Managing Wisconsin Medicaid’s Pharmacy Program

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Presentation Outline

• Federal regulations
  o What are the federal regulations that make managing Medicaid pharmacy programs different from commercial pharmacy management?

• Our toolbox
  o What tools do we use to manage our programs based on unique nature of Medicaid rules?

• Pharmacy management statistics
  o How does Wisconsin Medicaid do at managing our costs?

• Future opportunities
  o How does our data inform us on where new tools are needed for better management?
What are the federal regulations that make managing Medicaid pharmacy programs different from commercial pharmacy management?

Federal Regulations
Federal Regulations

• Social Security Act (SSA) 1905(a) defines 29 categories of services that may or must be covered by Medicaid programs.
  o “Prescribed drugs” are an optional state plan service

• SSA 1927 defines “payment for covered outpatient drugs”
  o Defines “covered outpatient drugs” for the purpose of 1905(a)12 “prescribed drugs”
  o The Medicaid Drug Rebate Program requires drug manufacturers to provide rebates to offset costs of most outpatient drugs
  o In exchange, Medicaid programs that cover outpatient covered drugs must cover all Food and Drug Administration (FDA) approved drugs for any “medically accepted indication”
Federal Regulations (cont.)

• The following types of drugs are excluded from coverage:
  o Less-than-effective, as defined by the FDA
  o Experimental or have no medically accepted indications

• SSA requires Medicaid programs to provide Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)
  o HealthCheck” is the term used for EPSDT in Wisconsin since 1990.
  o Medicaid covers HealthCheck services for children under 21 years of age.

• All Medicaid-covered services, whether mandatory or optional, must be covered for children if medically necessary.
Our Toolbox

What tools do we use to manage our programs based on unique nature of Medicaid rules?
What’s in Our Toolbox?

• Delivery system
  o Fee-for-service or managed care
  o Medical or pharmacy benefit – requires billing through one avenue

• Market competition and selective contracting to obtain lower costs for preferred agents (diabetic supplies, supplemental rebates, Preferred Drug List (PDL), specialty pricing)

• Prior authorization (PA) criteria
  o Submitted via STAT-PA (phone) or clinical form (paper/electronic)
  o Brand medically necessary (BMN)
What’s in our Toolbox? (cont.)

• Pricing policies and systems edits
  o Analytics driven real-time alerts: quantity limits, early refill, three month supply, fill limits, diagnosis restrictions, age/gender
  o Medication therapy management
  o 340B
  o Differential dispensing fee
  o Drug Utilization Review
  o Lock-in program

• Prescriber education
What’s Not in our ToolBox?

• Drug tiers with differential co-payments
  o Federal law requires that individuals pay no more than 5 percent of their household annual income on cost-sharing

• Restrictive formulary/generic-only coverage/single statewide formulary
  o Preferred Drug List is Medicaid’s alternative. Federal law requires Medicaid must cover products for manufacturers participating in drug rebate program

• Restrictive networks of participating pharmacies
Wisconsin Medicaid Program Review of Stimulant Drug Use in Children and Adolescents: Survey and Outcomes

Given the high volume, cost, and daily dosages of stimulants prescribed to Wisconsin Medicaid Program* members, the Wisconsin Drug Utilization Review (DUR) Board established a maximum daily dosage for children 14 years of age and younger and initiated a review of stimulants prescribed to children in this age group exceeding 125 percent of that maximum daily dosage threshold.

Follow-Up Review:

140 providers responded to the survey. A follow-up review was conducted eight months later:

- 50 percent reduction in the number of children who exceeded the daily dosage threshold.
- 41 percent reduction in the number of prescribers who had members exceeding the daily dosage threshold.

*Indicates members enrolled in Wisconsin state health care programs, including Wisconsin’s Medicaid and BadgerCare Plus programs.

List of Stimulants and Maximum Daily Dosages Established by Wisconsin DUR Board:

- Amphetamine Mixed Salts (Adderall): 75 mg per day
- Dextroamphetamine (Focalin): 37.5 mg per day
- Dextroamphetamine: 50 mg per day
- Lisdexamfetamine (Vyvanse): 87.5 mg per day
- Methylphenidate: 75 mg per day
- Methylphenidate ER (Concerta): 90 mg per day
- Methylphenidate Transdermal (Daytrana): 37.5 mg per day

**Critical Findings from the Survey**

Prescribers use varying strategies for determining stimulant dosages, including the following:

- Dose on a milligram/kilogram (mg/kg) basis.
- Employ the “start low, go slow” method, which uses clinical response and absence of adverse effects to guide dosage maximum.
- Use larger dosages for children felt to be “rapid metabolizers.” (Note: This approach is rarely verified with genetic studies. While there is genetic variability in the metabolism of amphetamines, there is little evidence for similar variable metabolism of methylphenidate compounds.)

Prescribers use Attention Deficit/Hyperactivity Disorder (ADHD) symptom checklists inconsistently. Clinic managers and prescribers indicated the use of checklists depends greatly on clinic infrastructure, which includes staffing patterns and adherence to procedures for distributing, tracking, and retrieving checklists. By specialty, prescribers using checklists for at least 75 percent of their patients as follows:

- 87 percent of pediatricians
- 50 percent of nurse practitioners
- 40 percent of family practitioners or physician assistants
- 40 percent of psychiatrists

**Ongoing Clinical Considerations for Prescribers**

The Wisconsin DUR Board offers the following clinical considerations regarding stimulant dosing for children:

- Given the well-known concerns about appetite suppression, weight and growth suppression, cardiovascular effects of stimulant medications, and potential for diversion and abuse, prescribers are encouraged to be vigilant with escalating dosages of stimulants.
- Rather than dosing on an mg/kg basis, both the American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry recommend dosing titration up to the maximum recommended dosage, stopping when the optimum clinical effect has been reached without adverse side effects.
- Practitioners prescribing stimulant dosages greater than 125 percent of the maximum daily dosage should document a thorough individual and family cardiovascular history, as well as obtain a cardiovascular assessment from a primary care provider and/or cardiologist if there are any historical concerns.

**Access the Wisconsin DUR Newsletter**
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<tr>
<th>Drug</th>
<th>Pre-intervention Dosage</th>
<th>Post-intervention Dosage</th>
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Percentage Change Pre-intervention versus Post-intervention

Amphetamine Mixed Salts (Adderall): -16.1%

Dexmethylphenidate (Focalin): -29.6%

Dextroamphetamine: -42.6%

Lisdexamphetamine (Vyvanse): -32%

Methylphenidate: -37.4%

Methylphenidate ER (Concerta): -14.7%

Methylphenidate Transdermal (Daytrana): -22.1%
Pharmacy Management Statistics

How well is Wisconsin Medicaid managing costs?
Total and Net Paid Amount PMPM

- **Total Paid**
  - 2009: $56.88
  - 2010: $56.88
  - 2011: $56.88
  - 2012: $56.88
  - 2013: $57.76
  - 2014: $75.08
  - 2015: $85.12

- **Net Paid**
  - 2009: $31.96
  - 2010: $31.96
  - 2011: $31.96
  - 2012: $31.96
  - 2013: $27.32
  - 2014: $27.32
  - 2015: $27.32
  - 2016: $31.41
Future Opportunities

Where does our data show us that new tools are needed?
What Tools are Needed?

• Value-based purchasing
  – SMART D
• Policies to address orphan drugs
• Pricing transparency
• Flexibility