Behavioral Health Partnership Oversight Council
Coordination of Care Subcommittee

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Meeting Summary: July 18, 2007

Next meeting: Wednesday September 26, 2007 2:30 PM LOB Room 3800

May meeting summary: Accepted without change.

Discussion about Health Net and Anthem response to the procedures for notifying a practitioner when a script has been rejected because the prescribed dosage or number of pills is outside the industry limits. Health Net was asked to define "unresolved reject report" and how the information is used when the provider is notified of the script rejection. Anthem process calls first for the pharmacist to contact the prescribing provider; the PBM would contact the provider as part of the PA process if the pharmacist contacts the PBM first rather than the prescribing provider. Procedure relies primarily on the local pharmacy than the PBM.

Pharmacy Follow up

- ✓ Pharmacy screen message, by health plan, for dispensing temporary supply of drugs when required prior authorization (PA) is not obtained:
  - Health Net and WellCare need to change their screen message to reflect temporary supply process.
  - Anthem is still working on their message change since the May 4th DSS Deputy Commissioner assurance that Anthem would change the message. The current message, according to Sheldon Toubman, still says "not covered" which means members may not receive a temporary drug supply for the prescribed medication.
  - Rose Ciarcia will bring pharmacy screen issues back to DSS for completion of screen message corrections. **Review at the September 26th meeting.**

Mercer Pharmacy study

Discussion about the study process schedule and study specifics, including if script rejections due to possible drug interactions or outside industry limit standards (see above) would be captured in the study. It was agreed that Mercer, DSS and interested SC members participate in a conference call in August regarding the study 'migration list' that will identify substitute drugs.
(Please see summary of August conference call page 3).

DCF Psychotropic Medication Consent Process Changes

Dr. Janet Williams, Medical Director, DCF presented the final plan for DCF approval process for psychotropic medications prescribed for DCF-involved children. ***Beginning October 1, 2007,***

the DCF medication consent process will be streamlined with consent processed through a Centralized Medication Consent Unit (CMCU) staffed with two psychiatric APRNs that will work closely with the three DCF Regional Medical (psychiatrist) Directors to triage, review and expedite all psychotropic medication requests. The timeline for psychotropic medication approvals is 12 hours for urgent requests and 36 hours for routine requests. The over all goal of the process change is to increase the level of expertise used in making the medication decisions and increase the efficiency of granting consent. Practitioner requests for psychotropic medication consent for DCF-involved children can be submitted to the CMCU by:

- Fax : 1-800-GetMeds
- Email: Getmeds.dcf@ct.gov using the ***DCF-465, request for psychotropic Medication Form.***

The DCF approved list is separate from the HUSKY MCO drug formulary. Since there is existing psychiatric oversight for pediatric psychotropic drug prescribing for DCF- involved children that are HUSKY A members, ***it was suggested that DCF children be exempt from MCO formularies for psychotropic medications***. ***DSS will bring this to CTBHP DSS attention*** as the MCOS are now in contract negotiations with DSS. The DCF Psychotropic Medication Advisory Committee (PMAC) that was developed in response to 2005 legislation has standardized the processes related to the use of psychotropic medications, including medication guidelines with recommended medical monitoring protocols. DCF will present this at a future meeting. These protocols may be useful for medical providers that assume some level of pediatric psychotropic medication management.

CTBHP/Primary Care Integration: Dr Stephen Kant (ValueOptions)

Dr. Kant summarized the progress to date of the CTBHP Committee:

- Fall presentation to Primary Care providers of Committee's work
- Reviewing coordination of the BH Enhanced Care Clinics (ECCs) with primary care expectations.
- Developed templates for Memorandum of Understanding (MOU) between ECCs and primary care practices.

Transportation Update

Deferred to the September meeting: Logisticare has compiled the consumer survey results and will provide details at the September 26th meeting.

CTBHP/MCO Coordination update: Sandra Quinn

Care Coord Mtg 7 18 07.ppt

(See report above). Discussion deferred to the September meeting. DSS has communicated with WellCare on BHP/MCO care coordination. WellCare is revising their procedures.

Summary: Mercer/ Coordination of Care SC Prescription Study Conference Call 8-06-07
Submitted by: Sheila B. Amdur

8/06/07: Rose Ciarcia, Sheldon Toubman, Sheila Amdur, Nan Jeannero/Kevin Johnston/Chris Babbitt, Lee Van der Baan, Stephen Kant, Janet Williams, Connie Catrone

9,000 different drugs rejected from all MCO's, although there may be more rejections. Built migration lists, so if member received substitution of "appropriate" drug, counted as received. Will look to see which drugs are being substituted; not part of scope to see which drugs are being substituted—migration list will tell us what substitutes are. Dr. Williams noted if drugs with more metabolic issues for children are being used, then this is of concern (other drugs being substituted for Abilify). Mercer will determine with Rose how this impacts scope.

1. How are delays accounted for in terms of time it takes to get substitute drugs? Mercer is running 7 and 14 days, and will also provide a report quantifying average times, within the 7 days, when drugs were authorized, by type of drug. Will have a sense of range of time it took to get prescription filled? After one time override, will also see after the month if they get appropriate drug.
2. Will be individual review of claim files in which they can't tell which substitute drug used.

Nan Jeannero: Looked at groupings of drugs on 180 lists, and determined if appropriate substitute drugs provided. Should not be duplications among lists. "Acceptable" alternatives would be within class. If alternatives not provided that are acceptable, then listed as rejection. Initial scope of study on Prior Authorization, but will also look at "Plan Limits Exceeded (above dosage allowed)," and "Drug not Covered," so that we see how many are being rejected. This was deemed important because MCOs sometimes use rejection code 70 ("drug not covered") for drugs not on their formularies but covered through prior authorization-- if we only looked at rejection code 75 ("prior authorization required"), we would miss many situations where covered drugs are rejected at the pharmacy due prior authorization requirements, which is the focus of the study."

1. Sheldon Toubman: Many drugs are covered for kids that may not be covered for adults. Mercer is looking at these, and has created migration lists for these; children are separated from adults. **Nan Jeannero suggested that we look at the detail of the migration lists to see what is included, what should be included, and what is not included. (Description of groups drugs are in, as well as migration lists, referencing the number of lists on which alternative drugs appear. Alternatives listed in most likely order. These are Mercer lists.)**
2. Break down on # of rejections based on original rejection (codes 70, 75, 76). Mercer will talk about this. If someone told "Drug not covered," more likely to walk away.
3. Dr. Kant: Is physician involved in change of drug? Yes, only physician can make change, except brand to generic.
4. Lists will show what drugs have been rejected and what are potential alternatives?
5. **Response to Mercer on lists by August 31.**