MassHealth Pharmacy Program: Strategies and Lessons

Prepared for Community Catalyst

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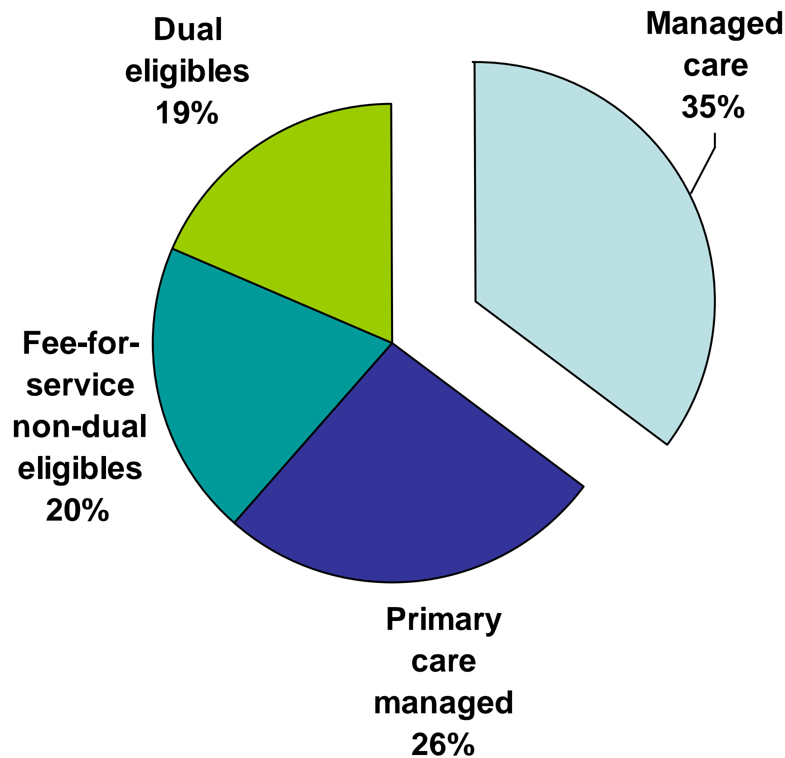
- MassHealth Pharmacy program features
- Cost impact of program
- MassHealth implementation strategies
- Summary of successes and challenges

MassHealth Pharmacy Program Implementation report

- Focused on implementation process from 2001
- Interviews with >30 stakeholders
  - Providers
  - Advocacy groups
  - Program officials provided data

- Additional documentation, meeting schedules and notes, internal reports
- Limited transparency to conduct direct quality reviews or economic analyses

MassHealth Overview



MassHealth pharmacy Spending:
$493 million FY08
6% of MassHealth budget

MassHealth Pharmacy Program Description

MassHealth Pharmacy Program Operational Entities

Policy Division

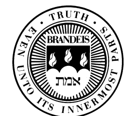
Pharmacy Policy Leadership
Policy development
Policy analysis
Clinical reports
Decision making authority

U Mass Med School

New Product Reviews
Therapeutic Class Reviews
Maintenance of MHDL
Conduct DUR and PA
Quality Review of MHDL and PA

ACS State Health Care (Smart PA)

Claims processing
"Smart PA" Software
Rebate Financial Mgt



Major Features of MassHealth Pharmacy Program

- Drug list staged implementation, began 2001
- Price management
  - MAC list
  - Usual and customary pricing
- Generics first
- Additional cost containment strategies
  - Quantity limits
  - fail first
- Smart PA
- Monitoring quality

MassHealth Drug List Unique Features

- Managed by U Mass Medical School
- Clinical work groups outside members
- Use of algorithms to automate prior authorization
- No supplemental rebates initially (limited number of contracts added after implementation)
- Staged implementation: 32+ classes established guidelines
- Clinical initiatives for several classes

Staging the MassHealth Drug List

Date	Drug class implemented
November 2001	Program regulations revised (130CMR 406.400), requiring prescribers to obtain prior authorization for brand drugs if generic approved equivalent available
November 2001- September 2002	Dermatological agents; Gonadotropin-releasing hormone analogs; Growth hormones; Hematologic agents; Immune globulins; Immunologic agents/ immunomodulators; impotence agents; Central-acting muscle relaxants.
August 2002	Gastrointestinal agents - Histamine 2 antagonists, proton pump inhibitors
September 2002	Non-steroidal anti-inflammatory drugs (NSAIDs)
October 2002	Antihistamines
December 2002	Statins
March 2003	Triptans; Hypnotics; Antidepressants
April 2003	Topical corticosteroids; Narcotic agonist analgesics
May 2003	Alpha-1 adrenergic blocking agents; Beta-adrenergic blocking agents; Calcium channel blocking agents; Renin-angiotensin system antagonist agents (ACE-inhibitors and ARBs)
June 2003	Intranasal corticosteroids; Oral antidiabetic agents; Respiratory inhalant products; Anticonvulsants
July 2003	Atypical antipsychotic agents
February 2005	Topical antifungal agents

Drug List Management: Prior Authorization

- Managed by UMass Medical School
- Patients grandfathered in if medication becomes restricted (*only for life of the prescription*)
- Process:
  - Use of data: "Smart PA" has created algorithms for point of service approval
  - Paper-based (fax only requests)
    - Individual forms for each drug/ rx/ patient
  - About 7,000 PA requests per month, 40 percent "denials"
- Most common reasons for denials (reported)
    - Insufficient information
    - Lack of evidence of step therapy
- Appeals process: 60/yr to hearing

Comparative Considerations

- Drug list and management meets certain national standards
  - 24 hour prior authorization response
  - Certain drugs exempted
  - Emergency prescriptions available (if current rx only)
- Prior authorization process compared to other states
  - Coxibs, angiotensin receptor blocker drugs, antidepressants
- Review of initiatives

Cost Impact of Program

MassHealth Pharmacy: Selected Initial Cost Management Targets

- **MHDL** –(**$99M** cost avoidance first full year of implementation)
  - Includes use of: Quantity Limits, Dosage Limits, Age Limits, Therapeutic Substitution
- **Brand PA** – (**$43M** cost avoidance first full year of implementation)
- **Early Refill Edit** – (**$29M** cost avoidance first full year of implementation)
- **SMAC** – weekly update of maximum generic pricing - lowest published generic price (**$12M** cost avoidance first full year of implementation)

Source: Estimates provided by MassHealth Pharmacy Program

MassHealth Pharmacy Trends in Context

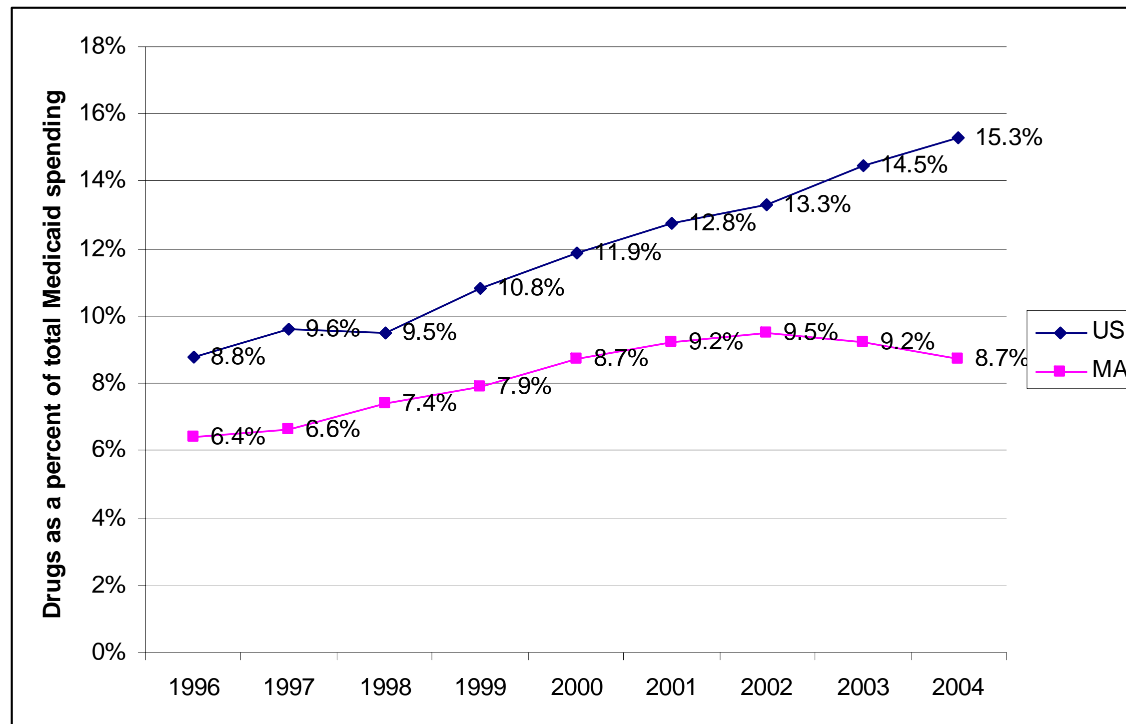
Medicaid annual spending per enrollee for drugs and other durables

Year	MA	US
1996	$421	$334
1997	$461	$376
1998	$483	$445
1999	$557	$546
2000	$643	$601
2001	$719	$664
2002	$780	$705
2003	$792	$766
2004	$797	$823

Y-axis: $- to $900 (in $100 steps)

Source: CMS Statistical Supplement 2007, CMS Office of the Actuary February 2007 (Accessed 09/09)

MassHealth Pharmacy Trends in Context:
Prescription drug spending as a percent of total Medicaid program personal health spending



Source: CMS Statistical Supplement 2007, CMS Office of the Actuary February 2007 (Accessed 09/09)

MassHealth Implementation Strategies

Implementation Strategies Overview

- Defining the Criteria
- Sequencing the Process
- Managing the Process
- Minimizing conflict

Defining the Criteria- Clinical Dominance

- Clinical criteria are the starting point for decisions
- Clinically the central rule is do no harm- saving should not come at the cost of patient risk
- When disagreements arise on risk issues with stakeholders: move to less contentious issue

Sequencing the Process: Select which issues are first addressed

Areas of clinical consensus before areas of high savings- low conflict targets

- Low conflict issues in managing costs
  - Use Generics over brands when they are equivalent
  - Control polypharmacy
- Focusing on drug categories that are less contentious

Managing the Process

- Bringing key stakeholders into the clinical review process
- Invite a wide range of stakeholders
  - Advocates
  - Providers
  - Experts
  - Minimal input from drug manufacturers
- Requiring participation via clinical expertise – a clinician must be the representative in the process

Minimizing Conflict

- Avoiding serious conflicts when clinically defensible resistance arises - mental health drugs as an example
- Managing legislative interventions- legislation requires Commissioner of Mental Health to sign off on new restriction on MH drugs—a non-clinically based step

Conflict Avoidance: Mental Health Medications

- Stakeholders invited into decision-making
- Psychiatric drugs were a significant focus of the initial process as large savings seemed possible
  - Mental Health Drugs represented highest proportion of Medicaid Costs (8 of top ten drugs by spending)

- Of the four drugs from which the largest saving were anticipated,
  - Two were not pursued at the time planned due to strong stakeholder resistance.
    - Stakeholder resistance was based on disagreements on the clinical impact of proposed changes
  - The program understood that a prolonged conflict in this area would impede program implementation and choose to focus on less contentious and less well organized areas

Summary: The MassHealth Model

- Staged approach
- Collaboration across academic, operational, clinical
- Internal research for evidence
- Use of data systems
- Bring all stakeholders to the table early
- Two phases:
  - Development
  - Administrative oversight and continued operation

Summary: Major Successes

- Considerable drug cost savings, both reversing Massachusetts trends and as compared to national
- Clinical focus is a priority
- Effective outreach to stakeholders in clinical decision making
- Implementation sequenced to balance clinical criteria, savings potential and practical political consideration
- Strong administrative systems for effective operations

Summary: Additional Challenges

- Continued cost pressures
  - New medications
  - Increasing prices for existing brand drugs
  - Specialty drugs
- Continued drug list management for more costly/clinically/politically difficult medications
- Accountability
  - Proactive clinical management
  - Monitoring outcomes

MassHealth Pharmacy Program Status

Medicaid Prescription Drug Quality and Cost Management

November 13, 2009

Paul L. Jeffrey, Pharm.D.

MassHealth Director of Pharmacy

MassHealth Overview (FY10)

- Members
  - 1.23M Members (↑3.4%> FY09)
    - Contracted MCO - 430,500 members (35%)
    - MassHealth Managed - 799,500 members (65%)
      - 26% Primary Clinician Care Plan ("In-house" managed care)
        - » Behavioral health, carved out
      - 39% Fee-for-Service (Most have other insurance)
        - » Approximately 225,000 Medicare Dual Eligibles (Federal Rx Benefits – Part D)
- Dollars
  - State Budget - $27.05B ($28.17B, FY09)
  - EOHHS Budget - $13.68B
  - MassHealth Budget - $8.93B
  - Pharmacy Budget - $536M (Medicare D "Clawback" – $268.6M)
    - 6% of the MassHealth Budget (9% with Clawback)

Quality of Care – Drug Therapy

- "The degree to which **drug therapy** for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge".

Institute of Medicine

(paraphrase)

Drug Use Review (DUR)
CFR 42 § 1396r-8

- Ensure prescriptions are:
  - appropriate
  - medically necessary
  - not likely to result in adverse medical results
- Identify and reduce frequency of patterns of:
  - fraud, abuse, gross overuse, inappropriate or medically unnecessary care
  - potential and actual adverse reactions to drugs

Medical Necessity
130 CMR 450.204(B)

- Reasonably calculated to prevent… alleviate… suffering and pain…illness or infirmity
- No other medical service, comparable in effect, available and suitable for the member, that is more conservative or less costly to the Commonwealth
- Must be of a quality that meets professionally recognized standards and must be substantiated by records including evidence of such medical necessity and quality

MassHealth Pharmacy
Organizational Chart

Governor
⇩
Secretary, Health and Human Services
⇩
Director, Office of Medicaid

UMass Medical School
⇩
Commonwealth Medicine
⇩
Office of Clinical Affairs

Pharmacy Program
(Director)

Claims Processing and Rebate Management Contractor

ACS State Healthcare

Clinical Support and DUR Program Contractor

UMMS

- Program Policy & Regulations
- POPS Operations
- Drug Utilization Review (UMMS)
- Program Quality Initiatives
- Professional and Public Relations

MASSHEALTH DRUG REVIEW PROCESS

External Stakeholders:
- Members
- Providers
- PhRMA

THERAPEUTIC CLASS REVIEW

NEW PRODUCT INTRODUCTION

- UMass Medical School, Clinical Pharmacy Services

Utilization Review
- Prospective (Point of Sale)
- Retrospective (Data Analysis)

Quality Review
- Claims Integrity
- Prior Authorization

Pharmacy Policy Committee
Rx Director
Rx Staff

Monograph Prepared:
- Literature Evaluation
- Data Analysis
- Financial Modeling

Validate Decision

Internal Review

Open Access Prior Authorization:
- Formal Request (Fax/Mail)
- Automated (Smart PA)
- Step Edit (Fail First)

Quantity Limits

- Drug Use Review Board
- Associate Medical Directors

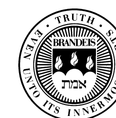
Affiliated Agencies:
- Dept Mental Health
- Dept Public Health

Current and Planned Activities

- Expanded use of Smart PA
  - 130 rules active Fall 2009
    - Incorporate prescriber databases
- Interactive website (in development)
- Improve information technology
  - Next generation claims processing (in development)
    - Electronic prescribing (in development)
    - Incorporate laboratory results and behavioral health into Smart PA (planned)

Current and Planned Activities

- Improved outcomes
  - Robust quality studies (in development)
  - Integrate pharmacy data into emerging care management strategy (planned)
  - Address underutilization, adherence (planned)



Questions ??

THANK YOU !