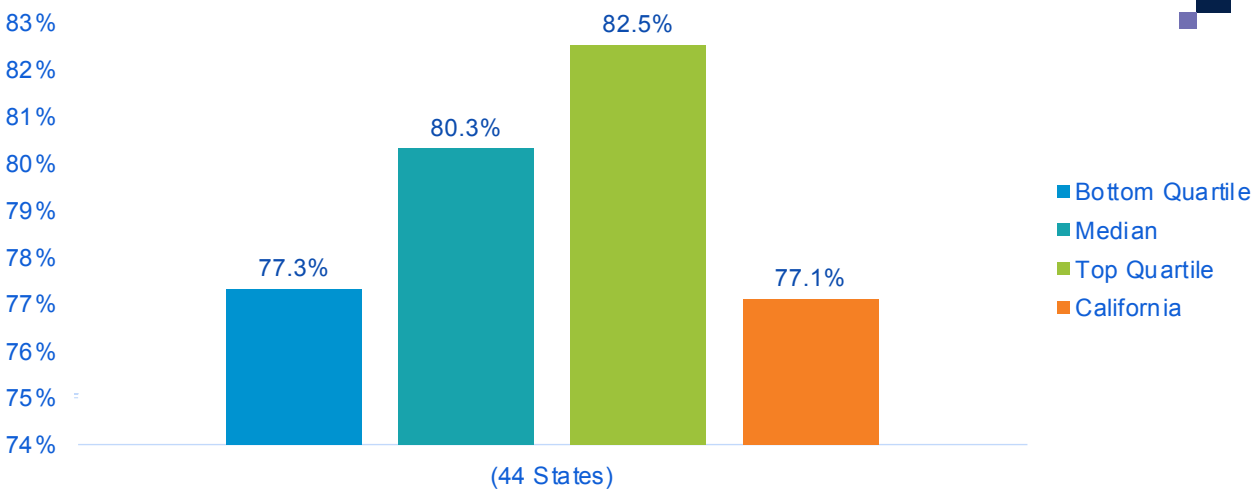
Adherence to Antipsychotics: SAA-AD



Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

- Reports the percentage of adults between 18 and 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was conducted

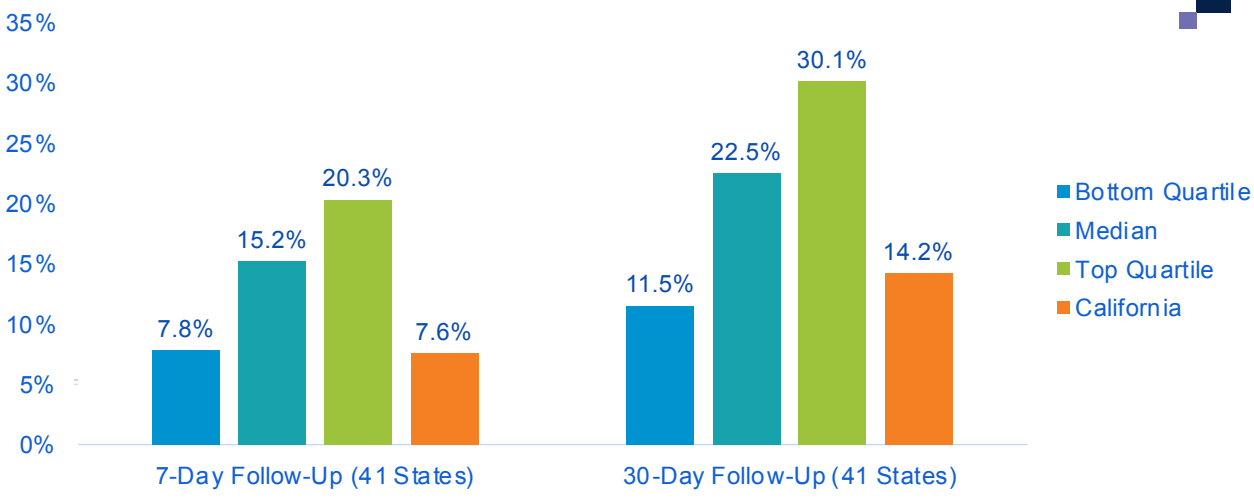
Diabetes Screening: SSD-AD



Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)

- Reports the percentage of emergency department (ED) visits for adults 18 years of age or older who had a principal diagnosis of alcohol and other drug (AOD) abuse or dependence with a follow-up visit within 7 days and 30 days of the ED visit
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was completed

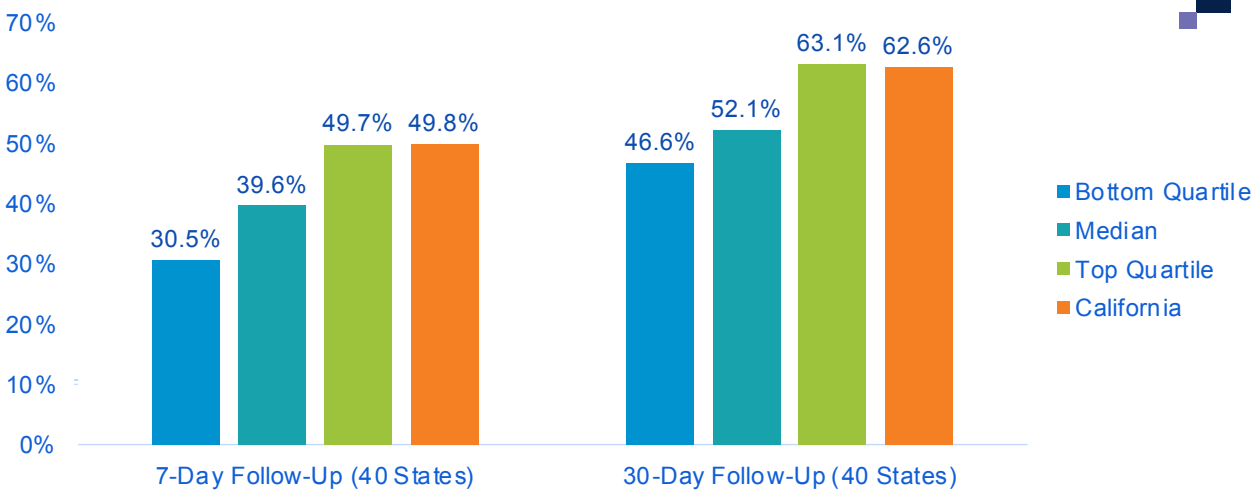
Follow-Up After ED Visit: FUA-AD



Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)

- Reports the percentage of emergency department (ED) visits for adults 18 years of age or older who had a principal diagnosis of mental illness or intentional self-harm with a follow-up visit within 7 days and 30 days of the ED visit
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs, excludes duals
  - An internal validation was completed

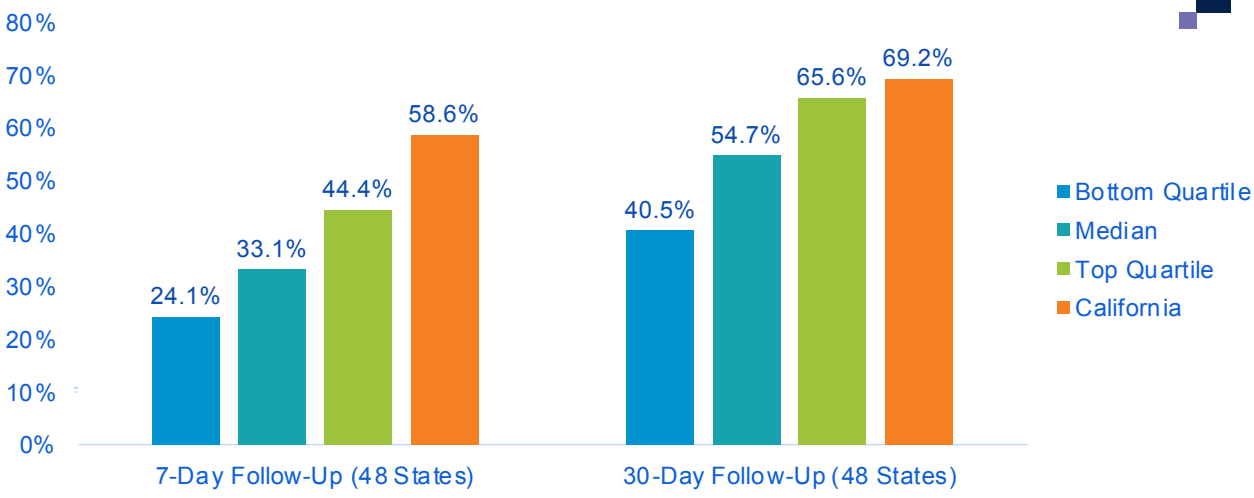
Follow-Up After ED Visit: FUM-AD



Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

- Reports the percentage of discharges for adults 18 years of age or older hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit with a mental health practitioner within 7 and 30 days after discharge
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs
  - An internal validation was conducted

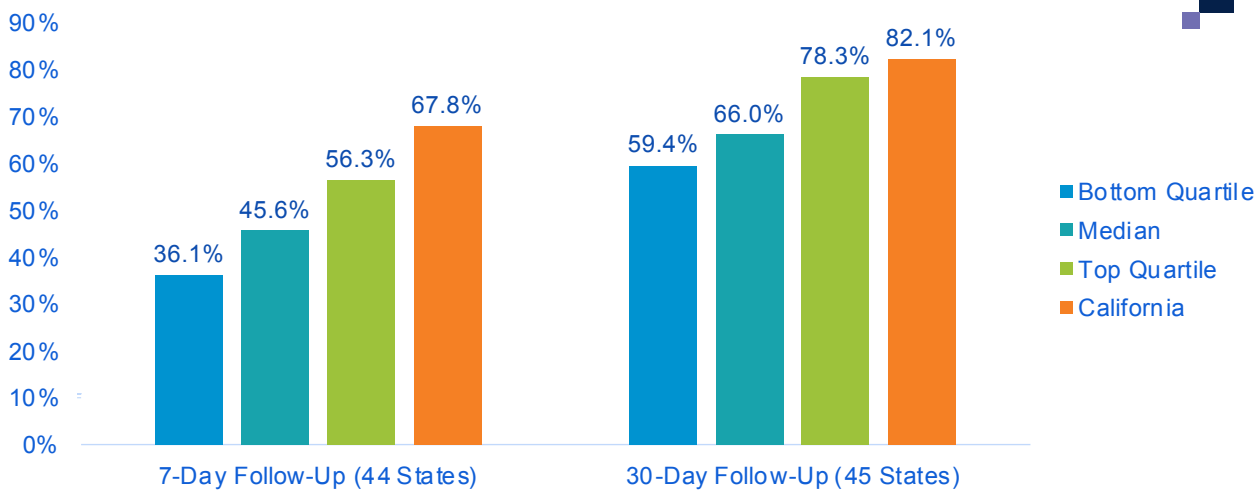
Follow-Up After Hospitalization: FUH-AD



Follow-Up After Hospitalization for Mental Illness: Age 6 to 17 (FUH-CH)

- Reports the percentage of discharges for children between 6 and 17 years of age hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit with a mental health practitioner within 7 and 30 days after discharge
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs
  - An internal validation was conducted

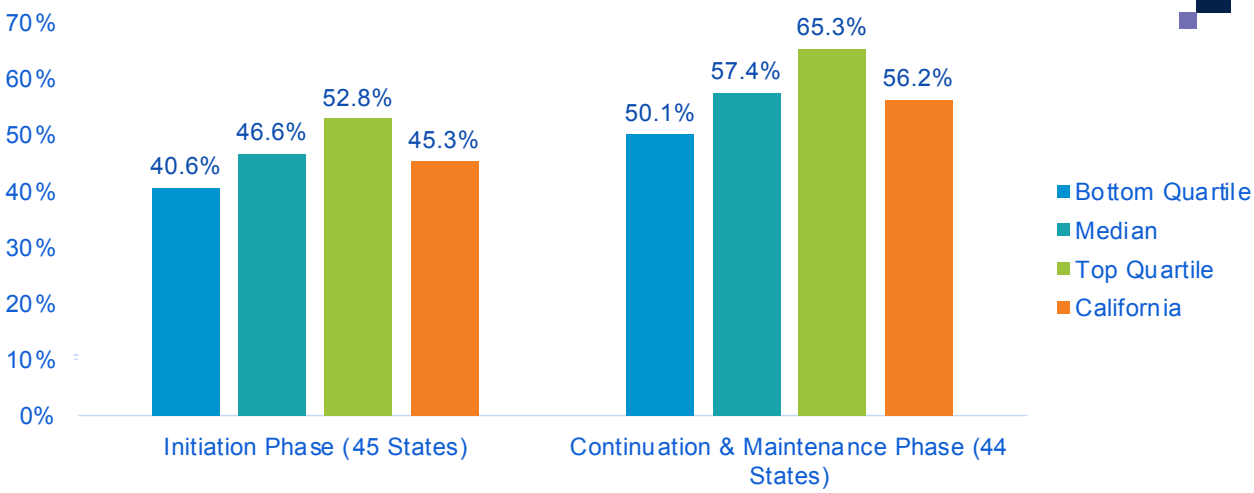
Follow-Up After Hospitalization: FUH-CH



Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)

- Reports the percentage of children between 6 and 12 years of age with a newly prescribed medication for ADHD who had at least one visit during the 30-day initiation phase and at least two visits during the 9-month continuation and maintenance phase
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs
  - An internal validation was conducted

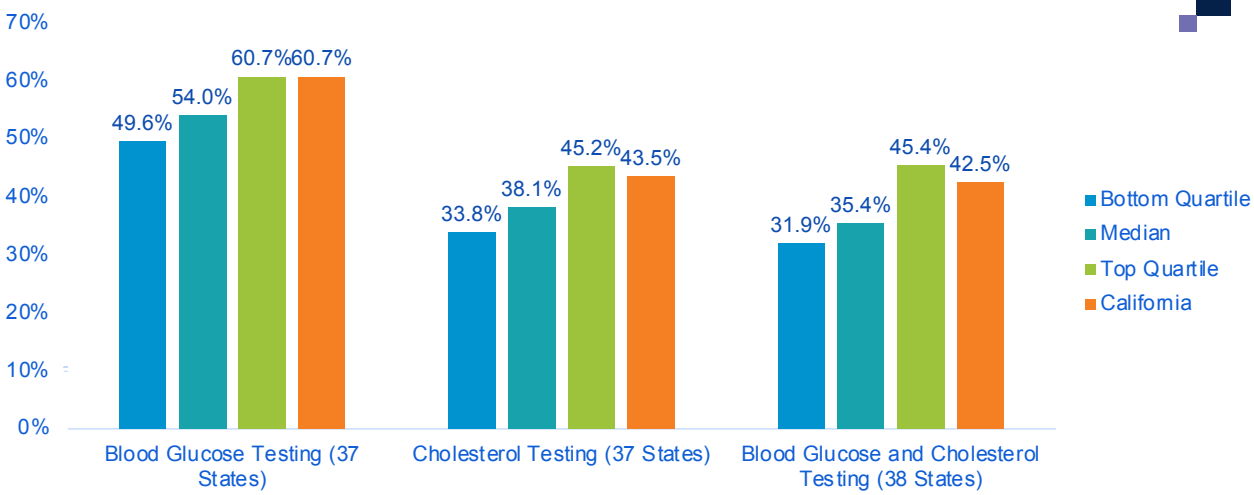
Follow-Up ADHD Medication: ADD-CH



Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

- Reports the percentage of children and adolescents between 1 and 17 years of age who had two or more antipsychotic prescriptions and had metabolic testing for blood glucose, cholesterol, and both blood glucose and cholesterol
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs
  - An internal validation was conducted

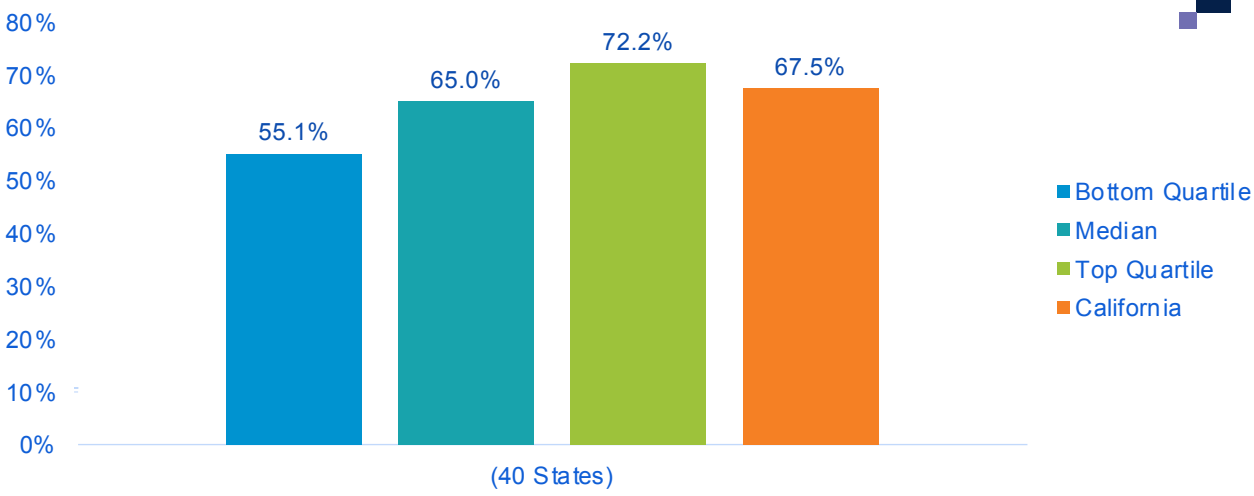
Metabolic Monitoring: APM-CH



Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)

- Reports the percentage of discharges for children between 1 and 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment
- Higher rates are better on this measure
- FFY 2020 rate includes FFS and 25 MCOs
  - An internal validation was conducted

First-Line Psychosocial Care: APP-CH



Board questions/recommendations?

Future Topics: Retrospective Reviews

- Core Set Measures: Primary Care Access and Preventive Care (November meeting)
- NSAIDs
- Pharmacist furnishing of hormonal contraceptives
- Assessment of opioid use and mortality (stratified by gender)
- Antipsychotic polypharmacy in adults
- SGLT2 inhibitors in patients without diabetes for heart failure

Board questions/recommendations?

UCSF

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

UCSF

Updated Alerts: Q2 2022 Target Drugs

Drug Description	Alerts Turned On
NALMEFENE HCL	MC (Drug – Disease)
TIRZEPATIDE	MC (Drug – Disease)

Board questions/recommendations?

Prospective DUR Alert Review

- Starting with this meeting, ProDUR alerts will be discussed in greater detail with the Board
- Programming logic has changed for the following alerts since implementation of Medi-Cal Rx:
  - Drug-Allergy (DA)
  - Drug-Pregnancy (PG)
  - Drug-Drug Interaction (DD)

Next Steps

- Board recommendations for additions, deletions, and/or changes will be submitted to DHCS for review
- Status of recommendations will be reported to the DUR Board at future DUR Board meetings, as needed

Board questions/recommendations? 6

QUARTERLY SUMMARY
MEDI-CAL PROGRAM DRUG USE REVIEW
REPORT PERIOD: 2nd QUARTER 2022 (APRIL – JUNE 2022)

Executive Summary

The DUR quarterly report provides information on both prospective and retrospective drug utilization for all claims processed by the Medi-Cal Rx program. For this quarterly report, the prospective and retrospective data cover the second quarter of 2022 (2022 Q2).

Prospective DUR

As shown in **Table 1.1**, a total of 46,002,851 claims were submitted for processing during 2022 Q2, with 23% generating DUR messages or alerts upon submission. Claims without DUR messages or alerts were more likely to be rejected (93% of rejected claims had no DUR messages or alerts).

Table 1.2 provides more details on the frequency of DUR messages or alerts (average of 1.21 per claim with a DUR message or alert). A summary for each of the 12 prospective DUR alerts is provided in **Tables 2.1-2.12**, with greater detail provided on the total number of alerts, the total and percentage of alerts with outcomes denied or paid, total paid claims, and the percentage of paid claims that had an alert. Of note, the ingredient duplication (ID) and therapeutic duplication (TD) alerts were inactive between January 21, 2022, and May 26, 2022. **Tables 3.1-3.3** are new tabled that summarize the high cumulative dose (HC) alert. For 2022 Q2, 90.3% of all submitted opioid claims in 2022 Q2 had no HC alert (up from 87.7% in the previous quarter) and 97.4% of paid claims for opioids in 2022 Q2 had no HC alert (was 97.5% in the previous quarter). In addition, the data show that 95.0% of all submitted opioid claims in 2022 Q2 were for ≤ 90 MME/day (up from 93.5% in the previous quarter) and 98.5% of all paid claims for opioids in 2022 Q2 were for ≤ 90 MME/day (same as the previous quarter). Almost half (47.3%) of claims with the HC alert were for ≤ 90 MME/day.

Retrospective DUR

Medi-Cal Rx pharmacy utilization data in **Table 4** show increases in total eligible beneficiaries and total paid claims from both the prior quarter (2022 Q1) and the prior-year quarter (2021 Q2). Total utilizing beneficiaries in 2022 Q2 decreased slightly from the prior quarter by < 1% and increased in comparison to the prior-year quarter by 12%. In 2022 Q2, approximately 31% of eligible Medi-Cal Rx beneficiaries had a paid claim through Medi-Cal Rx, which was the same as the prior quarter.

As shown in **Table 5**, the greatest increases in utilizing beneficiaries and paid claims processed by Medi-Cal Rx in comparison to both the prior quarter and the prior-year quarter were seen in the 0 -12 years group, most likely due to the U.S. Food and Drug Administration (FDA) approval of COVID-19 vaccines for children between the ages of 6 months and 5 years on June 17, 2022.

A review of the top 20 drug therapeutic categories in Medi-Cal Rx (**Table 6**) by percentage of utilizing beneficiaries with a paid claim showed across-the-board decreases in total paid claims per day and total percentage of utilizing beneficiaries with a paid claim in comparison to both the prior quarter and prior-year quarter for COVID-19 VACCINES, which showed decreases only for adult formuations.

Finally, **Table 7** showed COVID-19 ANTIGEN TEST moving from 17th-ranked to 9th-ranked with a 49% increase in total paid claims from the prior quarter. Other drugs in the Top 20 that posted across-the-board increases in total paid claims per day and total percentage of utilizing beneficiaries with a paid claim in comparison to both the prior quarter and prior-year quarter included IBUPROFEN, AMOXICILLIN, ACETAMINOPHEN, FLUTICASONE PROPIONATE, LORATIDINE, GABAPENTIN, CETIRIZINE HCL, and CEPHALEXIN.

Appendix A: Prospective and Retrospective DUR Tables

Tables 1.1-1.2. Summary of Prospective DUR Alert Transactions in Medi-Cal Rx.

Table 1.1 provides summary level data (by volume) on pharmacy claims processing and DUR alert and messaging activities for the reporting period. A comparison to the prior quarter is included for reference.

Table 1.1: Overview of Claims Processed – 2022 Q2						
Total Claims	Without DUR Alerts/Messages		With DUR Alerts/Messages		Grand Total	
	2022 Q2	% Change from *Prior Quarter*	2022 Q2	% Change from *Prior Quarter*	2022 Q2	% Change from *Prior Quarter*
Paid	21,569,100	**3.9%**	6,541,180	**-13.5%**	28,110,280	**-0.8%**
Denied	2,865,707	**-37.9%**	1,090,186	**-73.1%**	3,955,893	**-54.4%**
Reversed	7,681,001	**1.7%**	2,794,130	**-5.5%**	10,475,131	**-0.4%**
Rejected	3,207,359	**-37.2%**	254,188	**-41.9%**	3,461,547	**-37.5%**
Total Processed	***35,366,390***	***-7.2%***	***10,636,461***	***-29.3%***	***46,002,851***	***-13.5%***

Data Source: Magellan Medicaid Administration (MMA) ca_ca_531_m_20220706000138 Report

Table 1.2 provides a summary of the number of alerts and messages generated for each therapeutic problem type (sorted by total alert/message frequency). A comparison to the prior quarter is included for reference. Average alerts/messages per day is used to account for a variable number of days in each quarter.

Table 1.2: Summary of ProDUR Alerts/Messages by Therapeutic Problem Type – 2022 Q2			
Therapeutic Problem Type	2022 Q2		% Change from *Prior Quarter*
	Total Alerts/Messages	Average Alerts/ Messages per Day	
Drug-Drug Interaction (DD)	6,004,875	65,988	**-7.1%**
Overuse Precaution (ER)	3,043,779	33,448	**-6.9%**
Underuse Precaution (LR)	1,388,874	15,262	**-10.6%**
Therapeutic Duplication (TD)*	825,607	9,073	**6.1%**
Drug-Disease (MC)	504,968	5,549	**-71.8%**
Ingredient Duplication (ID)*	399,562	4,391	**8.6%**
High Dose Alert (HD)	308,737	3,393	**-19.9%**
Low Dose Alert (LD)	209,645	2,304	**-24.2%**
Additive Toxicity (AT)	169,581	1,864	**-6.3%**
Drug-Age Precaution (PA)	20,909	230	**-87.6%**
Drug-Allergy (DA)	651	7	**-45.0%**
Drug-Pregnancy Alert (PG)	614	7	**-75.9%**
All DUR Alerts/Messages	***12,877,802***	***141,514***	***-15.5%***

*The ID and TD alerts were turned off between January 21, 2022, and May 26, 2022.

Data Source: MMA ca_ca_531_q_20220706000138.xlsx Report

Tables 2.1-2.12. Prospective DUR Alert Transactions by Therapeutic Problem Type in Medi-Cal Rx.

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 alerts, the percentage of alerts with outcomes denied and paid, total claims submitted, total paid claims, and the percentage of paid claims that had an alert. **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) – 2022 Q2*

Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	HYDROCODONE/ ACETAMINOPHEN	51	21	41.2%	15	29.4%	322,440	0.0%
2	OXYCODONE HCL	41	32	78.0%	4	9.8%	50,685	0.1%
3	OXYCODONE HCL/ ACETAMINOPHEN	31	15	48.4%	13	41.9%	60,053	0.1%
4	MORPHINE SULFATE	26	19	73.1%	4	15.4%	19,533	0.1%
5	GABAPENTIN	21	4	19.0%	15	71.4%	446,771	0.0%
6	CYCLOBENZAPRINE HCL	20	1	5.0%	10	50.0%	151,448	0.0%
7	ASPIRIN	18	3	16.7%	15	83.3%	527,985	0.0%
8	TRAMADOL HCL	13	9	69.2%	2	15.4%	83,932	0.0%
9	DICLOFENAC SODIUM	13	4	30.8%	6	46.2%	245,275	0.0%
10	GUAIFENESIN/ DEXTROMETHORPHAN	13	0	0.0%	1	7.7%	21,114	0.1%

*Data are available from pre-overridden alerts only for the DA alert.

Table 2.2: Top 10 Drugs by Therapeutic Problem Type – Drug-Pregnancy (PG) – 2022 Q2

Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	IBUPROFEN	183	7	3.8%	148	80.9%	836,732	0.0%
2	ATORVASTATIN CALCIUM	97	3	3.1%	84	86.6%	715,476	0.0%
3	LISINOPRIL	64	0	0.0%	60	93.8%	432,215	0.0%
4	LOSARTAN POTASSIUM	38	1	2.6%	32	84.2%	302,032	0.0%
5	NAPROXEN	31	0	0.0%	26	83.9%	155,557	0.0%
6	DICLOFENAC SODIUM	30	0	0.0%	25	83.3%	245,275	0.0%
7	NORETHINDRONE	28	0	0.0%	16	57.1%	29,413	0.1%
8	MELOXICAM	16	0	0.0%	16	100.0%	100,478	0.0%
9	LISINOPRIL/ HYDROCHLOROTHIAZIDE	13	0	0.0%	10	76.9%	46,173	0.0%
10	PROPRANOLOL HCL	12	0	0.0%	10	83.3%	84,067	0.0%

Table 2.3: Top 10 Drugs by Therapeutic Problem Type – Drug-Disease (MC) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	IBUPROFEN	124,489	5,524	4.4%	86,413	69.4%	836,732	14.9%
2	METFORMIN HCL	114,465	2,878	2.5%	83,053	72.6%	588,494	19.5%
3	PROPRANOLOL HCL	23,174	670	2.9%	15,309	66.1%	84,067	27.6%
4	CLOPIDOGREL BISULFATE	15,672	346	2.2%	11,500	73.4%	52,431	29.9%
5	NAPROXEN	14,545	509	3.5%	9,845	67.7%	155,557	9.4%
6	DICLOFENAC SODIUM	13,596	671	4.9%	9,120	67.1%	245,275	5.5%
7	ESTRADIOL	13,590	582	4.3%	8,329	61.3%	42,332	32.1%
8	SULFAMETHOXAZOLE/ TRIMETHOPRIM	12,058	517	4.3%	8,788	72.9%	104,112	11.6%
9	ATORVASTATIN CALCIUM	11,522	267	2.3%	8,688	75.4%	715,476	1.6%
10	NORGESTIMATE-ETHINYL ESTRADIOL	11,229	527	4.7%	7,544	67.2%	54,271	20.7%

Table 2.4: Top 10 Drugs by Therapeutic Problem Type – Drug-Drug Interaction (DD) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	IBUPROFEN	243,417	5,895	2.4%	187,107	76.9%	836,732	29.1%
2	HYDROCODONE/ ACETAMINOPHEN	232,255	50,692	21.8%	127,016	54.7%	322,440	72.0%
3	GABAPENTIN	184,686	50,888	27.6%	106,702	57.8%	446,771	41.3%
4	TRAZODONE HCL	164,375	6,609	4.0%	123,946	75.4%	217,711	75.5%
5	BUPROPION HCL	152,509	6,313	4.1%	110,857	72.7%	182,351	83.6%
6	ASPIRIN	129,550	16,883	13.0%	89,356	69.0%	527,985	24.5%
7	SERTRALINE HCL	125,976	3,210	2.5%	94,842	75.3%	273,058	46.1%
8	LISINOPRIL	110,068	2,330	2.1%	85,730	77.9%	432,215	25.5%
9	ESCITALOPRAM OXALATE	109,298	2,979	2.7%	81,127	74.2%	193,871	56.4%
10	FUROSEMIDE	102,144	2,516	2.5%	75,396	73.8%	125,236	81.6%

Table 2.5: Top 10 Drugs by Therapeutic Problem Type – Therapeutic Duplication (TD) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	TRAZODONE HCL	57,113	2,263	4.0%	43,017	75.3%	217,711	26.2%
2	BUPROPION HCL	49,757	2,039	4.1%	35,900	72.2%	182,351	27.3%
3	SERTRALINE HCL	39,511	1,089	2.8%	28,769	72.8%	273,058	14.5%
4	ALBUTEROL SULFATE	36,777	910	2.5%	24,972	67.9%	672,609	5.5%
5	QUETIAPINE FUMARATE	32,027	766	2.4%	24,509	76.5%	162,479	19.7%
6	FLUOXETINE HCL	31,109	775	2.5%	22,627	72.7%	180,309	17.3%
7	ESCITALOPRAM OXALATE	28,288	702	2.5%	20,388	72.1%	193,871	14.6%
8	GABAPENTIN	23,254	4,689	20.2%	13,785	59.3%	446,771	5.2%
9	LEVOTHYROXINE SODIUM	22,504	559	2.5%	14,305	63.6%	330,398	6.8%
10	DULOXETINE HCL	22,475	637	2.8%	16,355	72.8%	109,220	20.6%

*Data are available in 2022 Q2 for the TD alert beginning May 26, 2022.

Table 2.6: Top 10 Drugs by Therapeutic Problem Type – Overutilization (ER) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	ATORVASTATIN CALCIUM	95,326	7,194	7.5%	47,472	49.8%	715,476	13.3%
2	METFORMIN HCL	84,917	6,585	7.8%	40,161	47.3%	588,494	14.4%
3	GABAPENTIN	70,288	17,326	24.7%	29,158	41.5%	446,771	15.7%
4	AMLODIPINE BESYLATE	64,771	5,163	8.0%	30,682	47.4%	404,958	16.0%
5	LISINOPRIL	62,619	5,007	8.0%	30,961	49.4%	432,215	14.5%
6	ALBUTEROL SULFATE	59,585	10,486	17.6%	27,262	45.8%	672,609	8.9%
7	ASPIRIN	57,483	9,875	17.2%	27,716	48.2%	527,985	10.9%
8	BLOOD SUGAR DIAGNOSTIC	54,052	6,158	11.4%	30,234	55.9%	400,664	13.5%
9	LEVOTHYROXINE SODIUM	50,041	4,060	8.1%	23,333	46.6%	330,398	15.1%
10	LOSARTAN POTASSIUM	48,593	3,689	7.6%	23,060	47.5%	302,032	16.1%

Table 2.7: Top 10 Drugs by Therapeutic Problem Type – Underutilization (LR) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	ATORVASTATIN CALCIUM	154,170	5,196	3.4%	112,616	73.0%	715,476	21.5%
2	GABAPENTIN	139,726	13,751	9.8%	95,551	68.4%	446,771	31.3%
3	AMLODIPINE BESYLATE	91,650	3,234	3.5%	63,149	68.9%	404,958	22.6%
4	LEVOTHYROXINE SODIUM	76,324	4,378	5.7%	52,326	68.6%	330,398	23.1%
5	SERTRALINE HCL	74,619	4,143	5.6%	51,872	69.5%	273,058	27.3%
6	ESCITALOPRAM OXALATE	50,207	2,967	5.9%	34,603	68.9%	193,871	25.9%
7	FLUOXETINE HCL	49,691	2,488	5.0%	35,112	70.7%	180,309	27.6%
8	BUPROPION HCL	47,558	2,647	5.6%	32,808	69.0%	182,351	26.1%
9	QUETIAPINE FUMARATE	36,106	1,140	3.2%	25,638	71.0%	162,479	22.2%
10	FUROSEMIDE	34,407	625	1.8%	24,404	70.9%	125,236	27.5%

Table 2.8: Top 10 Drugs by Therapeutic Problem Type – Additive Toxicity (AT) – 2022 Q2*								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	GABAPENTIN	73,358	2,159	2.9%	49,578	67.6%	446,771	16.4%
2	CYCLOBENZAPRINE HCL	21,826	716	3.3%	14,238	65.2%	151,448	14.4%
3	BACLOFEN	20,364	581	2.9%	14,000	68.7%	110,821	18.4%
4	TIZANIDINE HCL	11,911	400	3.4%	7,485	62.8%	39,346	30.3%
5	METHOCARBAMOL	10,511	313	3.0%	6,837	65.0%	48,648	21.6%
6	PREGABALIN	8,810	310	3.5%	5,876	66.7%	39,337	22.4%
7	HYDROCODONE/ ACETAMINOPHEN	3,867	979	25.3%	1,525	39.4%	322,440	1.2%
8	LORAZEPAM	2,102	370	17.6%	1,285	61.1%	82,142	2.6%
9	OXYCODONE HCL	2,033	773	38.0%	661	32.5%	50,685	4.0%
10	OXYCODONE HCL/ ACETAMINOPHEN	1,984	581	29.3%	708	35.7%	60,053	3.3%

*Outcome data are available from pre-overridden alerts only for the AT alert.

Table 2.9: Top 10 Drugs by Therapeutic Problem Type – Ingredient Duplication (ID) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	ALBUTEROL SULFATE	36,939	919	2.5%	25,096	67.9%	672,609	5.5%
2	LEVOTHYROXINE SODIUM	21,043	492	2.3%	13,285	63.1%	330,398	6.4%
3	GABAPENTIN	18,665	3,464	18.6%	11,133	59.6%	446,771	4.2%
4	QUETIAPINE FUMARATE	18,476	406	2.2%	14,018	75.9%	162,479	11.4%
5	FLUOXETINE HCL	15,794	378	2.4%	11,015	69.7%	180,309	8.8%
6	BUPROPION HCL	15,764	393	2.5%	11,070	70.2%	182,351	8.6%
7	SERTRALINE HCL	15,226	450	3.0%	10,390	68.2%	273,058	5.6%
8	METFORMIN HCL	14,551	323	2.2%	8,483	58.3%	588,494	2.5%
9	OLANZAPINE	10,873	269	2.5%	8,098	74.5%	101,037	10.8%
10	HYDROCODONE/ ACETAMINOPHEN	10,798	1,916	17.7%	5,037	46.6%	322,440	3.3%

*Data are available in 2022 Q2 for the ID alert beginning May 26, 2022.

Table 2.10: Top 10 Drugs by Therapeutic Problem Type – Drug-Age (PA) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	AMITRIPTYLINE HCL	16,911	732	4.3%	11,389	67.3%	55,751	30.3%
2	DOXEPIN HCL	3,936	90	2.3%	2,319	58.9%	11,820	33.3%
3	PERPHENAZINE/ AMITRIPTYLINE HCL	31	7	22.6%	16	51.6%	33	93.9%
4	CODEINE PHOSPHATE/ GUAIFENESIN	23	1	4.3%	11	47.8%	13,716	0.2%
5	AMITRIPTYLINE/ CHLORDIAZEPOXIDE	3	1	33.3%	2	66.7%	8	37.5%
6	PSEUDOEPHED/CODEINE/ GUAIFEN	2	0	0.0%	0	0.0%	0	N/A
7	TETRACYCLINE HCL	2	0	0.0%	1	50.0%	2,137	0.1%
8	ACETAMINOPHEN WITH CODEINE	1	1	100.0%	0	0.0%	48,174	0.0%
[In 2022 Q2 there were PA alerts for only eight drugs]								

Table 2.11: Top 10 Drugs by Therapeutic Problem Type – High Dose (HD) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	ACETAMINOPHEN	39,150	9,048	23.1%	18,469	47.2%	403,824	9.7%
2	IBUPROFEN	26,594	1,335	5.0%	16,404	61.7%	836,732	3.2%
3	HYDROCODONE/ ACETAMINOPHEN	21,355	11,204	52.5%	5,365	25.1%	322,440	6.6%
4	OLANZAPINE	16,132	462	2.9%	11,551	71.6%	101,037	16.0%
5	ESCITALOPRAM OXALATE	14,580	461	3.2%	10,167	69.7%	193,871	7.5%
6	PROMETHAZINE/ DEXTROMETHORPHAN	13,041	467	3.6%	9,151	70.2%	138,148	9.4%
7	ZOLPIDEM TARTRATE	12,705	306	2.4%	7,464	58.7%	52,100	24.4%
8	CIPROFLOXACIN HCL/ DEXAMETH	8,370	293	3.5%	4,866	58.1%	10,882	76.9%
9	IPRATROPIUM BROMIDE	8,031	408	5.1%	4,761	59.3%	20,650	38.9%
10	ALBUTEROL SULFATE	6,547	346	5.3%	1,649	25.2%	672,609	1.0%

Table 2.12: Top 10 Drugs by Therapeutic Problem Type – Low Dose (LD) – 2022 Q2								
Rank	Drug	Total Claims with Alerts	Outcome Denied		Outcome Paid		Total Paid Claims	% Paid Claims with Alerts
			Total	%	Total	%		
1	DULOXETINE HCL	15,047	565	3.8%	9,972	66.3%	109,220	13.8%
2	ATORVASTATIN CALCIUM	13,462	419	3.1%	9,420	70.0%	715,476	1.9%
3	DIVALPROEX SODIUM	12,291	463	3.8%	8,722	71.0%	94,207	13.0%
4	BUPROPION HCL	12,223	633	5.2%	8,455	69.2%	182,351	6.7%
5	LITHIUM CARBONATE	11,041	488	4.4%	7,706	69.8%	35,958	30.7%
6	NITROGLYCERIN	6,769	205	3.0%	4,506	66.6%	18,863	35.9%
7	METRONIDAZOLE	4,887	304	6.2%	2,593	53.1%	96,697	5.1%
8	LORAZEPAM	4,571	624	13.7%	2,730	59.7%	82,142	5.6%
9	ACYCLOVIR	4,473	211	4.7%	3,033	67.8%	55,545	8.1%
10	CLINDAMYCIN HCL	4,244	212	5.0%	2,897	68.3%	48,149	8.8%

Date Source: MMA ca_ca_531_q_20220706000138.xlsx Report

Tables 3.1 – 3.3 Summary of High Cumulative Dose (HC) Alert.

The following tables provides greater detail for the HC alert, which is generated when there is greater than 90 morphine milligram equivalent (MME) per day on a single claim or across multiple claims.

Table 3.1: Medi-Cal Rx HC Alert Summary – 2022 Q2						
Total Opioid Claims	No HC Alert	% Change from *Prior Quarter*	HC Alert	% Change from *Prior Quarter*	Total	% Change from *Prior Quarter*
Paid	509,753	**2.1%**	13,380	**5.3%**	523,133	**2.1%**
Denied	185,402	**-31.4%**	78,472	**-31.2%**	263,874	**-31.3%**
Reversed	196,741	**17.3%**	4,236	**-13.4%**	200,977	**16.4%**
Total*	891,920	**-4.9%**	96,089	**-27.0%**	988,009	**-7.6%**

*Includes 25 rejected claims

Data Source: MMA MME All Claims Q1Q22022 20220727

Table 3.2: Medi-Cal Rx Opioid Claims MME Summary – 2022 Q2						
	Total Opioid Claims – Individual Claims					
	≤ 90 MME/day	% Change from *Prior Quarter*	90 – 500 MME/day	% Change from *Prior Quarter*	90 – 500 MME/day	% Change from *Prior Quarter*
Paid	515,463	**2.2%**	7,587	**0.1%**	83	**-16.2%**
Denied	224,962	**-30.9%**	38,486	**-33.6%**	426	**-26.8%**
Reversed	198,379	**17.0%**	2,545	**-16.7%**	53	**-10.2%**
Total*	938,829	**-6.1%**	48,618	**-29.1%**	562	**-24.1%**

*Includes 25 rejected claims

Data Source: MMA MME All Claims Q1Q22022 20220727

Table 3.3: Summary of Drugs by High Cumulative MME (HC) – 2022 Q2									
Drug	Total Submitted Claims	Claims with HC Alerts						Total Paid Claims	% Paid Claims with HC Alert
		Total	%	Outcome Denied		Outcome Paid			
				Total	%	Total	%		
HYDROCODONE/ ACETAMINOPHEN	507,483	11,370	2.2%	9,690	85.2%	1,276	11.2%	287,832	0.4%
TRAMADOL HCL	124,766	1,096	0.9%	959	87.5%	118	10.8%	74,681	0.2%
OXYCODONE HCL/ ACETAMINOPHEN	101,301	13,339	13.2%	11,677	87.5%	1,289	9.7%	51,662	2.5%
OXYCODONE HCL	94,433	30,651	32.5%	24,621	80.3%	4,576	14.9%	38,474	11.9%
ACETAMINOPHEN WITH CODEINE	83,953	406	0.5%	380	93.6%	23	5.7%	45,445	0.1%
MORPHINE SULFATE	34,088	15,629	45.8%	12,563	80.4%	2,346	15.0%	13,488	17.4%
HYDROMORPHONE HCL	13,054	6,578	50.4%	5,507	83.7%	840	12.8%	4,456	18.9%
METHADONE HCL	12,837	9,465	73.7%	7,273	76.8%	1,654	17.5%	3,267	50.6%
FENTANYL	5,791	4,681	80.8%	3,494	74.6%	856	18.3%	1,475	58.0%
TAPENTADOL HCL	2,235	1,363	61.0%	1,119	82.1%	186	13.6%	443	42.0%
BUTALBIT/ACETAMIN/ CAFF/CODEINE	1,922	40	2.1%	36	90.0%	4	10.0%	376	1.1%
TRAMADOL HCL/ ACETAMINOPHEN	1,830	0	0.0%					349	0.0%
OXYCODONE MYRISTATE	1,281	732	57.1%	571	78.0%	119	16.3%	396	30.1%
HYDROCODONE BITARTRATE	950	187	19.7%	141	75.4%	28	15.0%	318	8.8%
CODEINE/BUTALBITAL/ ASA/CAFFEIN	602	2	0.3%	2	100.0%	0	0.0%	169	0.0%
HYDROCODONE/ IBUPROFEN	408	37	9.1%	33	89.2%	3	8.1%	102	2.9%
OXYMORPHONE HCL	359	308	85.8%	239	77.6%	37	12.0%	65	56.9%
CODEINE SULFATE	281	0	0.0%					44	0.0%
BUTORPHANOL TARTRATE	147	39	26.5%	34	87.2%	3	7.7%	47	6.4%
LEVORPHANOL TARTRATE	140	110	78.6%	94	85.5%	12	10.9%	26	46.2%
OPIUM/BELLADONNA ALKALOIDS	61	16	26.2%	16	100.0%	0	0.0%	1	0.0%
FENTANYL CITRATE	30	30	100.0%	22	73.3%	7	23.3%	7	100.0%
PENTAZOCINE HCL/NALOXONE HCL	24	10	41.7%	1	10.0%	3	30.0%	10	30.0%
DHCODEINE BT/ ACETAMINOPHN/CAFF	19	0	0.0%					0	0.0%
MEPERIDINE HCL	13	0	0.0%					0	0.0%
MEPERIDINE HCL/PF	1	0	0.0%					0	0.0%
Total	***988,009***	***96,089***	***9.7%***	***78,472***	***81.7%***	***13,380***	***13.9%***	***523,133***	***2.6%***

Data Source: MMA MME All Claims Q1Q22022 20220727

Table 4. Summary of Medi-Cal Rx Pharmacy Utilization.

This table shows pharmacy utilization in Medi-Cal Rx, including the percent change from the prior quarter and prior-year quarter.

Table 4: Medi-Cal Rx Pharmacy Utilization Measures					
Category	Current Quarter 2022 Q2	Prior Quarter 2022 Q1	Prior-Year Quarter 2021 Q2	% Change from *Prior Quarter*	% Change from *Prior-Year Quarter*
Total Eligible Beneficiaries	15,565,839	15,441,176	14,851,057	**0.8%**	**4.8%**
Total Utilizing Beneficiaries	4,814,192	4,822,082	4,312,916	**-0.2%**	**11.6%**
Total Paid Rx Claims	28,110,280	27,355,057	24,819,069	**2.8%**	**13.3%**
Average Paid Rx Claims per Day	308,904	303,945	272,737	**1.6%**	**13.3%**
Average Paid Rx Claims per Eligible Beneficiary	1.81	1.77	1.67	**1.9%**	**8.1%**
Average Paid Rx Claims per Utilizing Beneficiary	5.84	5.67	5.75	**2.9%**	**1.5%**

Data Source: Magellan Medicaid Administration (MMA) First Rx Systems – Claims Processed Reports

Table 5. Medi-Cal Rx Pharmacy Utilization by Age Group.

This table presents pharmacy utilization data in Medi-Cal Rx, broken out by age group, including the percent change from the prior quarter and prior-year quarter.

Table 5: Medi-Cal Rx Pharmacy Utilization by Age Group						
Age Group (years)	Current Quarter 2022 Q2 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	2,267,323	**13.3%**	**75.3%**	784,907	**7.3%**	**59.8%**
13 – 18	1,475,467	**-1.5%**	**20.5%**	421,087	**-9.2%**	**8.4%**
19 – 39	6,693,597	**2.7%**	**16.7%**	1,403,636	**-5.4%**	**2.2%**
40 – 64	14,374,636	**2.0%**	**12.0%**	1,671,565	**0.3%**	**8.3%**
65+	3,300,730	**-0.8%**	**-11.5%**	533,042	**3.6%**	**3.2%**
Total*	28,111,753	**2.4%**	**13.3%**	4,814,237	**-1.0%**	**11.6%**

Data Source: Magellan Medicaid Administration (MMA) Pharmacy Utilization by Age Reports

Table 6. Top 20 Drug Therapeutic Categories in Medi-Cal Rx.

This table presents utilization of the top 20 drug therapeutic categories in Medi-Cal Rx, 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 6: Top 20 Drug Therapeutic Categories by *Total Utilizing Beneficiaries*

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2022 Q2 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 Total Utilizing Beneficiaries *Prior-Year Quarter*
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	1,159,253	**6.9%**	**21.7%**	854,746	17.8%	**7.6%**	**23.8%**
2	3	ANTIHYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB(STATINS)	956,919	**-1.6%**	**5.5%**	582,887	12.1%	**3.1%**	**12.3%**
3	5	ANTIHISTAMINES - 2ND GENERATION	805,762	**10.7%**	**21.6%**	525,244	10.9%	**11.9%**	**28.9%**
4	7	PENICILLIN ANTIBIOTICS	560,345	**14.4%**	**47.9%**	495,050	10.3%	**14.2%**	**46.2%**
5	4	VITAMIN D PREPARATIONS	760,457	**5.2%**	**-4.1%**	436,231	9.1%	**2.4%**	**-0.2%**
6	12	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	673,325	**-5.4%**	**31.9%**	414,149	8.6%	**-4.5%**	**36.9%**
7	6	ANTICONVULSANTS	976,845	**1.0%**	**8.2%**	392,777	8.2%	**2.5%**	**7.7%**
8	8	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	771,045	**1.7%**	**11.7%**	366,695	7.6%	**2.4%**	**10.8%**
9	10	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	587,743	**-0.4%**	**6.9%**	358,772	7.5%	**3.7%**	**13.5%**
10	9	PROTON-PUMP INHIBITORS	597,309	**0.8%**	**4.6%**	348,545	7.2%	**2.3%**	**8.9%**
11	24	ANALGESIC/ANTIPYRETICS,NON-SALICYLATE	402,991	**14.5%**	**77.8%**	330,964	6.9%	**13.8%**	**77.1%**
12	11	PLATELET AGGREGATION INHIBITORS	585,108	**0.9%**	**-2.8%**	326,087	6.8%	**3.1%**	**3.9%**
13	13	ANTIHYPERTENSIVES, ACE INHIBITORS	528,132	**-3.3%**	**-1.0%**	318,190	6.6%	**1.4%**	**5.5%**
14	15	LAXATIVES AND CATHARTICS	534,711	**10.8%**	**17.6%**	303,582	6.3%	**9.7%**	**17.7%**
15	N/A	DIAGNOSTIC TEST DEVICES AND SUPPLIES	389,164	**48.5%**	**N/A**	300,044	6.2%	**50.1%**	**N/A**
16	14	TOPICAL ANTI-INFLAMMATORY STEROIDAL	420,884	**5.3%**	**11.5%**	296,895	6.2%	**6.2%**	**11.7%**
17	19	NASAL ANTI-INFLAMMATORY STEROIDS	400,677	**11.9%**	**28.3%**	286,002	5.9%	**11.9%**	**32.9%**
18	17	CALCIUM CHANNEL BLOCKING AGENTS	465,255	**-2.2%**	**4.7%**	273,926	5.7%	**1.9%**	**10.0%**
19	22	ANTIEMETIC/ANTIVERTIGO AGENTS	356,201	**12.5%**	**32.6%**	268,093	5.6%	**12.9%**	**33.7%**
20	2	COVID-19 VACCINES	262,623	**-69.2%**	**-73.9%**	243,677	5.1%	**-67.3%**	**-63.9%**

Data Source: Magellan Medicaid Administration (MMA) Top 20 Therapeutic Class Reports

Table 7. Top 20 Drugs in Medi-Cal Rx.

This table presents the utilization of the top 20 drugs in Medi-Cal Rx, 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 7: Top 20 Drugs by *Total Utilizing Beneficiaries*

Rank	Last Year Rank	Drug Description	Current Quarter 2022 Q2 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	834,466	**7.6%**	**27.8%**	671,963	14.0%	**8.4%**	**29.1%**
2	3	ATORVASTATIN CALCIUM	714,896	**-1.6%**	**6.8%**	440,124	9.1%	**3.2%**	**13.6%**
3	5	ALBUTEROL SULFATE	671,139	**-5.4%**	**32.2%**	415,110	8.6%	**-4.4%**	**37.5%**
4	10	AMOXICILLIN	404,240	**15.3%**	**49.4%**	366,292	7.6%	**15.4%**	**48.3%**
5	4	METFORMIN HCL	587,743	**-0.4%**	**6.9%**	358,772	7.5%	**3.7%**	**13.5%**
6	17	ACETAMINOPHEN	402,991	**14.5%**	**77.8%**	330,964	6.9%	**13.8%**	**77.1%**
7	12	FLUTICASONE PROPIONATE	473,104	**8.6%**	**28.4%**	320,773	6.7%	**9.1%**	**32.7%**
8	6	ASPIRIN	527,668	**1.4%**	**-3.9%**	311,071	6.5%	**3.3%**	**3.1%**
9	N/A	COVID-19 ANTIGEN TEST	389,164	**48.5%**	**N/A**	300,044	6.2%	**50.1%**	**N/A**
10	8	LORATADINE	454,431	**6.3%**	**10.5%**	296,862	6.2%	**7.3%**	**17.1%**
11	7	CHOLECALCIFEROL (VITAMIN D3)	458,743	**8.7%**	**-7.9%**	270,690	5.6%	**3.0%**	**-5.1%**
12	11	LISINOPRIL	431,633	**-3.0%**	**0.2%**	260,173	5.4%	**1.7%**	**7.0%**
13	15	AMLODIPINE BESYLATE	404,537	**-2.3%**	**4.8%**	241,864	5.0%	**2.0%**	**10.4%**
14	13	BLOOD SUGAR DIAGNOSTIC	400,142	**-1.5%**	**-1.4%**	239,822	5.0%	**0.3%**	**2.7%**
15	14	OMEPRAZOLE	388,541	**-0.8%**	**-0.1%**	235,601	4.9%	**1.2%**	**5.5%**
16	16	GABAPENTIN	446,362	**2.0%**	**7.9%**	227,204	4.7%	**3.1%**	**7.5%**
17	25	CETIRIZINE HCL	315,740	**16.0%**	**39.0%**	219,249	4.6%	**17.5%**	**48.2%**
18	21	CEPHALEXIN	202,738	**12.1%**	**15.3%**	186,251	3.9%	**12.1%**	**13.9%**
19	18	HYDROCODONE/ ACETAMINOPHEN	322,514	**3.5%**	**5.3%**	184,568	3.8%	**2.9%**	**-1.0%**
20	22	LOSARTAN POTASSIUM	301,760	**-1.2%**	**9.1%**	181,741	3.8%	**3.3%**	**15.6%**

Data Source: Magellan Medicaid Administration (MMA) Top 20 Drug Reports

MEDI-CAL FEE-FOR-SERVICE PROGRAM
PHYSICIAN-ADMINISTERED DRUGS
CALENDAR YEAR 2021

This is a summary of physician-administered drug utilization among Medi-Cal Fee-for-Service enrollees who were certified as eligible beneficiaries during the 2021 calendar year. These tables no longer include claims from the Family Planning, Access, Care, and Treatment (Family PACT) program, as Family PACT uses presumptive eligibility and has restrictions on allowable drugs that differ from the Medi-Cal Fee-for-Service program.

In order to show changes in utilization over time, **Table 1** shows the comparison to the prior year (2020).

Table 1: Utilization of Physician-Administered Drugs

Total Utilizing Beneficiaries			Total Paid Claims			Total Reimbursement Dollars Paid		
2021	2020	% Change	2021	2020	% Change	2021	2020	% Change
1,462,312	1,357,421	**7.7%**	2,383,081	2,129,804	**11.9%**	$167,896,167	$155,290,342	**8.1%**

The top 20 physician-administered drugs are presented by total utilizing beneficiaries (**Table 2**), total reimbursement dollars paid (**Table 3**), and reimbursement paid per utilizing beneficiary (**Table 4**). For reference, a comparison to the prior year (2020) and the prior-year ranking are included to show change over time.

Table 2: Top 20 Physician-Administered Drugs by *Total Utilizing Beneficiaries*							
Rank	Last Year Rank	HCPCS Code	Drug Description	2021 Total Utilizing Beneficiaries	% Change Total Utilizing Beneficiaries from 2020	2021 Total Reimbursement Dollars Paid	2021 Total Paid Claims
1	1	J7030	0.9 % SODIUM CHLORIDE	70,263	**1.1%**	$616,989	90,313
2	2	J1885	KETOROLAC TROMETHAMINE	67,426	**1.5%**	$343,593	79,464
3	3	J2405	ONDANSETRON HCL/PF	64,063	**11.2%**	$279,118	80,232
4	4	Z7610	ACETAMINOPHEN	55,343	**-2.2%**	$423,431	65,576
5	5	Z7610	IBUPROFEN	37,262	**-11.8%**	$282,400	40,278
6	6	J2270	MORPHINE SULFATE	29,675	**7.9%**	$234,898	36,302
7	7	Z7610	HYDROCODONE/ ACETAMINOPHEN	28,600	**4.5%**	$263,253	32,504
8	9	90670	PNEUMOC 13-VAL CONJ-DIP CRM/PF	28,480	**21.8%**	$449,387	34,840
9	8	J0696	CEFTRIAXONE SODIUM	26,830	**2.2%**	$152,464	30,956
10	12	Q9967	IOHEXOL	25,102	**26.7%**	$229,750	28,080
11	15	J7120	RINGER'S SOLUTION, LACTATED	21,893	**17.0%**	$175,074	26,108
12	14	J3010	FENTANYL CITRATE/PF	21,767	**11.6%**	$86,696	26,921
13	13	Z7610	ONDANSETRON	20,186	**3.3%**	$191,886	21,975
14	22	Q9967	IOPAMIDOL	19,359	**30.8%**	$195,182	21,777
15	10	S0191	MISOPROSTOL	19,329	**-11.8%**	$52,354	19,953
16	16	J1100	DEXAMETHASONE SODIUM PHOSPHATE	18,933	**3.4%**	$111,523	27,675
17	11	S0190	MIFEPRISTONE	18,897	**-7.9%**	$1,231,737	19,334
18	17	J1200	DIPHENHYDRAMINE HCL	17,659	**1.1%**	$99,117	27,688
19	21	90715	DIPHTH,PERTUSS (ACELL),TET VAC	16,889	**9.9%**	$548,490	16,875
20	23	J2704	PROPOFOL	16,647	**16.2%**	$109,994	21,417

Table 3: Top 20 Physician-Administered Drugs by *Total Reimbursement Dollars Paid*							
Rank	Last Year Rank	HCPCS Code	Drug Description	2021 Total Reimbursement Dollars Paid	% Change Total Reimbursement Dollars from 2020	2021 Total Utilizing Beneficiaries*	2021 Total Paid Claims*
1	32	J7189	COAGULATION FACTOR VIIA,RECOMB	$12,970,520	**> 100%**	< 20	135
2	1	J3399	ONASEMNOGENE ABEPARVOVEC-XIOI	$9,835,607	**8.4%**	< 20	< 20
3	2	J7307	ETONOGESTREL	$7,280,350	**-8.7%**	2,094	2,094
4	3	J9306	PERTUZUMAB	$6,468,914	**-18.4%**	252	4,586
5	7	J9271	PEMBROLIZUMAB	$6,410,614	**23.6%**	333	2,112
6	5	Q4081	EPOETIN ALFA	$4,763,197	**-15.9%**	3,601	158,408
7	10	J9299	NIVOLUMAB	$3,990,989	**21.7%**	185	1,586
8	6	J2505	PEGFILGRASTIM	$3,763,949	**-33.5%**	649	1,950
9	9	J7298	LEVONORGESTREL	$3,468,480	**-8.4%**	1,046	1,048
10	11	J9354	ADO-TRASTUZUMAB EMTANSINE	$2,756,733	**-10.8%**	76	996
11	13	J2326	NUSINERSEN SODIUM/PF	$2,710,557	**32.9%**	< 20	52
12	4	J9355	TRASTUZUMAB	$2,569,767	**-58.2%**	149	997
13	8	J9035	BEVACIZUMAB	$2,443,450	**-42.7%**	1,296	3,913
14	24	Q2041	AXICABTAGENE CILOLEUCEL	$2,342,027	**57.0%**	< 20	< 20
15	19	J9229	INOTUZUMAB OZOGAMICIN	$2,308,328	**34.8%**	< 20	132
16	12	J7300	INTRAUTERINE COPPER DEVICE	$2,058,395	**-8.0%**	666	669
17	21	J1303	RAVULIZUMAB-CWVZ	$2,033,272	**21.2%**	< 20	131
18	126	J9144	DARATUMUMAB-HYALURONIDASE-FIHJ	$1,981,675	**> 100%**	77	752
19	N//A	J3398	VORETIGENE NEPARVOVEC-RZYL	$1,961,108	**N/A**	< 20	< 20
20	15	J0897	DENOSUMAB	$1,842,898	**0.4%**	1,044	2,599

*Cells with numbers less than 20 have been changed for privacy

Table 4: Top 20 Physician-Administered Drugs by ***Reimbursement Paid per Utilizing Beneficiary***							
Rank	**Last Year Rank**	**HCPCS Code**	**Drug Description**	**2021 Reimbursement Dollars Paid per Utilizing Beneficiary**	**% Change Reimbursement Dollars Paid per Utilizing Beneficiary from 2020**	**2021 Total Paid Claims***	**2021 Total Utilizing Beneficiaries***
1	1	J3399	ONASEMNOGENE ABEPARVOVEC-XIOI	$1,967,121	**-34.9%**	< 20	< 20
2	N/A	J1322	ELOSULFASE ALFA	$1,089,032	**N/A**	73	< 20
3	17	J7189	COAGULATION FACTOR VIIA,RECOMB	$682,659	**> 100%**	135	< 20
4	N/A	J3398	VORETIGENE NEPARVOVEC-RZYL	$653,703	**N/A**	< 20	< 20
5	4	Q2042	TISAGENLECLEUCEL	$441,004	**4.0%**	< 20	< 20
6	3	J1743	IDURSULFASE	$439,709	**-39.1%**	44	< 20
7	5	Q2041	AXICABTAGENE CILOLEUCEL	$390,338	**4.6%**	< 20	< 20
8	9	J1303	RAVULIZUMAB-CWVZ	$254,159	**51.5%**	131	< 20
9	8	J2326	NUSINERSEN SODIUM/PF	$225,880	**-11.4%**	52	< 20
10	11	J0222	PATISIRAN SODIUM, LIPID COMPLEX	$152,625	**0.4%**	80	< 20
11	14	J3590	ASPARAGINASE ERWINIA-RYWN	$132,486	**46.2%**	< 20	< 20
12	12	J9229	INOTUZUMAB OZOGAMICIN	$128,240	**19.8%**	132	< 20
13	N/A	C9073	BREXUCABTAGENE AUTOLEUCEL	$93,251	**N/A**	< 20	< 20
14	N/A	J7201	FACTOR IX REC, FC FUSION PROTN	$88,878	**N/A**	20	< 20
15	18	J9039	BLINATUMOMAB	$82,611	**33.9%**	150	< 20
16	16	J9204	MOGAMULIZUMAB-KPKC	$81,675	**11.0%**	43	< 20
17	N/A	A9513	LUTETIUM LU 177 DOTATATE	$67,789	**N/A**	20	< 20
18	86	J7183	ANTIHEMOPHILIC FACTOR/VWF	$62,693	**> 100%**	< 20	< 20
19	45	J9315	ROMIDEPSIN	$60,255	**> 100%**	40	< 20
20	7	J7205	ANTIHEMOPH.FVIII REC,FC FUSION	$54,565	**-80.6%**	46	< 20

*Cells with numbers less than 20 have been changed for privacy

MEDI-CAL DRUG USE REVIEW (DUR) PROGRAM
QUARTERLY EVALUATION REPORT – 2nd Quarter 2022

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 articles published between April 2020 and June 2020:

- Drug Safety Communication: Withdrawal of All Ranitidine Products – April 2020
- Improving Quality of Care: Update of Risks Associated with Use of Fluoroquinolones – April 2020
- Clinical Guideline: Reproductive Health in Rheumatic and Musculoskeletal Diseases – May 2020

Evaluation of Educational Articles

Drug Safety Communication: Withdrawal of All Ranitidine Products – April 2020

- **Background:** On April 1, 2020, the U.S. Food and Drug Administration (FDA) requested a manufacturer's market withdrawal of ranitidine because FDA laboratory testing results showed that levels of a compound called N-nitrosodimethylamine (NDMA) may increase to unacceptable levels over time when stored at higher than room temperature. NDMA is an environmental contaminant that is found in water and foods, including dairy products, vegetables, and grilled meats. Its classification as a probable carcinogen is based on animal studies; studies in humans are very limited. While the FDA did not observe unacceptable levels of NDMA in any ranitidine products, the decision was made that ranitidine products should not be available to consumers unless quality can be assured. All ranitidine products, including the oral liquid/syrup, were withdrawn by their manufacturers and are no longer available in the U.S.

- **Purpose:** The purpose of this evaluation is to review FDA safety communications regarding ranitidine since the publication of the original article and to describe any relevant updates.

- **Data Criteria and Findings:** Since the publication of this educational article, there has been no additional action taken by the FDA regarding ranitidine. However, following the withdrawal of ranitidine from the market, the Division of Applied Regulatory Sciences (DARS) within the Center for Drug Evaluation and Research (CDER) conducted a randomized, placebo-controlled clinical trial and an in-vitro study to determine if ranitidine could convert to NDMA in humans. The results from both studies found that ranitidine did not convert to NDMA in humans. In 2021, the prior article that had reported elevated NDMA excretion after ingestion of ranitidine was retracted by the authors due to potentially unreliable measurements. Although ranitidine products are unavailable at this time, the FDA noted in their original statement that if a company can provide evidence that their ranitidine product is stable and the amount of NDMA does not increase to unsafe levels over time, the FDA may consider allowing that ranitidine product back on the U.S. market.

- **Analysis:** To date, FDA testing has not found NDMA in similar medications such as famotidine, cimetidine, esomeprazole, lansoprazole, or omeprazole**.** In 2021, a new over-the-counter (OTC) product was approved with famotidine as the active ingredient.

- **Limitations:** None.

- **Research/Policy Recommendations:**
  1. Continue to monitor research and FDA communications regarding ranitidine and other histamine-2 receptor antagonists (H2RAs).
  2. Continue to periodically evaluate use of H2RAs within the Medi-Cal population.

- **Clinical Recommendations:**
  1. Providers should advise patients about alternative options to ranitidine that are available. There are multiple drugs approved for the same or similar uses as ranitidine that do not carry the same risks from NDMA. To date, the FDA's testing has not found NDMA in famotidine, cimetidine, esomeprazole, lansoprazole, or omeprazole.
  2. Health care professionals should be aware of a new OTC product (Zantac 360) approved with famotidine as the active ingredient. This should not be confused with the product with a similar name (Zantac) that contained ranitidine.

- **Board Recommendation:**
  1. No recommendations at this time.

Improving Quality of Care: Update of Risks Associated with Use of Fluoroquinolones – April 2020

- **Background:** Fluoroquinolones are broad-spectrum antibiotics that are FDA-approved to treat various bacterial infections, including infections caused by gram-negative bacilli. Over the last decade, the FDA has issued multiple drug safety communications highlighting potential adverse events associated with use of fluoroquinolones. Due to safety concerns, fluoroquinolones should not be prescribed to community-dwelling patients who have other treatment options for acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis, and uncomplicated urinary tract infection (UTI), as the risks outweigh the benefits. 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 that fluoroquinolones should be initiated only after other antibiotic classes have been tried and failed, or in cases of demonstrated drug resistance. Approximately two-thirds (n = 17,024; 57%) of fluoroquinolone use during November 1, 2018, and October 31, 2019, appeared to be potentially inappropriate based on the new FDA recommendations, with 2,092 beneficiaries (7%) having a primary or secondary diagnosis of acute bacterial exacerbation of chronic bronchitis, a total of 4,679 beneficiaries (16%) with acute sinusitis, and 10,253 beneficiaries (34%) with an uncomplicated UTI.

- **Purpose:** The purpose of this evaluation is to review use of fluoroquinolones in the Medi-Cal population since the publication of the original article and describe any relevant updates.

- **Data Criteria and Findings:** For this evaluation, the same inclusion/exclusion criteria as the original article were followed, with the measurement year updated to include dates of service from November 1, 2020, through October 31, 2021.

Medi-Cal population	Article data: 11/1/18 – 10/31/19	Evaluation data: 11/1/20 – 10/31/21	Percent change
Community-dwelling Medi-Cal fee-for-service beneficiaries with at least one paid claim for a fluoroquinolone during the measurement year (excluding those with a history of penicillin or other drug allergy that would impact the use of fluoroquinolones as a first-line therapy)	***29,876***	***20,886***	***-30.1%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate based on FDA recommendations	57.0%	8.4%	***-48.6%***

Percentage of fluoroquinolone use that appeared to be potentially inappropriate for uncomplicated UTI	34.3%	6.8%	***-27.5%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate for acute sinusitis	15.7%	0.9%	***-14.8%***
Percentage of fluoroquinolone use that appeared to be potentially inappropriate for acute bacterial exacerbation of chronic bronchitis	7.0%	0.6%	***-6.4%***

To address the continued use of fluoroquinolones prescribed for uncomplicated UTI, educational outreach letters were mailed by the DUR program on July 10, 2020. The letter was sent to 136 prescribers that had prescribed fluoroquinolones for an uncomplicated UTI to at least two Medi-Cal FFS community-dwelling beneficiaries since January 1, 2020. Each letter included the updated Medi-Cal DUR article on fluoroquinolones and a provider response survey.

Within six months following the mailing, paid claims for fluoroquinolones prescribed to community-dwelling patients for uncomplicated UTI decreased by 47.9% for those prescribers. During this same period, paid claims decreased significantly less for nitrofurantoin monohydrate/macrocrystals (decreased by 5.8%) and trimethoprim/sulfamethoxazole (decreased by 4.9%). Further, a total of 36 prescribers (26.4%) had no paid claims for fluoroquinolones for any reason. The response rate (within 90 days) was 7%, and the returned mail rate was 5%.

- **Analysis:** While the eligible Medi-Cal FFS population decreased by 3% between November 2018 and November 2020, there was a 30% decrease in community-dwelling FFS beneficiaries being prescribed a fluoroquinolone during the measurement year. In addition, the potentially inappropriate use of fluoroquinolones decreased from 57% to 8%, with the most significant decreases seen in potentially inappropriate fluoroquinolone use that appeared to be for uncomplicated UTI.

  A preliminary review of Medi-Cal Rx data shows this trend has continued into 2022, with only 519 FFS beneficiaries identified with potentially inappropriate use of fluoroquinolones for sinusitis, bronchitis, or uncomplicated UTI out of 6,396 beneficiaries with a paid claim for a fluoroquinolone between January 1, 2022, and June 30, 2022, or 8% (the same percentage seen in the analysis above). Of note, during this same period in 2022, the Medi-Cal MCO population had 6,561 beneficiaries identified with potentially inappropriate use of fluoroquinolones for sinusitis, bronchitis, or uncomplicated UTI out of 51,870 beneficiaries with a paid claim for a fluoroquinolone, or 13%. This indicates

there may be future opportunities for educational outreach for MCO plans to address inappropriate prescribing.

- **Limitations:** None.

- **Research/Policy Recommendations:**
  1. Continue to monitor research and FDA communications regarding antibiotic stewardship and safety of fluoroquinolones.
  2. Continue periodic evaluation of appropriate prescribing of antibiotics in the Medi-Cal population.

- **Clinical Recommendations:**
  1. Fluoroquinolones should not be prescribed to community-dwelling patients who have other treatment options for acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis, and uncomplicated urinary tract infection (UTI), as the risks outweigh the benefits.
  2. Prescribers should consider patient-specific factors that may increase risk for fluoroquinolone toxicity, including potential drug-drug interactions, renal dysfunction, and patients of advanced age.
  3. Avoid fluoroquinolones in patients who have previously experienced serious adverse reactions associated with fluoroquinolones.
  4. Individuals who are prescribed a fluoroquinolone should be counseled on the potential for serious adverse effects, including tendinopathy, tendon rupture, peripheral neuropathy, severe hypoglycemia, CNS effects, and mental health side effects such as disturbances in attention, disorientation, agitation, nervousness, memory impairment and delirium.
  5. Fluoroquinolones should be discontinued if any serious side effects occur, and the treatment course should be completed with a non-fluoroquinolone antibacterial drug.
  6. Report side effects involving fluoroquinolones or other medications to the FDA MedWatch program. Adverse effect reports can be submitted to MedWatch online through the MedWatch Online Voluntary Reporting Form, available on the FDA website.
  7. Encourage patients to read the Medication Guide that they receive with their fluoroquinolone prescriptions.

- **Board Recommendations:**
  1. Continue to monitor antibiotic use in the Medi-Cal population and provide updates to the Board, as needed.

Clinical Guideline: Reproductive Health in Rheumatic and Musculoskeletal Diseases – May 2020

- **Background:** In April of 2020, the American College of Rheumatology (ACR) published the organization's first guideline on how to manage reproductive health issues in patients with rheumatic and musculoskeletal diseases (RMDs). The guideline reviews appropriate use of medications pre-conception, during pregnancy, and while breastfeeding. In addition, the guideline complements general practice guidelines for safe and effective contraception to prevent unplanned pregnancy, to engage in pre-pregnancy counseling, and for physicians and patients to have ongoing discussions regarding pregnancy.

- **Purpose:** The purpose of this evaluation is to review the literature and the ACR guidelines since the publication of the original article and to describe any relevant updates.

- **Data Criteria and Findings:** On June 24, 2022, the Supreme Court issued a decision in *Dobbs v. Jackson Women's Health Organization*, which overturned the constitutional right to have an abortion that was established in *Roe v. Wade*. At least 24 states have, or will soon have, bans on abortion that could expose rheumatology professionals, pharmacists and, in some cases, patients to harsh criminal and civil penalties. With abortifacient drugs, such as methotrexate, facing more scrutiny, access issues have emerged for rheumatology professionals who depend on these drugs to treat patients with rheumatic disease. On July 28, 2022, the ACR Statement on Access to Reproductive Healthcare was published, which asserts that rheumatology health professionals and patients should not face legal consequences for utilizing medically necessary care, that patients with RMDs must be able to access appropriate reproductive healthcare, and healthcare professionals must be allowed to provide evidence-based care that is in the best interest of their patients.

- **Analysis:** In patients with RMDs, pregnancy may lead to severe adverse maternal and fetal outcomes. Furthermore, it is difficult to avoid use of medications in patients with RMDs during pregnancy, as uncontrolled systemic inflammation may be associated with poor pregnancy outcomes. Since the *Dobbs v. Jackson Women's Health Organization* decision, concerning reports are emerging regarding patients with RMDs having disrupted access to methotrexate, including rheumatologists who have stopped renewing prescriptions for methotrexate and reported pharmacists refusing to fill prescriptions for methotrexate. It is important to point out these challenges are unique to women, as men with RMDs are unlikely to encounter the same challenges as women when attempting to fill a prescription for methotrexate.

- **Limitations:** None.

- **Research/Policy Recommendations:**
  1. Continue to monitor clinical practice guidelines related to appropriate use of medications.
  2. Continue to research issues regarding access to medications used in the treatment of RMDs among women of reproductive age in California.

- **Clinical Recommendations:**
  1. Health care professionals should follow recommended practice guidelines on how to manage reproductive health issues in patients with RMDs, including promotion of the following:
     a. Safe and effective contraception to prevent unplanned pregnancy,
     b. Pre-pregnancy counseling to encourage conception during periods of disease quiescence and while receiving pregnancy-compatible medications, and
     c. Ongoing physician-patient discussion with obstetrics/gynecology collaboration for all reproductive health issues
  2. To monitor disruptions to methotrexate access, patients and members of the rheumatology care team are being asked report access issues to the ACR at advocacy@rheumatology.org.

- **Board Recommendations:**
  1. Evaluate the use of methotrexate in the Medi-Cal population with RMDs before and after *Dobbs vs. Jackson* and provide updates to DHCS and the Board, as needed.