Pharmacy Benefit Carve-Outs in Medi-Cal Managed Care

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Magellan HEALTH SERVICES

Scale & Resources

60M
Total lives touched every day

$15B
Annual drug spend

40 yrs
Pharmacy experience

69M
Annual adjusted claims

4.4M
Pharmacy calls handled

$1.8B
Total rebates managed

900
Pharmacists
Clinical case mgt
Customer service

2M
Prior authorizations

39 Health plans
25 Medicaid management
50 States and D.C.

States and D.C.
with commercial PBM
The Behavioral Health Carve Out

Services Carved Out to the County
• Starting 1/1/2014 Medi-Cal plans now cover outpatient Behavioral Health services for members with mild to moderate conditions:
  — Outpatient services for the purpose of monitoring drug therapy
  — Outpatient laboratory, drugs, supplies, and supplements, Individual/group mental health evaluation and treatment
• Psychological testing
  — Psychiatric consultation

The Pharmacy Carve-Outs
• Selected psychotropic medications (antipsychotics, some antidepressants, and some mood stabilizers)
• HIV/AIDS
• Alcohol, Opioid/Heroin Detoxification and Dependency Treatment
Angie: 55-year-old female

- Suffers from schizophrenia and significant alcohol dependence
- Inpatient 4 months ago for command hallucinations and changed to olanzapine
- Recently diagnosed with diabetes
  - Few social or family supports
  - Poor linkage to primary care

Angie is not alone
Patients’ co-morbidity rates are high among adults with mental health disorders¹
  - 68% with a mental health disorder have at least one co-morbid medical problem
  - 29% with a medical disorder have a co-morbid mental health condition

Smart Population Management

Patients with serious mental illness (SMI) are a small percentage of the Medicaid population but account for a large percentage of Medicaid spend.

Today, the medical conditions of this population are largely unmanaged.
Average annual spending on Medicare-Medicaid Beneficiaries, 2006-2009

Where are the states today?

State Medicaid Managed Care: Predominant Service Delivery Models

- MCO Fully Integrated for Behavioral & Physical Health, 14%
- MCO Fully Integrated Except One Behavioral Health Benefit (MRO, IP, or SUD), 11%
- Behavioral Health Carve-Out from FFS or PCCM, 4%
- No Managed Care, 2%
- FFS with ASO, 1%
- PCCM, 7%
What is the best way to manage these patients?
A story to carve in or carve out

- 1986 - 2005 drop health care spending for mental health and substance abuse from 9.3% to 7.3%¹
  - Coincides with many payers moving to captitated managed behavioral health carve outs
- Affordable Care Act
  - Increased focus on coordination of care
  - Expansion of the insured population

**Benefits of Carve Out**
- Management of specialty populations by specialist
- Unique needs of this population

**Risks of Carve Out**
- Additional mechanism for coordination of care
- Federal and state restrictions of sharing of information
  - Ensuring mental health parity

¹Dalzell, M. Mental Health: Under ACA, Is it Better To Carve In or to Carve Out?
Access to data in a carve out

Accessing data between providers is imperative to safely and effectively treat patients.

Important to receive data is a timely manner.

Access to data decreases duplicate prescribing and potential drug-drug interactions.

Coordination of care can be administratively time consuming.
Why is care coordination so complicated?

Carve Out
Care coordination is not the only key

- Recommendations from new randomized control trials takes approximately **17 years** to be incorporated into practice

- Lack of evidence based recommendations in practice can lead to non-optimal outcomes
Why do we need change?
Factors considered when prescribing medication

- PBM or HP
- Pharma Programs
- Pharma Reps
- Insurance
- Colleagues
- Medical journals
- Clinical practice guidelines
- Patient's response
- Your clinical knowledge

Adapted from: KRC Research, (2011)
Developing solutions

Advanced proprietary clinical algorithms identify prescribing patterns that are inconsistent with evidence-based guidelines resulting in personalized provider consultations.
To see the whole patient, pharmacy and medical claims systems must be integrated

**Pharmacy Data**
- Multiple opioid prescriptions from multiple doctors and pharmacies
- High dose medications
- Short acting inhaler without inhaled corticosteroid
- Early refills

**Medical Data**
- ER and hospitalization data
- Diagnosis claims to identify off label utilization
- Methadone opioid maintenance claims are not in pharmacy data
- Exclusion diagnosis: Cancer requiring higher dosing of opioids

**Whole Patient Management**
Identifying quality improvement opportunities

**Cumulative Dosing**
Across prescriptions and multiple prescribers

**Duplicate Therapy**
Antidepressants & Antipsychotics across multiple prescribers

**Off Label**
Bipolar Disorder with an antidepressant without a mood stabilizer

**Substance Abuse**
Suboxone and opioid utilization

**Pharmacy & Medical Integration**
Missing labs
Getting the data into the right hands

- Multimodal communication is important
  - Mail
  - Email
  - Telephonic
  - Fax
  - Virtual
  - Face to Face
- Prescriber versus nurses or medical assistance
- Push versus pull data
Providing actionable data

High Diazepam Equivalent Dose

Dr. Smith

Clinical Considerations:

- Patients listed in the table below have cumulative diazepam equivalence doses two times above the FDA recommended maximum.
- Use of high dose benzodiazepines can increase the risk of respiratory depression, and death if combined with other CNS depressants including other medications or alcohol.
- Combinations of multiple benzodiazepines can have additive effects and inadvertently can result in high diazepam equivalents.
- This medication list only contains prescriptions paid for by the payer listed above. Consider consultation of the state pharmacy controlled substance monitoring website for a full list.
- Patients listed below are receiving cumulative doses over 80 mg/day of diazepam (two times the FDA max).

Potential Actions:

- Consider target symptoms for each benzodiazepine, and consider tapering and discontinue unnecessary medications.
- Explore non-pharmacologic or non-benzodiazepine alternatives to address anxiety or insomnia symptoms.
- If the patient is receiving benzodiazepines from multiple providers consider discussing treatment plans with the other provider.
- Additional resources on benzodiazepine taper schedules and patient information sheets can be found at www.MagellanWholeHealthRx.com

Patients identified for this protocol: 3

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<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>Medication</th>
<th>Date of Start</th>
<th>Days</th>
<th>Days Supply</th>
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<td>6/09/1974</td>
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<td>30</td>
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High risk reporting across multiple prescribers

Risk Conditions Summary

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<tr>
<th>Group Organization Name</th>
<th>Duplicate Benzo</th>
<th>Benzo Opiate Combo</th>
<th>Diazepam Equivalent Daily Dose</th>
<th>Morphine Equivalent Daily Dose</th>
<th>DEDD/MEDD Combo</th>
<th>High Risk 4+4+4</th>
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<td>6</td>
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<td>88</td>
<td>57</td>
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<td>673</td>
<td>340</td>
<td>929</td>
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Number of Risk Conditions Summary

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Combining multiple initiatives is key to addressing potential dangerous behavior
**Proven results**

**Prescriber Change Can Happen**
- 46.6% decrease for mailings and subsequent additional 13.3% in a following pharmacist intervention

**Member Change Is Also Possible**
- 43.8% decrease for mailings and a subsequent decrease in 38.2% in pharmacist intervention
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Thanks

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