2014-2015 Budget Pharmacy Initiatives

Managed Care Policy and Planning Meeting June 12, 2014

Budget Initiatives

1. Prior Authorization for Non-Medically Accepted Indications
2. Align statewide Drug Utilization Review (DUR) programs by expanding point of sale clinical pharmacy editing in managed care plans (MCP)

Background

- SOS Law, Title 11-C, Section 369-bb 5. (a) (iii), gives the Medicaid Drug Utilization Review Board authority to collaborate with managed care organizations to address drug utilization concerns and to implement consistent management strategies across the fee-for-service and managed care pharmacy benefits.

Clinical reviews and recommendations previously shared with MCP's	
DOH Clinical Reviews	Date
Antiretroviral (ARV) Contraindications	10/7/2013
Short Acting Opioids	10/7/2013
Injectable Immunomodulators	10/7/2013
Suboxone	10/7/2013
Long Acting Opioids	1/2/2014
Benzodiazepines	1/2/2014
ARV Adherence	1/2/2014
Second Generation Antipsychotics (SGA) in Children	1/2/2014
Central Nervous System Stimulants and SGAs in Children	3/28/2014

- Both initiatives leverage point of sale clinical editing [aka "automated prior authorization (PA)"]:
  - Increases ability to do more comprehensive claims editing by reducing administrative burden and costs
  - Executes real-time PA decisions within the point of sale claims process. Therapy will automatically be approved for those patients who meet clinical criteria

Prior Authorization for Non-Medically Accepted Indications

- Conforms with Federal law [SSA Section 1927(g)(1)(B)(i)], and will leverage the use of automated prior authorization to reduce off label prescribing for certain drugs or drug classes where there is evidence of significant off label prescribing.
- Drug classes that have been identified as having significant non-medically accepted use include but are not limited to anti-convulsants, anti-depressants, anti-psychotics and chemotherapeutic agents.
- Plans can determine target areas based on Drug Utilization Review Board (DURB) recommendations or independent evaluation of data.
- Automated prior authorization (PA) logic used at the point of sale would allow claims to automatically pay where there is evidence of an FDA approved or Compendia supported diagnoses within claims system(s).
- PA would be required where there is no evidence in the claims system of an FDA or Compendia supported diagnoses.

Example #1

<u>Clinical Edit:</u> Antiretrovirals (ARVs)- Implemented 4/10/2014, in Medicaid FFS

- Confirm diagnosis for FDA or compendia supported uses.
- Absence of covered diagnosis will require PA

ARV Diagnosis Information from Clinical Review

	FFS+MC
ARV without ICD9 code 042 or V08 <65 yrs of age	10,704
	# Beneficiaries
Hepatitis B	7,691
HIV counseling or only 1 encounter with HIV	1,797
	# Beneficiaries
Either Hepatitis B or HIV (above)	8,747
% Either Hepatitis B or HIV (above)	81.7%
	# Beneficiaries
Beneficiaries with neither HIV nor Hepatitis B codes	1,957

Source: MDW 4/1/2012 – 3/31/2013 Data pull: ~10/1/2013

- Overall, 23% (10,704) of NY Medicaid beneficiaries receiving ARV medications during the one year analysis period did not have evidence of a confirmed diagnosis of HIV, even looking back 5 years into medical claims. This accounted for 10% of ARV claims during the analysis period.
- When taking into account HIV counseling or only 1 encounter with HIV and/or hepatitis B diagnosis, the percent of beneficiaries receiving ARV without evidence of HIV dropped to 4.2% (1,957) and ranged from 0.2% to 11.7% in MC & was 6.1% in FFS.

Align statewide Drug Utilization Review (DUR) programs by expanding point of sale clinical pharmacy editing in managed care plans (MCP)

- Further aligns statewide DUR programs by incorporating clinical pharmacy editing, to include consideration of non-pharmacy claims data elements such as diagnoses and/or relevant services.
  - Customize PA criteria to target utilization concerns related to specific diagnoses, procedure codes etc.

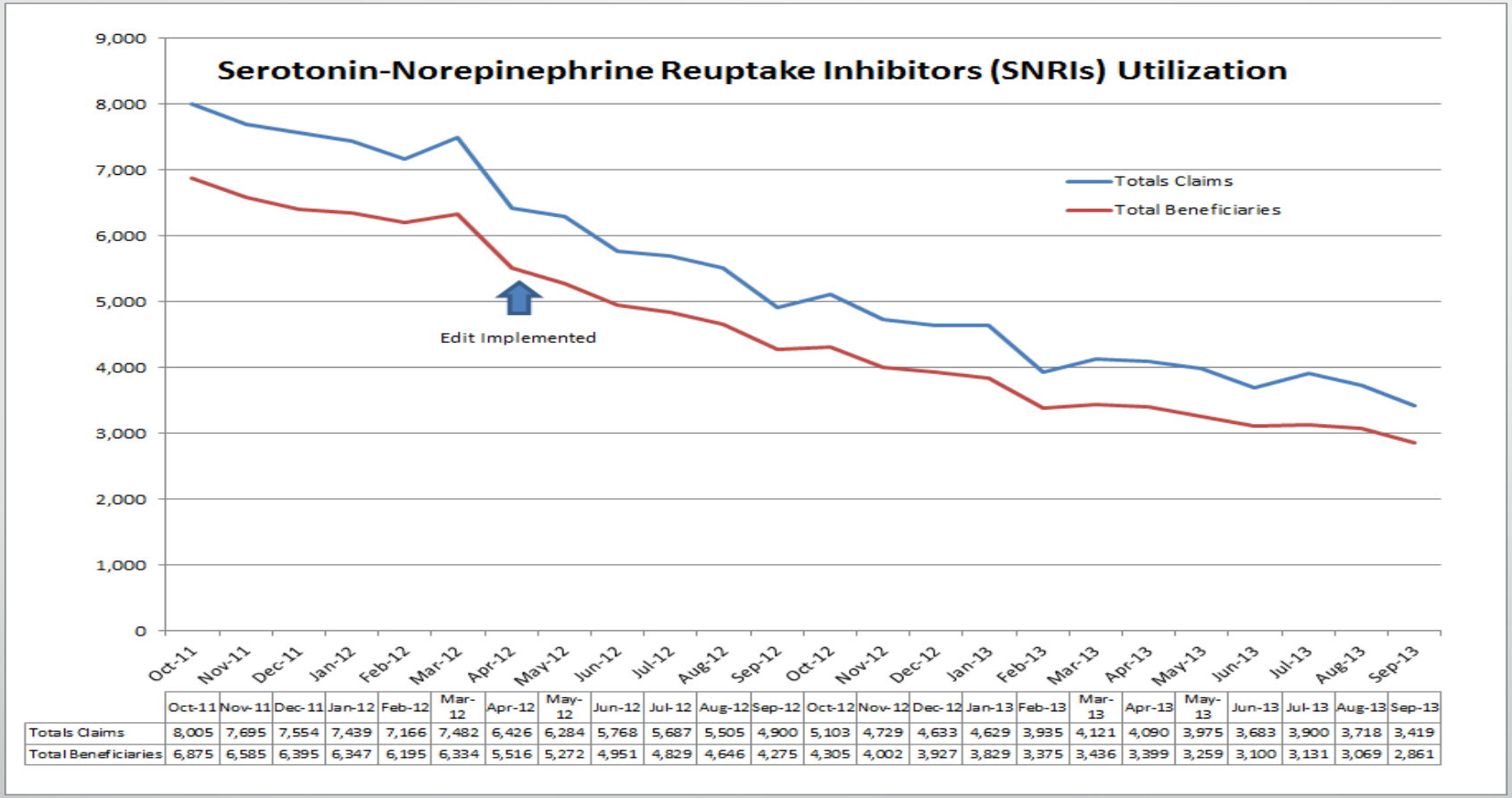
Example # 2

<u>Clinical Edit:</u> Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs), implemented in FFS on 4/12/2012

Trial of a SSRI prior to a SNRI is required:

- Step therapy is not required for the following diagnoses, chronic musculoskeletal pain (CMP), diabetic peripheral neuropathy (DPN), and fibromyalgia (FM)
- Cymbalta (duloxetine) therapy requires a trial with a Tricyclic Antidepressant (TCA) or gabapentin for the treatment of DPN

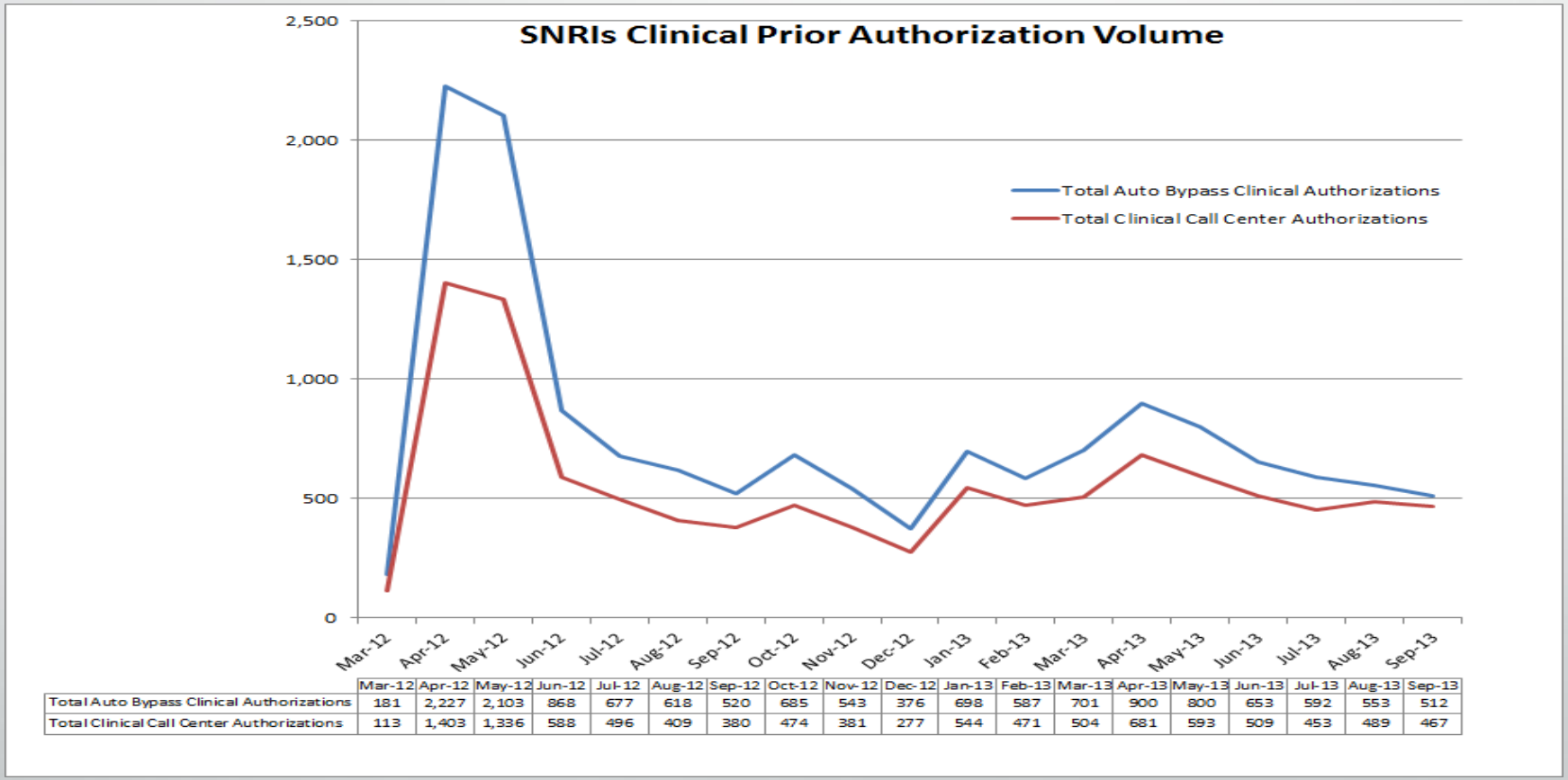
SNRI Utilization



	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Totals Claims	8,005	7,695	7,554	7,439	7,166	7,482	6,426	6,284	5,768	5,687	5,505	4,900	5,103	4,729	4,633	4,629	3,935	4,121	4,090	3,975	3,683	3,900	3,718	3,419
Total Beneficiaries	6,875	6,585	6,395	6,347	6,195	6,334	5,516	5,272	4,951	4,829	4,646	4,275	4,305	4,002	3,927	3,829	3,375	3,436	3,399	3,259	3,100	3,131	3,069	2,861

- Post implementation the average number of SNRI paid pharmacy claims declined by 40.0%

SNRI Clinical Approvals



	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Total Auto Bypass Clinical Authorizations	181	2,227	2,103	868	677	618	520	685	543	376	698	587	701	900	800	653	592	553	512
Total Clinical Call Center Authorizations	113	1,403	1,336	588	496	409	380	474	381	277	544	471	504	681	593	509	453	489	467

- 23.4% increase in beneficiaries utilizing SSRI prior to SNRI
- 28.3% fewer call center clinical authorizations than auto bypass clinical authorizations

Fiscal Estimate - PA for Non-Medically Accepted Indications

- Drug categories were selected based on empirical evidence of off label use (SUNY Buffalo literature review and drug utilization research within the Medicaid Program)
- Drug categories represent 22% of total Medicaid drug spend
  - Antipsychotics, Anti-Convulsants, Anti-Depressants, Chemotherapy Agents, Anti-Ulcer agents, Anti-arthritics, Anti-coagulants and Biologicals
- Assumes a 40% reduction in off label use

	2014-15 Impact		2015-16 Impact	
	Gross	State	Gross	State
FFS	($4.38M)	($2.19M)	($8.76M)	($4.38M)
Managed Care	($15.45M)	($7.72M)	($30.90M)	($15.45M)
Total Savings	**($19.83M)**	**($9.91M)**	**($39.66M)**	**($19.83M)**

Notes

2014-15 savings assume 10/1/14 implementation date

Savings are net of rebates

Fiscal Estimate – Expand point of sale clinical editing in Managed Care Plans

- Estimated savings percentage, post implementation, of selected edits as evaluated by SUNY Buffalo based on analysis of encounter data submitted by managed care plans.
  - Limit of 4 opioids per month
  - FQD limits for PPIs, Lyrica, Restasis, and Singulair
  - Step Edit for Cymbalta
- Assumes a 50 % reduction in MC spend by drug costs through targeted enhanced clinical editing.

2014-15 Impact		2015-16 Impact	
Gross	State	Gross	State
($6.24M)	($3.12M)	($12.48M)	($6.24M)

Notes:

2014-15 savings assume a 10/1/2014 implementation date
Savings are net of Rebates

Conclusion

- Enhanced clinical editing can reduce costs and improve patient care for the entire Medicaid Program by;
  - decreasing administrative functions (fax transmission, phone calls and time-consuming expensive manual clinical reviews).
  - decreasing inappropriate use and enforcing clinically appropriate use of medications by; incorporating data from pharmacy claims, medical claims, eligibility systems and in some cases call center.
- DOH will continue to provide support via DURB clinical reviews and evaluation of Medicaid data.