The Pulse

Winter 2018

Parkland Community Health Plan, Inc.

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Important Message - Updating Provider Information

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It is important for Parkland Community Health Plan (PCHP) to keep our provider network information current. Up-to-date provider information allows PCHP to accurately generate provider directories, process claims and communicate with our network of providers. Providers must notify PCHP of changes in writing at least 30 days in advance when possible, such as:

- Change in practice ownership or Federal Tax ID number
- Practice name change
- A change in practice address, phone or fax numbers
- Change in practice office hours
- New office site location
- **Primary Care Providers Only:** If your practice is open or closed to new patients
- When a provider joins or leaves the practice

Changes should be submitted on the Provider Information Update Form located on the PCHPs website at **www.parklandhmo.org** under the Provider Forms section.

Send changes to:
Email: **PCHP.CREDENTIALING@phhs.org**

Contact your Provider Services Representative at **1-888-672-2277** if you have questions.

Pharmacy Corner

5 trends shaping health system pharmacies next year
Healthcare leaders should expect changes as specialty drug spending continues to grow and health systems move to bring services closer to patients, among other trends in the new year, according to a new report from the McKesson Rx team.

Here are five predictions for health system pharmacies:

1. Spending on specialty drugs will grow. Currently, specialty drugs represent about 45 percent of the pharmaceutical market spend in the U.S. In 2018, hospitals saw a 16 percent growth in the market, according to an IQVIA, National Sales Perspectives report. This trend shows no signs of slowing in 2019, according to McKesson.
2. The rise of convenient, "next-door" healthcare. To keep costs down and ensure patients have easy access to healthcare, health system pharmacies are working to bring care closer to patients. Employers are looking to contract directly with local providers to establish regional markets. Many of these contracts in 2018 centered on pharmacy services being integrated into retail locations or stand-alone medical clinics, a trend McKesson expects to continue into next year. McKesson also said it has observed several examples of health systems partnering to expand pharmacy and health services locally.
3. 340B compliance gets tougher, requires more focus. As Congress considers changes to the 340B Drug Pricing Program and program compliance gets tougher, health systems will need to increase their focus on compliance and performance. To ensure they meet program requirements, McKesson recommends tapping industry experts.
4. Data tracking and managing will become a core focus. Pharmacy directors are facing pressure to use data and analytics to optimize their health system pharmacies. Pharmacists will be called on to make monitoring drug spending and utilization continued top priorities next year, McKesson said.
5. Public policy will drive transparency. While prescribed medications are cost-effective in comparison to invasive procedures or repeated emergency room visits, the industry needs transparency about drug costs. Policies are in the works, and McKesson expects them to increase visibility about how prescription drug prices are set.

Non-Risk Based Payment for Crysvita

Crysvita (burosumab-twza) is indicated for the treatment of adults and children one year of age and older with x-linked hypophosphatemia (XLH), a rare, inherited form of rickets.

Crysvita will be included on the Nov. NDC-to-HCPCS Crosswalk with an effective date of Nov. 1, 2018. HHSC will account for the ingredient cost of Crysvita coverage in managed care using a non-risk payment process. Please refer to the "Non-Risk Based Payments for Crysvita" policy document for additional information.

In addition, the "Non-Risk Based Payment Drug Reference Table" lists clinician-administered drugs that must be designated with Financial Arrangement Code value of "20" on encounters. This table is intended as a resource to assist health plans in designating the appropriate code on

Update to 2018 Influenza Vaccine Guidance

HHSC has expanded the age range for optional coverage of the flu vaccine through the pharmacy benefit as of Oct. 19. Health plans have the option to allow pharmacies to bill for flu vaccines provided to people age seven and older in a pharmacy setting. If the health plan decides to pay pharmacy claims for influenza vaccines, health plan staff must:

- Ensure the influenza vaccine is a Medicaid-covered benefit
- Submit the value "7" in the "Submission Clarification Code" field (42Ø-DK) to designate the drug as non-formulary/ medically necessary on the encounter
- Submit the value "Q" (Drug not on Formulary) in the "Formulary Status" field (field 257)
- Submit the value "MA" in the "Professional Service Code" field (44Ø-E5) to designate the service on the encounter

Information on the procedure codes payable and the Medicaid influenza vaccine policy is found in sections 9.2.36 and 9.2.37 within the Texas Medicaid Provider Procedure Manual. This manual is updated monthly with the most-recent publication available online at **www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx**.

A separate "Flu Vaccine NDC/Procedure Code Crosswalk" will not be provided. Health plan staff, prescribing providers, clients, or any other interested party, may submit a proposal for changes to influenza vaccine coverage by completing the Topic Nomination Form (MS Word) and submitting both it and supporting documentation to MedicaidBenefitRequest@hhsc.state.tx.us. General questions regarding current influenza vaccine coverage may be sent **MCDMedicalBenefitsPolicyComment@hhsc.state.tx.us**.

Emergency Dispensing of Prescription Medications

The laws and rules governing the practice of pharmacy in Texas, allow pharmacists to provide emergency refills when the prescriber cannot be reached. Specifically, in an emergency, a pharmacist may use his/her professional judgment in refilling a prescription drug order for a drug (other than a Schedule II controlled substance) provided failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering.

In most cases, pharmacists may not dispense more than a 72-hour supply of medication. However, in the event of a natural or manmade disaster, the Texas Pharmacy Act (Sec. 562.054) and board rule 291.34 allow a pharmacist to dispense up to a 30-day supply of a prescription drug, other than a Schedule II controlled substance, without the authorization of the prescribing practitioner if:

- Failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;
- The natural or manmade disaster prohibits the pharmacist from being able to contact the practitioner;
- The governor has declared a state of disaster under Chapter 418, Government Code; and
- The board, through the executive director, has notified pharmacies in this state that pharmacists may dispense up to a 30-day supply of a prescription drug.

Accordingly, Allison Vordenbaumen Benz, R.Ph, M.S., Executive Director/Secretary, has authorized pharmacists in Texas to dispense up to a 30-day supply of medication (other than a II controlled substance) for patients affected in the counties in the disaster area. Board rule 291.34(b) (8)(E) outlines the procedures for dispensing medication in emergency situations as follows: §291.34 Records, (b) Prescriptions, (8) Refills.

(E) Natural or manmade disasters. If a natural or manmade disaster has occurred that prohibits the pharmacist from being able to contact the practitioner, a pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(i) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(ii) the quantity of prescription drug dispensed does not exceed a 30-day supply;

(iii) the governor has declared a state of disaster;

(iv) the board, through the executive director, has notified pharmacies that pharmacists may dispense up to a 30-day supply of prescription drugs;

(v) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(vi) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(vii) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this subsection;

(viii) the pharmacist affixes a label to the dispensing container as specified in §291.33(c)(7) of this title; and (ix) if the prescription was initially filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(I) the patient has the prescription container, label, receipt or other documentation from the other pharmacy that contains the essential information;

(II) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(III) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of clause (i) of this subparagraph; and

(IV) the pharmacist complies with the requirements of clauses (ii) - (viii) of this subparagraph

Opioids

Many people who develop a substance use disorder do so after initially receiving opioid prescriptions for an acute pain. In an effort to encourage appropriate use and reduce opioid over prescribing, MCOs must adhere to the requirements listed in the sections below.

A. Morphine Equivalent Dose and Day's Supply Limits

Morphine equivalent dose (MED) per day is used to describe the potency of one opioid to another for comparison. MED per day recommendations vary depending on clients' prior history of opioid use. Additionally, prescribing opioids for treatment of acute pain is rarely needed for more than seven days. Opioid prescriptions will be limited to a maximum of seven days for opioid naïve clients. This limitation is intended to reduce the risks of addiction or diversion of unused opioids.

With the exception of members with cancer, sickle cell anemia, or those receiving end of life, palliative, or hospice care, MCOs must implement the policies listed below for all other opioid naïve members and opioid experienced members.

1. Opioid naïve members:
   Opioid naïve is defined as members who have taken opioids for a duration less than or equal to (≤) seven days in the prior 45 day period.
   a. Authorization is required for an opioid prescription if the day supply exceeds seven days.
   b. The MCOs must not limit the maximum MED level to less than 50 MED for the opioid naïve clients.

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c. Authorization is required if the total daily dose of opioids exceeds 90 MED. Prior authorizations should be approved once per each claim.

2. *Opioid experienced members:*
Opioid experienced are defined as members who have taken opioids for duration greater than or equal to (≥) 60 days' supply of opioids within a quarter.
   a. Authorization is required if the total daily dose of opioids exceeds 90 MED.
   b. Duration of authorization should not be less than six months.

B. Retrospective Reviews
MCOs must perform annual retrospective drug utilization reviews on opioid overutilization to monitor prescribers for outlier activities. If the MCO identifies outlier prescribing patterns, then the MCO must conduct a review and, if necessary, an intervention, such as a letter or phone calls to the prescriber or a peer-to-peer review between the prescriber and the MCO.

C. Clinical Prior Authorization
HHSC has clinical prior authorization criteria approved by the Drug Utilization Review (DUR) Board related to opioid utilization. MCOs may choose to implement any of the approved criteria listed on the Vendor Drug Website.

Availability and Accessibility Requirements

Help us ensure your patients have timely and appropriate access to care. We want to remind providers of the required availability and accessibility standards, and ask that you review the standards listed below.

After hours access
The following are acceptable and unacceptable phone arrangements for contacting PCPs after normal business hours.

Acceptable:
- Office phone is answered after hours by an answering service, which meet the languages need of the major population groups served, that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned by a provider within 30 minutes.
- Office phone is answered after normal business hours by a recording which meets the language need of the major population groups served, directing the patient to call another number to reach the PCP or another designated provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
- Office phone is transferred after office hours to another location, where someone will answer the phone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable:
- Office phone is only answered during office hours.
- Office phone is answered after hours by a recording, which tells the patients to leave a message.
- Office phone is answered after hours by a recording, which directs patients to go to an emergency room for any services needed.
- Returning after hour calls outside of 30 minutes.