

Medicaid Physician & Managed Care Liaison Committee Meeting (MPMCLC)

Wednesday, July 29, 2015 from 10:00 AM - Noon
Conference Room 7A/B
600 East Broad St. Richmond, VA 23219

Meeting #5

AGENDA

I. Welcome & Introductions	Linda Nablo, Chief Deputy Director Department of Medical Assistance Services (DMAS)	10:00 am
II. Focus -- Increasing Provider Participation in the Medicaid Program	Committee Discussion	10:15 am
II. Update on Prior Authorization Legislation	Laura Lee Viergever Virginia Association of Health Plans	10:40 am
III. Proposed Managed Care Regulations	DMAS Staff	11:00 am
VI. Selection of FY 2016 MPMCLC Initiative(s)	Committee Discussion	11:15 am

Prior Authorization

MEDICAID PHYSICIANS AND MANAGED CARE LIAISON COMMITTEE

JULY 29, 2015

HB 1942/SB 1262 Summary

- HB 1942/SB 1242 originally required Virginia to develop a universal paper prior authorization form.
- Due to the advances in electronic prior authorization (ePA), this approach was discarded as obsolete.
 - NCPDP (National Council for Prescription Drug Programs) developed uniform standards for ePA.
 - Companies like SureScripts and CoverMyMeds are very accessible.
 - CoverMyMeds is no cost to providers and is web-based.

HB 1942/SB 1262 Summary (con't.)

HB 1942/SB 1262 requires health plan provider contracts to include provisions that:

1. Require the health plan, in a manner of its choosing, accept by telephone, fax, or electronic submission prior authorization requests for prescription drugs that are delivered from e-prescribing systems, electronic health records, or health information exchange platforms that utilize the National Council for Prescription Drug Programs' (NCPDP) SCRIPT standards;
2. Require the health plan communicate to the prescriber or designee within 24 hours of the submission of an urgent prior authorization request if submitted by telephone or whatever method directed by the health plan that the request is approved, denied, or further specific information is needed;
3. Require the health plan communicate to the prescriber or designee by telephone or fax or electronically within 2 business days of a regular, fully completed prior authorization request that the request is approved, denied, or further specific information is needed;
4. Require the health plan communicate to the prescriber or designee by telephone or fax or electronically within 2 business days of receipt of the additionally requested information that the prior authorization is approved or denied;

HB 1942/SB 1262 Summary (con't.)

5. Require if the prior authorization request is denied, the health plan communicates to the prescriber or designee telephonically, electronically, or by fax within the time frames established by 3 or 4, as applicable, the reasons for the denial;

6. Require prior authorization approved by another health plan be honored at least for the initial 30 days of an individual's prescription drug benefit coverage, subject to the current health plan's plan documents, upon the current health plan's receipt from the prescriber or designee documentation of the previous health plan's prior authorization approval;

7. Require the health plan to use a tracking system for all prior authorization requests and the identification information be provided electronically, telephonically, or by fax to the prescriber or designee, upon the health plan's response to the prior authorization request; and

8. Require the health plan's drug formularies, all drug benefits subject to prior authorization, all of the health plan's prior authorization procedures, and all the health plan's prior authorization request forms be made available through a central location on the health plan's website and that the information be updated within 7 days of approved changes.

Although the bill specifically excludes Medicaid business from the requirements, a budget amendment makes all of the provisions set out in the bill applicable to Medicaid business. As a result, the provisions of HB 1942/SB 1262 will be required for provider contracts entered into, amended, extended, or renewed on or after January 1, 2016, for Commercial business, and July 1, 2016, for Medicaid business.

HB 1942/SB 1262 Summary (con't.)

As part of HB 1942/SB 1262, VAHP, the Medical Society of Virginia (MSV), and the Virginia Academy of Family Physicians (VAFP) shall convene a work group to identify those prior authorization drug that are:

- the top 10 most frequently prescribed chronic disease management drugs,
- the top 10 most frequently prescribed mental health drugs,
- and generic drugs and
- common evidence-based parameters for approval by the health plans.

The work group is to report back to the Health Insurance Reform Commission and the Chairmen of the House and Senate Commerce and Labor Committees by July 1, 2016.

Prescription Drug Benefits 101

Building a Drug Formulary

- Health Plans develop drug formularies by using objective evaluations from independent physicians and pharmacies based foremost on clinical appropriateness.
 - Virginia law requires health plans to have a Pharmacy & Therapeutics Committee (P & T Committee) comprised of independent practicing physicians and pharmacies to develop plan drug formularies.
- Closed and/or Tiered formularies are tools health plans use to create efficiencies in the drug formularies.

Reasons for Prescription Drug Management

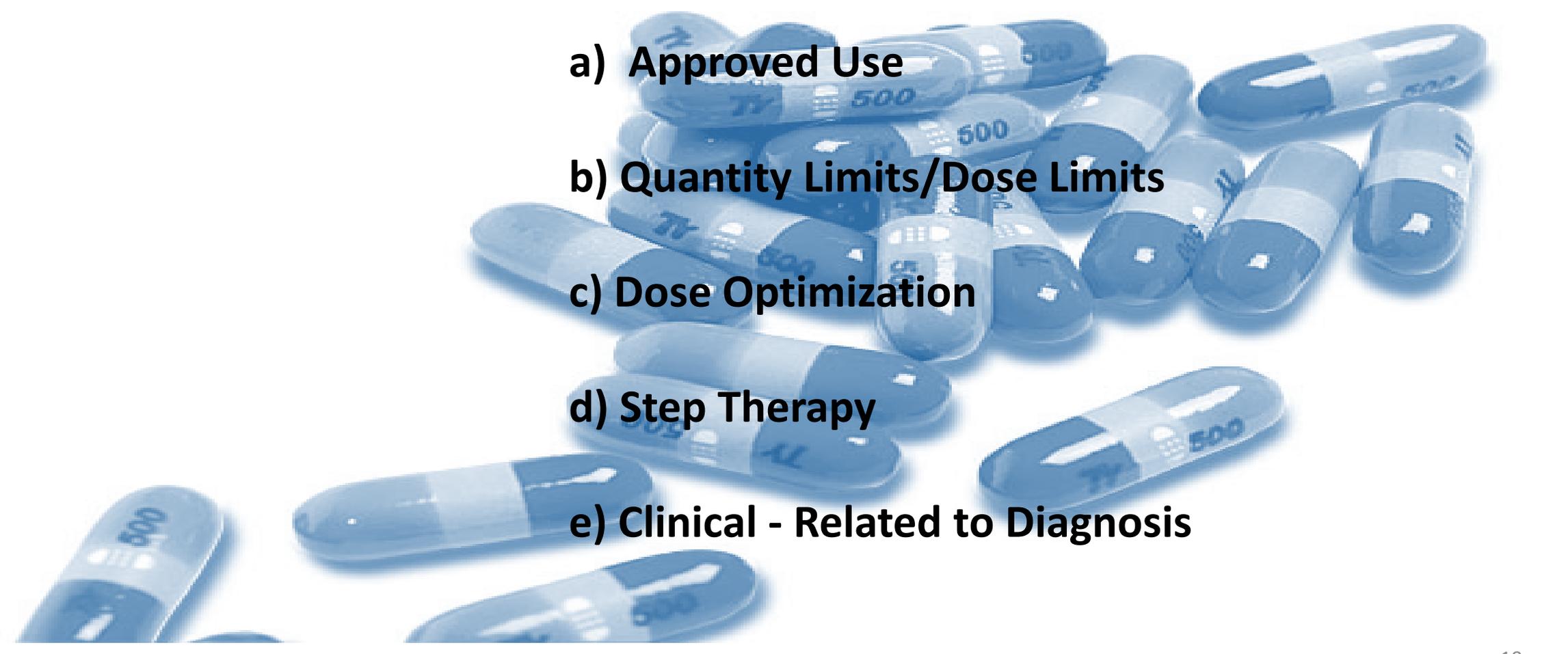
- Prescription drug costs represent more than 10% of the overall healthcare dollar.¹
- In 2014, spending on medications increased 13.1% due to the new high-cost therapies, brand-price inflation, and the use of compound medications.¹
- When reviewing the preliminary results of the health plan survey on the most prescribed drugs requiring prior authorization, many of the drugs are those that are advertised in a special effort to drive individuals to these higher cost drugs.

¹Express Scripts, “How We Build a Formulary,” June 25, 2015.

Why do health plans have Prior Authorization for prescription drugs?

- Patient safety
- Most effective/efficient level of care
- Cost
- Other reasons

Specific Reasons for Prior Authorization



a) **Approved Use**

b) **Quantity Limits/Dose Limits**

c) **Dose Optimization**

d) **Step Therapy**

e) **Clinical - Related to Diagnosis**

Preliminary Results of Plan Survey

Top Chronic Disease Drugs Requiring Prior Authorization

Drug Name	Prior Authorization Reasons (See Key)
1. Humira	a, b, d, e
2. Vyvanse	a, b, c, d, e
3. Abilify	a, b, c, d, e
4. Strattera	a, b, d, e
5. Methylphenidate	a, b, d, e
6. Androgel	b, d, e
7. Duloxetine	b, c, d
8. Nexium	c, e
9. Montelukast	b, d, e
10. Amphetamine	a, b, e
11. Latuda	a, b, d, e
12. Celebrex	d
13. Crestor	d
14. Oxycontin	a, b, c, e
15. Advair	a, d
16. Lyrica	a, b, d, e
17. Omeprazole	b

<p>Key</p> <p>a) Approved Use</p> <p>b) Quantity Limits/Dosage Limits</p> <p>c) Dose Optimization</p> <p>d) Step Therapy</p> <p>e) Clinical - Related to Diagnosis</p>

Top Mental Health Drugs Requiring Prior Authorization

Drug Name	Prior Authorization Reasons (See Key)
1. Vyvanse	a, b, c, d, e
2. Stattera	a, b, c, d, e
3. Methylphenidate	a, b, d, e
4. Duloxetine	b, c, d
5. Abilify	a, b, c, d, e
6. Focalin XR	a, b, c, d, e
7. Latuda	a, b, d, e
8. Amphetamine	a, b, d, e
9. Viibryd	b, d
10. Seroquel	a, b, d, e
11. Nuvigil	a, b, e

Key

- a) Approved Use
- b) Quantity Limits/Dosage Limits
- c) Dose Optimization
- d) Step Therapy
- e) Clinical - Related to Diagnosis

Top Generic Drugs Requiring Prior Authorization

Drug Name	Prior Authorization Reasons (See Key)
1. Buprenorphine	a, b, c, e
2. Duloxetine	b, c, d
3. Dextroamphetamine	a, b, d, e
4. Tretinoin	a, e
5. Amphetamine	a, b, d, e
6. Methylphenidate	a, b, d, e
7. Omeprazole	b
8. Montelukast	b, d, e
9. Fentanyl patch	b, e
10. Escitalopram	b, c
11. Quetiapine	a, b, c, e
12. Pantoprazole Sodium	b
13. Modafinil	a, b, e

<p>Key</p> <p>a) Approved Use</p> <p>b) Quantity Limits/Dosage Limits</p> <p>c) Dose Optimization</p> <p>d) Step Therapy</p> <p>e) Clinical - Related to Diagnosis</p>

Prior Authorization Requests

Top Reasons for Denied Prior Authorizations:

- Patient does not meet established clinical criteria.
- Incomplete information submitted by provider's office.
- Non-formulary Drug –comparable Preferred Drug on formulary.

Top Reasons for Overturns of Denied Prior Authorizations:

- Patient now meets established clinical criteria.
- Additional information submitted sufficient to authorize the drug.

Patient Safety

Why all Stakeholders should be engaged

Recent Express Scripts Study

Express Scripts conducted an in-depth examination of more than 36 million de-identified pharmacy claims from 6.8 million insured Americans of all ages who filled at least one prescription for an opioid to treat short term or longer-term pain from 2009 through 2013.

Several alarming statistics came out of this study that are relevant to why health plans require prior authorization for some prescription drugs.

Express Scripts Study Results

Patients Likely to Use Prescription Opiates Long-Term:

Nearly one half of patients who took opiate painkillers for more than 30 days in the first year of use continued to use them for three years or longer.

Almost 50% of those patients were taking only short-acting opioids, putting them at higher risk of addiction.

Express Scripts Study Results

Most Long-Term Opioid Users Take Dangerous Drug Combinations: Nearly 60% of patients using opioids were taking a combination of drugs that are dangerous and potentially fatal; among these mixtures, almost one in three patients were prescribed anti-anxiety drugs known as benzodiazepines along with an opioid – the most common cause of overdose deaths involving multiple drugs.

Express Scripts Study Results

A small number of physicians wrote a large number of prescriptions: 5% of opioid prescribers wrote 40% of narcotic prescriptions nationwide in 2011-2012, with family practice and internal medicine seeing some of the largest volume of high prescribers.

Out of the more than 500,000 prescribers whose practices were analyzed, only 385 were identified as pain specialists.

How Can Stakeholders Work Together?

- Patient education about prescription drug addiction and the risks of long-term (more than 30 days) opioid use.
- Physician education about proper prescribing of opioids and the use of pain management specialists for long-term pain.
- Better and more frequent use of the Prescription Monitoring Program (PMP) to identify those individuals at risk.

How Can Stakeholders Work Together?

- Patient Utilization Management & Safety (PUMS) programs (Lock-in programs).
- Collaborative initiatives involving physicians, health plans, hospitals, DMAS, and other interested stakeholders, focusing on drug diversion and proper treatment.
 - Collection of actionable, real-time data such as ER notes, PMP, and other patient health records to create a program identify and help direct care for both addicted individuals and those with chronic conditions to reduce the likelihood of addiction.
 - Use of data to measure success in established program goals.





CMS *Proposed* Rules for Medicaid Managed Care

**DMAS Comments
Presented to the
MPMCLC
July 29, 2015**

BACKGROUND

- o On May 26, the Centers for Medicare & Medicaid Services (CMS) released a notice of *proposed* rulemaking (NPRM) that, once adopted as final regulation, represents the first major update to the rules governing Medicaid managed care since 2002

BACKGROUND

- o The *proposed* rule, all 653 pages, impacts managed care delivery for both Medicaid and Children's Health Insurance Program (CHIP)
- o Seeks to align the rules governing Medicaid managed care with those of other sources of health insurance coverage such as Medicare Advantage and Qualified Health Plan (public Exchange) as beneficiaries may move across these programs

PROPOSED RULE

- o Modernizes managed care regulations to update the programs' rules and strengthen the delivery of quality care for beneficiaries
- o Includes several new and significant provisions intended by CMS to address the significant growth in Medicaid managed care enrollment, the accelerating transition to managed care for Medicaid beneficiaries with special health care needs (such as dual eligible members and those with long-term care needs), and the ACA's Medicaid coverage expansion and insurance market reforms

VIRGINIA HISTORY

- DMAS has been delivering health care services to Medicaid beneficiaries through a managed care system since 1996
- The primary delivery system is our statewide 1915(b) mandatory managed care program known as Medallion 3.0 and covers over 750,000 beneficiaries (including TANF, ABDs and Foster Care) through six health plans, three of which are national plans, and three are regional plans owned by health systems
- Virginia was the third state to implement the dual eligible demonstration project (CCC) that covers almost 30,000 enrollees in five regions across the state with three health plans
- We will be moving towards the development and implementation of Managed Long-Term Supports and Services (MLTSS) within the next two years.

REVIEW OF THE RULE

- Review process: team from the divisions of Health Care Services, Policy, Provider Reimbursement, Program Operations, Program Integrity, Appeals, and Integrated Care
- CMS hosted webinars on each of the major areas of the regulations that were informative and extremely helpful during our review process
- Actively engaged in discussions with the National Association of Medicaid Directors (NAMD) on every aspect of the proposed regulatory package and fully supports the comments submitted by the organization
- Our comments, while they are reflective of specific regulatory issues of concern to the Commonwealth of Virginia, also supplement the comments submitted by NAMD
- We strongly believe that DMAS is in compliance with many of the proposed regulation requirements and with proper resources, can become compliant with some of the other provisions

COMMENTS...

- o CMS asked for comments on all areas of the *proposed* rule
- o DMAS submitted to CMS our comments that highlight some of the areas of concern for the Commonwealth
- o Most comments recommend state flexibility
- o Our major areas that affect providers are following...

CMS PROPOSES

- States must screen and enroll all network providers of MCOs that are not otherwise enrolled with the state to provide services to FFS Medicaid beneficiaries

DMAS COMMENTS

- Recommends that CMS allow states the option to delegate these activities by contract to the health plans and that this delegation authority be explicitly stated in the regulations
- DMAS currently does not require MCO providers to enroll with Medicaid as we believe this promotes mainstreaming and alignment to the commercial markets
- DMAS requires that all health plans are NCQA accredited and therefore Virginia's MCOs have provider screening mechanisms in place to meet their NCQA accreditation

CMS PROPOSES

- o That any contract arrangement that directs expenditures made by the MCO for delivery system or payment provider initiatives would use a common set of performance measures across all payers and providers
- o For example, the state may require Medicaid health plans to use value-based purchasing, require plans to participate in program-wide delivery system reform initiatives, or define minimum reimbursement rates for network providers

DMAS COMMENTS

- o While having a common set of performance measures for value based purchasing is valued, there should be flexibility when it comes to MCO requirements of performance measurement for providers
- o There is too much variation in provider setting, specialty, and patient population characteristics to require all payers and providers to focus on the same performance measures
- o States should retain the ability to dictate performance measures on providers for special projects such as DSRIP, SIM, value based purchasing arrangements, etc.
- o MCOs are utilizing value-based purchasing arrangements currently and these will be discussed at the next meeting

CMS PROPOSES

- o In order to ensure network adequacy, states must establish time and distance standards for the following network provider types:
 - o primary care (adult and pediatric);
 - o OB/GYN;
 - o behavioral health;
 - o specialist (adult and pediatric);
 - o hospital;
 - o pharmacy;
 - o pediatric dental;
 - o LTSS providers

DMAS COMMENTS

- o Recommends that CMS not be prescriptive in the standards or the types of providers, including LTSS providers
- o States should be allowed to set the standards vs. specific federal standards
- o CMS should permit the state to grant exceptions for areas which are well-known as having shortages or having access issues before the MCO actively begins contracting

INFORMATION LINKS

➤ Proposed Rule

https://www.federalregister.gov/articles/search?conditions%5Bregulation_id_number%5D=0938-AS25

➤ Comments on Regulations {As of 11:59 pm yesterday, 873 comments received}

<http://www.regulations.gov/#!/docketDetail;D=CMS-2015-0068>

➤ NAMD

<http://medicaiddirectors.org/node/1241>