
SPECIALTY PHARMACY NEWS

PA Medicaid MCO Is Three Years Into SP Program Despite Limits

As a Medicaid managed care organization (MCO) with certain benefit-design limitations, Philadelphia-based AmeriHealth Mercy jumped right into product and service cost control and utilization management (UM) when starting its "pharmacy-based" injectable/biological management program roughly three years ago, Associate Vice President of Pharmacy Services James Brehany, Pharm.D., said at the 17th Annual National Managed Health Care Congress held March 7 - 9 in Washington, DC.

For example, the 310,000-member Medicaid MCO cannot charge a copay for prescription drugs, so it does not have the ability to cost shift or cost share as some plans might do, "which is one of the reasons we had to work so hard to manage utilization," said Brehany. Since the HMO uses an IPA model, the plan's physicians are paid on a capitated basis and accept no financial responsibility for oral or injectable drugs. The company has a formulary with a prior-authorization (PA) process for medical necessity, to which any additions and deletions must be approved by the Pennsylvania Department of Public Welfare and the plan's pharmacy and therapeutics (P&T) committee. And Pennsylvania also has an "any-willing-provider" statute that prevents the creation of any kind of limited or restricted networks for access to pharmaceutical products.

Given those plan aspects, Brehany said the HMO decided on a three-phase injectable/biological program strategy that involved:

- (1) Product and service cost control,
- (2) Basic UM, and
- (3) Case management and disease state management.

Partly because of some of the successes demonstrated by AmeriHealth Mercy's PBM product, PerformRx, the company elected to put the responsibility of managing injectables solely in the pharmacy department. "We wanted to put the same programs and practices in place that we used with our oral medications for our typical pharmacy benefit with our injectable and biotech drugs," said Brehany. "So we left [specialty pharmacy] as a medical benefit and carved out the management of that benefit to the pharmacy department."

MCO Found Lack of Claims Oversight

A self-assessment of the MCO's injectable claims found that they were "not really being reviewed with

any great oversight." AmeriHealth Mercy saw that provider claims were being submitted through the medical claims department on paper HCFA 1500 forms, resulting in duplicate billings (through the PBM unit and paper claims through the MCO). In addition, the HMO typically didn't know what drugs were actually being billed or how much was being paid for any one drug because of the imprecise coding (HCPCS, J, S and Q codes), and it had trouble tracking utilization because the claims data were being stored in multiple systems.

Prior to implementing the program, AmeriHealth Mercy was also not getting any kind of discounts on injectable products. Instead, it was paying out the average wholesale price (AWP) plus a percentage. There was no injectable formulary or prospective drug utilization review, and the cost trend of injectable drugs was 30% to 35% annually.

Cost Control Was Split Four Ways

The initial cost-control phase of the SP implementation involved four main elements and some subsequent revisions, according to Brehany. They are:

(1) Centralizing the billing for injectable products.
 "The first step we feel is — unless you know how you're paying, what you're paying and who you're paying — you really can't do the rest of the steps. So the first thing is to get an idea of where you're at and get a handle on the billing," said Brehany. In centralizing the billing process, the MCO limited the PBM's ability to bill for any of the injectable products, which also resulted in a lower incidence of duplicate billing.

(2) Implementing a specialty injectable network.
 This enabled the company to negotiate better pricing than it had on the medical side. Instead of the previous AWP plus a percentage, AmeriHealth Mercy negotiated rates ranging from AWP - 15% to AWP - 30%, depending on the product, according to Brehany.

(3) Putting in a "product replacement" distribution system, which took away from the physicians their ability to bill for medications when they used a medication for a particular patient population. Instead, they would have to let the health plan know what that medication was, and the MCO would replace it. All injectable (including self-injectable) products had to be distributed to providers and members through contracted vendors.

Because this program was affecting patient access, the health plan eventually had to enlarge the replace-

ment distribution network and made self-injectable drugs available through the retail pharmacy network (pharmacies had been unhappy with new program requirements). "We continue to use the drug replacement program but are allowing physicians to bill and be paid at the same price that we're paying our replacement vendors, so if they want to dispense the product and bill us, we would allow it and they can be compensated," added Brehany.

(4) Requiring prior authorization. In addition, all products — with the exception of insulin and specific behavioral health products — would require PA before the products could be dispensed, which can result in "quite a bit of savings," he said. He pointed out, however, that "when we're talking about prior authorizing these types of drugs, it's not to say 'yes' or 'no' to them, but to check utilization, appropriate dose, appropriate duration of therapy — any ways we can eliminate waste."

UM, Case Management Get Additional Savings

Once the MCO had the major cost-related issues sorted out, it began setting up UM and case management programs one disease state at a time. In 2001, it implemented programs to manage Synagis (palivizumab), an expensive and often overutilized vaccine for respiratory syncytial virus (RSV) in young children, and Procrit (epoetin alfa) for chemotherapy-related anemia. In 2002, it began managing treatments for growth hormone, hepatitis C, multiple sclerosis and rheumatoid arthritis, and in 2003 Epogen (epoetin alfa) for end-stage renal disease, and in 2004 Fuzeon (enfuvirtide) for HIV, Xolair (omalizumab) for allergic asthma and Risperdal Consta (risperidone) for schizophrenia.

AmeriHealth Mercy decided not to have the UM segment be managed by the drug distributors in order to avoid bias. "It's much more egregious in this particular area when you have a vendor who stands to make \$2,000, \$3,000, or \$4,000 off a single order. Their ability to be clear on how they can dispense this particular product gets a little muddy," Brehany said.

Synagis was one of the areas that showed significant results for both AmeriHealth Mercy and one of its affiliate plans, Virginia Premier Health Plan, which in 2004 incorporated some of the above strategies into its own injectable management program. While the "cost-effectiveness of Synagis remains controversial," AmeriHealth Mercy instituted PA criteria for appropriate use based on guidelines set by the American Academy of Pediatrics and included the product in its drug replacement program, which eliminated overpayment, said Brehany.

With the estimated five-month cost of RSV vaccinations at between \$3,500 and \$6,500 per patient, AmeriHealth Mercy found value in reviewing all Synagis requests and ended up saving an estimated \$2.5 million in the first few years of the program. In the first year, for example, it reviewed 403 requests and denied 37, saving approximately \$350,000. In the third year, it reviewed 545 requests, denied 131 of those, and saved approximately \$980,000. Brehany said those denials had little effect on the medical side, with virtually no hospitalizations or additional medical needs for those patients who were denied.

Melvin Pinn, M.D., senior medical director of Virginia Premier, said the most important consideration in Synagis management is whether the child is born premature or has congenital heart disease. It also "takes awhile to convince providers that they don't need to give Synagis to a kid who has a smoker in the household," he said. The 92,000-member Medicaid MCO has saved more than \$500,000 since implementing the program in 2004 to prevent inappropriate utilization.

Brehany told *SPN* the use of Phase Three programs, which feature more specialized case and disease management, is having a greater impact on appropriate utilization than the point-of-sale (POS) edits developed in Phase Two. "However, as the ability to use POS electronic adjudication for injectables/biologicals/biotech drugs improves, the usefulness and benefits of the Phase Two edit process will also improve."

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