Connecticut
Medicaid Managed Care Council

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Meeting Summary: **Jan12, 2004**

Sen. Toni Harp Jeffrey Walter

Attendance (see attached list)

Jeffrey Walter, Dr. Lisa Karabelnik, a child psychiatrist at Hartford Hospital, Rose Ciarcia and Lee VanderBaan (DSS) met in November 2003 to review key problems related to Medicaid managed care drug formularies and psychotropic medications. Subsequent to that meeting, Senator Toni Harp, Chair of the Medicaid Managed Care Council, requested representatives from the provider community, DSS, DCF and managed care organizations meet with her to identify the problems from each representative's perspective as well as short term and long term solutions to this chronic issue.

The key discussion issues seemed to center on the following areas: Prior Authorization (PA) process and differences among plans, the denial/appeal processes, the training level and specialty of the Pharmacy Benefit Manager (PBM) reviewer, the make-up of each PBM's Pharmacy & Therapeutic Committee (P&T) and clinical issues related to therapeutic equivalents of generic drugs. The following reflect highlights from the discussion from the representative participants:

Health Practitioners

PA Process can be lengthy, compounded by 4 different managed care drug formularies and PA forms:

- In theory, providers would contact the PBM for PA of a formulary or off-formulary drug while the patient is at the practice site. The reality is that often PBM response

delays are well beyond a reasonable time for the patient to remain at the office. Additionally, a denial of the PA extends the time for the prescription to be filled.

- Temporary drug supply (TS) provisions are identified in the DSS/MCO contracts: the patient should receive a temporary supply of the drug if the practitioner indicates it is urgent or the pharmacy cannot reach the practitioner while the patient is in the pharmacy. The DCF noted that 215 DCF children had not received prescriptions in a timely manner; of these, 10% decompensated, were seen in the Emergency Room, had the potential for hospitalization and some lost foster care placements.

- The prescribing practitioner is not informed that a prescription has not been filled, unless the family notifies the practitioner.

- Staff in the PBM that are unfamiliar with child psychiatry and children's psychotropic medications have often denied PA requests.

Internal health plan processes

- Sen. Harp asked if each plan's P&T Committee includes a child psychiatrist and if the health plans/PBMs use evidence-based practices that target this subset of the pediatric population – those with mental health diagnoses. While Anthem stated they believe their formulary policies do focus on children, other responses were not forthcoming. Sen. Harp expects these questions to be answered in future meetings.

- Inpatient and outpatient drug formularies differ, therefore on hospital discharge, the patient may not have timely access to the drug prescribed during hospitalization.

- The PA process restarts when a patient changes health plans, or in the case of DCF children, changes address or regions.

- The Wheeler Clinic stated that their review of denied drugs showed that on appeal 100% of the requests were granted. Other providers noted that often on successful appeal of a denial, the same reason is submitted that was in the original PA request. Considerable practice site and PBM administrative time is spent on denials & appeals, yet in many cases the original provider request is granted.

Practitioner prescription clinical decisions

- Drugs may be prescribed based on the clinician's experience with the drug and their pediatric population rather than solely on diagnosis.

- Regarding generic equivalents, the extended release stimulants (not available as a generic) are ordered for reasons of patient compliance and/or family situations (i.e. prescribing a long tem acting drug that has no 'street' values).

Health Plans

The plans and PBMs noted that the pharmacies with whom they contract have been notified of the contractual TS policy. If there is a break down in the process, the plan needs to know this in order to correct the problem. Anthem stated they have a full time psychiatrist and full time pharmacist that works with providers and the Medical Director returns all practitioner calls. *Julie OH, the Health Net Director of Pharmacy*, submitted a draft "quick look" provider reference for the formulary psychotropic drugs, which may be of help to providers when prescribing medications. *Health Net noted that sufficient clinical information is often not provided when non-formulary or PA for drugs is requested.*

The Department of Social Services

David Parrella stated that:

- There is a need for pharmacy cost containment measures as drugs costs in the CT Medicaid program now exceed hospital costs. *Mr. Parrella stated that generic equivalency would remain as a way of managing pharmacy utilization and cost.*

- Special populations within the HUSKY program such as DCF children may require a different approach, given the medication barriers in this group. The DCF is near completion of psychotropic drug protocols that will apply to DCF children.

- The plan PA procedures need to be looked at in regard to high percentages of overturned denials per specific drugs.

- The long term solutions will involve either the DSS would take over the HUSKY formulary as part of the Medicaid FSS Preferred Drug program (i.e. a 'carve-out' of pharmacy in the HUSKY program) or mandate the plans adopt a single formulary that is the same as the Medicaid formulary.

Rose Ciarcia (DSS) stated there are several short-term collaborative initiatives that can be undertaken now to reduce some of the administrative burdens, which include developing uniform PA forms across MCOs, streamline the PA process and create the "quick look" formulary reference for the three plans.

The DSS will review data from the health plans regarding the percentage of overturned denials and the drugs involved prior to the next meeting that will be scheduled by DSS.

(*Italics highlight comments by participants after review of the summary.)*