Unraveling the DNA of Managed Care

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Learning Objectives

• Define Managed Care

• Describe roles and responsibilities within a managed care organization

• Discuss hot topics in healthcare as they relate to managed care pharmacy
The presenters for this activity have been required to disclose all relationships with any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.

- Lauren Megargell, Pharm.D.
  - PerformRx Employee
- John Barrett, BSPharm, RPh.
  - PerformRx Employee
What is Managed Care?

A. The science or practice of the preparation and dispensing of medicinal drugs

B. An organized approach to financing and delivery health care, designed to improve the quality and accessibility of health care in a cost-effective manner

C. Providing both medical and non-medical services designed to meet a person’s health or personal needs during a short or long period of time

D. Practice or arrangement by which a company or government agency provides a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a premium
Question #2

Which of the following groups is **NOT** a major player in Managed Care Pharmacy?

A. Manufacturers  
B. Pharmacies  
C. DEA  
D. Consumers
Which of the following is a responsibility of the P&T Committee?

A. Review clinical guidelines
B. Evaluate and select drugs for the formulary
C. Develop procedure for the use and access of drugs
D. All of the above
E. None of the above
What is Managed Care?

An organized approach to financing and delivering health care, designed to improve the quality and accessibility of health care in a cost-effective manner.

• 1960s-1980s: Primarily fee-for-service insurance through employer

Rapidly escalating health care costs

Fragmented health care delivery

• HMO Act of 1973
  – Provided funding for federally qualified health maintenance organizations (HMOs)
Managed care is a prepaid, subscription health service, with defined benefits and fee structure:

- Members share costs through a monthly membership fee (premium)
- Predictable member access fees (copayment)
- Large membership distributes financial risk

Incentives for:
- Healthy lifestyle
- Preventative care
Who are the Main Players in Managed Care?

• Today, most health insurance *prescription drug programs* operate under managed care principles
  – Employer (Commercial) = 152 million members
  – Medicaid = 57 million members
  – Medicare Part D = 43 million members
  – Veterans Administration = 10 million members
  – Exchanges = 10 million members

**272+ Million Members**

**Based off data from 2016**
What Services are Covered Where?

**Medical Benefit**
- Inpatient Hospital Care
- Outpatient Services

**Pharmacy Benefit**
- Some OTC Drugs

**Medical & Pharmacy**
- Professional Services
- Prescription Drugs
- Vaccinations
- Devices
- Supplies
<table>
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<th>Pharmacy Benefit Management Services</th>
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### Clinical

**Benefit Design**
- Consumer driven health

**Formulary Management**
- Support P&T committee

**Drug Information**

**Clinical Programs**
- Utilization management
  - Prior authorization
  - Quantity limits
- Patient safety
  - Drug utilization review
  - Fraud/abuse prevention
- Health and Wellness
  - Disease management
  - Medication Therapy Management

### Operations

**Contact Center**

**Mail Order Pharmacy**

**Pharmacy Network Mgmt**
- Discount Drug Card
- P4P Programs

**Claims Processing**

**Implementation & Project Mgmt**

**PDE Encounters**

**Portal & Technology Operations**

**Rebate Mgmt**

**Specialty Pharmacy**

### Administration

**Account Management**

**Informatics**

**Marketing**

**Regulatory Compliance**
• A list of drugs approved for use in a given setting
  – Employer Groups
  – Hospitals and Health Systems
  – Pharmacy Benefit Managers

• Dictates prescription drug/class coverage and the level of coverage (i.e. patient copayment)
Pharmacy & Therapeutics (P&T)
Committee Composition

• Typically 10-15 members
• Primarily physicians and pharmacists
  – Includes local providers and specialists as well as plan medical and pharmacy director
• May include lay member(s)
  – Represents plan members
  • Ex. consumer advocates
• Meet oversight body requirements
  – CMS – Medicare P&T committees include at least one practicing pharmacist and one practicing physician who are experts regarding care of the elderly or disabled individuals
  – URAC – At least 50% of the pharmacists and physicians must be independent and free of conflict (health plan and pharmaceutical manufacturers)

• P&T Committee Example
  – Pennsylvania DHHS Pharmacy and Therapeutics Committee
• Objectively appraises, evaluates and selects drugs for the formulary

• Meets as frequently as is necessary to review and update the appropriateness of the formulary in light of new drugs and new indications, uses, or warnings affecting existing drugs
  – Most P&T committees meet quarterly
  – May be more frequently
  – Mechanism to address emergent issues
    • Ex. Market withdrawals
P&T Responsibilities

Committee Responsibilities

- Review clinical guidelines
- Review pharmacoeconomic studies
- Evaluate/select drugs for formulary
- Develop procedures for use/access of drug
- Oversee quality improvement programs
- Manage education programs
Decision Criteria

- Clinical efficacy
- Safety
- Therapeutic need
- Clinical guidelines
- Standards of medical practice
- Other treatment options
- Pharmacoeconomic models
- Cost
• What is a Rebate?
  – A rebate is a discount provided by the pharmaceutical manufacturer to the insurer as part of a formulary status agreement.

• Rebates may be
  – Flat rate
  – Market share driven
  – Value based

• Rebate revenues are shared by
  – Health Plan
  – Pharmacy Benefit Manager
  – Member
Drug Utilization Review

• Ongoing review of health care prescriber, pharmacist dispensing and patient use of medications
• Pharmacists, in collaboration with prescribers and other members of the healthcare team, can initiate action to improve drug therapy for patients
• Types
  – Prospective
  – Concurrent
  – Retrospective
Member & Provider Education

Medication Therapy Management

- Immunization
- Medication therapy reviews
- Pharmacotherapy consults
- Disease management coach/support
- Pharmacogenomics applications
- Other clinical services
- Anticoagulation management
- Health, wellness, public health
- Medication safety surveillance
Benefits to the Patient

Clinical
- Optimize medication therapy
- Increase adherence
- Improve clinical outcomes of disease management

Economic
- Reduce drug costs for patient
- Health plan cost-saving

Efficiency
- Streamline medication therapy
- Improve record keeping
- Increase accountability

Safety
- Prevent medication errors
- Resolve drug-related problems
- Catch adverse events

What is Medication Therapy Management (MTM). Clinical Apothecary. Available at: https://clinicalapothecary.com/2018/04/13/what-is-medication-therapy-management-mtm/
Pharmacy Network

• Contract between a PBM/health plan and
  – Individual pharmacy
  – Pharmacy chain
  – Pharmacy group

• Allows pharmacy to fill and be reimbursed for medications dispensed for a member of a health plan

• Outlines rights and responsibilities of contracted relationship
  – Credentialing
  – Payment
  – Auditing
Emergent Topics in Managed Care

- Direct and Indirect Remuneration (DIR)
- Transparency
- Safe Harbor
- Value Based Contracting
- State PDL for Medicaid
- Point of Care Testing
- Pharmacists as Providers
• DIR” stands for “direct and indirect remuneration” and was initially a term coined by the Centers for Medicare and Medicaid Services (CMS) related to the Medicare Part D benefit to address price concessions (e.g. drug manufacturer rebates) that would ultimately impact the gross prescription drug costs of Medicare Part D plans that were not captured at the point of sale.

• Really a “catch-all” term designed to encompass a number of different types of “fees” including “pay to play” fees for network participation as well as periodic reimbursement reconciliations.
• Pricing
  – Traditional Pricing
    • PBM charges a payer more than they reimburse a pharmacy for a certain drug, and keep the difference
  – Pass Through Pricing
    • PBM charge a payer the same price the reimburse the pharmacy...
    • There is a set administrative fee involved with the pass-through model

• Maximum Allowable Cost
  – Refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available (“multi-source brands”).¹

Safe Harbor

- Eliminates protection for manufacturer rebates on prescription drugs for Medicare Part D plans and Medicaid MCOs, including PBMs acting under contract with these plans.
- Does not apply to rebates to other payers (e.g., commercial).
- Does not apply to rebates required under law (e.g., Medicaid Drug Rebate Program).
- On July 10, the Trump Administration announced that it would withdraw a proposed rule to eliminate the safe harbor in the federal anti-kickback law for rebates negotiated by pharmacy benefit managers (PBMs) on behalf of Medicaid managed care plans and Medicare Part D plans.
Value Based Contracting

• Also known as risk sharing or outcomes based agreements
• Ties reimbursement with how well a drug performs for its intended use
• Pharma manufacturers and payers agree to link coverage and reimbursement levels to a drug’s effectiveness and/or how frequently it is utilized.
• Challenges in implementing value-based contracts:
  – How to monitor and track individual patients.
  – Pharma can’t control how a drug is prescribed or used and therefore is reluctant to accept outcomes produced.
  – Agreeing upon outcomes that are meaningful and measurable within a reasonable timeframe is challenging.
Pennsylvania’s Medicaid Managed Care Organizations (MCOs) currently pay for approximately 95% of the state’s Medicaid prescriptions.

Pennsylvania currently allows each Medicaid MCO to define and utilize its own preferred drug list (PDL).

Pennsylvania's Department of Human Services (DHS) has announced its intention for Medicaid MCOs to utilize a uniform, DHS established PDL starting 1/1/2020.

Pros and Cons
- Administrative Ease
- Consistent Access
- Rebate Maximization
- Pharmacy Impact
- Beneficiary Impact
• Point of Care Testing
  – Resource: 

• Pharmacists as Providers
  – California and Washington among the first states to successfully pass such legislation.
  – Collaborative Practice Agreements- Pennsylvania
Academy of Managed Care Pharmacy (AMCP)

- AMCP Resource Center
  - https://www.amcp.org/resource-center/tool-kits

- Fundamentals of Managed Care Pharmacy Certificate Program
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