Jamie Dudensing

TAHP
The Texas Association of Health Plans

Representing health maintenance organizations, health insurers, and other related healthcare entities operating in Texas.

About TAHP

Texas Association of Health Plans (TAHP) is a statewide trade association representing effectively all health plans (Commercial, Medicaid, CHIP and Medicare) doing business in Texas and is committed to improving access, value and quality of care throughout Texas.

WORKING TOGETHER FOR THE BETTERMENT OF EVERY TEXAN:

Searching for ways to contain cost growth without reducing access to needed health care services or creating undue burdens for providers.

- Ensuring actuarially sound rates for the Medicaid health plans allows the plans to more efficiently deliver quality services to Medicaid clients.
- Encourage HHSC to support policies and processes that best utilize Medicaid health plan expertise in delivering innovative solutions for quality health and life improvements while ensuring state funding stability.
- Ensuring clinical policy flexibility based on evidence based best practices is a key tool for health plans for improving health outcomes and managing overall costs.
- Ensure improved quality of care and the best use of increasingly precious Medicaid dollars by adopting a more sensible formulary approach and completing the pharmaceutical carve-in.

Did you know?

* HHSC currently contracts with 19 health plans around the state to serve Medicaid recipients
* Health Plans are accountable for the delivery of services to over
  - 90% of Texas Medicaid
  - 100% of CHIP recipients
* This model was first implemented in Texas almost 2 decades ago
* Texas is considered a leading innovator on the delivery of efficient and high-quality Medicaid programs

WORKING TOGETHER TO REDUCE ADMINISTRATIVE BARRIERS:

The current administrative structure for numerous, ongoing administrative requirements is based on a system in need of updating to reflect a more contemporary, technological age.

- Change the requirement for a legacy Texas Provider Identifier (TPI). Providers are already required to obtain a unique National Provider Identifier (NPI).
- Review the type and number of reports health plans are required to submit. Consider established national standards to reduce duplication of data and resources and to decrease cost and complexity where they exist for program functions and resources.
- Expand the use of online resources for member enrollment and re-enrollment, online provider directories, and member handbooks. Promote the expanded use of online resources provides for more accurate, real time data to better serve members and providers.
- Reduce the administrative complexities and eliminate duplication in the state's lengthy and cumbersome Medicaid enrollment and credentialing process.

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TAHP's Mission

The Texas Association of Health Plans (TAHP) is dedicated to its mission of advocating for public and private healthcare issues that improve access, affordability, and quality of care for many Texans.

THE TEXAS ASSOCIATION OF HEALTH PLANS (TAHP)

The Texas Association of Health Plans (TAHP) was founded in 1987 as the voice of health plans operating in Texas. Its membership of health maintenance organizations, health insurers, and other health care-related entities include some of our state's top employers. TAHP members provide health coverage for more than 90 percent of insured Texans, underscoring the Organization's commitment to improving access, value and quality of health care throughout the state.

TAHP brings together industry leadership to help forge solutions to critical health care issues facing Texas. Through their interaction with employers, consumers and providers, TAHP members bring unique insight and experience to the state's health care discussions. Serving as a resource to the Texas Legislature is a top priority of TAHP and its membership.

On behalf of its members, and the millions of Texans who benefit from health care coverage, TAHP is committed to enhancing our state's health care system by expanding access, maintaining affordability and ensuring quality care is delivered.

Did you know?

The health plan managed care model is recognized as a cost effective Medicaid delivery model. This delivery model:

* provides the state budget certainty
* assumes the financial risk of care delivery
* provides budget savings for state while delivering quality care
* offers access to full spectrum of medical services plus additional benefits not available under traditional Medicaid

Health Care Delivery Programs in Texas

STAR	STAR+PLUS	STAR Health	CHIP
Implemented in 1990	Implemented in 1998	Implemented in 2008	Established in 1997
Provides acute care services for non-disabled pregnant women and children	Provides acute and long term services and supports (LTSS) for Medicaid clients with disabilities and people jointly eligible for Medicaid and Medicare	Provides acute care services with emphasis on behavioral health and medication management.	Provides acute care services for children under age 19 and limited prenatal care for some at risk infants and their mothers
*STAR enrollment**	*STAR+PLUS enrollment**	*STAR Health enrollment**	*CHIP enrollment**
2,494,551	***412,490***	***31,260***	***602,457***

*Data from: http://www.hhsc.state.tx.us/research/index.html

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Texas Association of Health Plans
Medicaid Prescription Drug Formulary
Briefing Paper
November 2014

Recommendation:

Medicaid managed care health plans should assume both the clinical and administrative oversight for Medicaid and CHIP prescription drug management, in addition to holding risk for these services.

Prescription drug formularies, clinical edits and other related drug management processes are the backbone of truly integrated care, increased clinical quality and decreased medical costs across the full spectrum of care. This is not just a supplemental cost management strategy, but an outcomes improvement strategy.

Savings:

$64 million in general revenue savings in a biennium

Background:

In March of 2012, prescription drugs were carved into Medicaid managed care contracts in Texas and the monthly premiums were adjusted accordingly. In the process, managed care organizations (MCOs) took on the full risk for quality and care associated with Medicaid MCO consumers, but were not given the tools that are typically used in the private health insurance market and Medicare to control costs and improve health outcomes. Additionally, HHSC is holding plans financially accountable for improving health care outcomes without the full availability of these resources. Formulary design with drug clinical management is critical to effective pharmacy cost management. Instead, MCOs are handcuffed by a single statewide formulary (a tiered list of prescription drugs available to enrollees) that is developed and managed solely by HHSC with very little input or participation by MCOs, does not react quickly to market changes and does not support the use of the most effective clinical and safety guidelines.

HHSC has estimated that the state could achieve an additional savings of $64 million in general revenue (GR) per biennium by moving from a single statewide formulary in Texas Medicaid and CHIP programs to formularies developed by each MCO[1]. These savings would be in addition to the savings achieved from carving in the vendor drug program. Similarly, a TAHP-funded study completed by Milliman prior to the 83rd legislative session showed that the state could achieve a similar savings of $73.7 million (including administrative costs) in the 2014-15 biennium[2]. Both of these projected savings are in addition to savings generated from prescription drug rebates. The majority of savings are from an increased use of generic and lower cost drugs. The Milliman study shows that, in the best-case scenario, the state's generic dispensing rates (GDR) moves from 73.8% to 81.9% after applying the formulary and would have resulted in around $25 million in savings for the six month period from March 1, 2012 to August 31, 2012[3]. However, the state's Vendor Drug Program (VDP) has no experience and no actual strategy to accomplish this. A full carve-in would save the state significant dollars by using MCO experienced resources for improving GDR.

[1] HHSC Pharmacy Benefit Cost Containment Initiatives - Summary Document, 2/16/2013
[2] Milliman, Letter to TAHP re: Revised Pharmacy Savings Estimates, April 1, 2013. The $73.7 million does not include additional savings or offsets from the ACA Health Insurance Tax or state premium tax revenue and therefore compares to HHSC savings estimates for initiative 6a of $64 million.
[3] Projected Impact of Formulary Carve-In for Texas Medicaid and CHIP Programs, Milliman, 2013 (funded by the Texas Association of Health Plans).

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In addition to containing cost in the Medicaid program, fully integrating the pharmacy benefit would allow MCOs to apply pharmacy management tools that improve quality of care and health outcomes. The use of a single statewide formulary fails to recognize the complexities of managing prescription drug benefits for Medicaid. A single statewide formulary does not allow the flexibility to best balance the health priorities associated with integrated care coordination and stifles MCOs' ability to innovate. Additionally, the use of a single statewide formulary adds complexity for prescribing providers, who are used to clinically relevant formularies that do not change which drugs are allowed on the formulary as rebates change. Integrated care coordination based on sound clinical evidence, a hallmark of managed care, benefits enrollees by improving clinical quality safeguards, increasing patient compliance, promoting generic drug use, and preventing potentially harmful drug interactions.

While the state has been responsible for creating clinical safeguards and taking into account healthcare outcomes, it does not have the same expertise for managing care as the MCOs and is unable to respond quickly to changes in clinical standards and changes in the market. Viewing the drug benefit in isolation from other health care benefits and management tools makes it difficult to impossible to achieve the same health outcomes and safeguards for enrollees that MCOs could achieve given full carve in. For example:

- It can take a more than a year for HHSC to develop a new clinical edit on a drug.
- Step therapies are underutilized in the Medicaid program. These best practices would ensure that Medicaid members are getting the best treatments with the least side effects and in many cases at a lower cost to the state.
- Safety edits in the system have not been robust enough to prevent the inappropriate overprescribing of powerful antipsychotics to very young children.
- MCOs are able to offer life saving therapies more quickly than the VDP process as well as move to generics more quickly when they become available.
- MCOs can provide clinical edits based on national professional society recommendations in a more timely manner. For example, the American Academy of Pediatrics updated the criteria for infants eligible for Synagis, a very expensive ($1000) monthly injection to prevent a viral infection of the lungs in premature infants. The updated criteria were published in 2009 but not instituted by the VDP until the 2012-13 season.
- MCOs have the ability to communicate with physicians in a more timely manner (if allowed by HHSC) to assist with formulary changes and best practices in prescribing.

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Historically, a major driver of Texas's carve-out approach has been pharmaceutical rebates. In the past states were only eligible to receive federal rebates when paying for drugs on a fee-for-service basis; drugs purchased through MCOs were not eligible for rebates. Federal law has changed and states that carve prescription drugs into an MCO's capitated rates are now able to collect rebates. As a result, the state now has the opportunity to achieve additional rebate savings while fully integrating benefits to improve health care outcomes.

CONCLUSION:
Completing the pharmaceutical carve-in by adopting a more sensible formulary approach will make best use of increasingly precious Medicaid dollars and improve quality of care to a level that Texans deserve.

The October 2014 Sunset Commission staff report on the Health and Human Services Commission and System Issues found that "HHSC Has Not Fully Adapted Its Processes to Managed Care, limiting the Agency's Ability to Evaluate the Medicaid Program and Provide Sufficient Oversight ."

Specifically, the Sunset Report found that HHSC's oversight of drug benefits has not adjusted to managed care and that the focus on fee-for-service comes at the expense of the state providing sufficient oversight of managed care organizations and their subcontracted PBMs.

While Sunset staff has recommended several management actions and statutory changes, it has stopped short of recommending a full pharmaceutical carve in. TAHP believes now is the perfect opportunity to fully coordinate Medicaid Managed Care benefits, including moving to a fully carved-in pharmacy benefit. HHSC is using limited resources administering a benefit that is already effectively administered in the private market.

Health plans should assume both the clinical and administrative oversight for Medicaid and CHIP prescription drug management, in addition to being held at risk for these services.

Prescription drug formularies, clinical edits and other related drug management processes are the backbone of truly integrated care, increased clinical quality and decreased medical costs across the full spectrum of care. This is not just a supplemental cost management strategy, but a strategy to improve health outcomes.

An effective pharmacy program for Texas should focus on:

- *Providing the most effective pharmaceuticals for Medicaid members at the lowest cost.*
- *Ensuring formularies are crafted on evidence-based standards and other quality of care safeguards.*
- *Allowing for utilization management based on fully integrated care.*
- *Ensuring a program that reacts quickly to new safety concerns, changes in the market and new clinical standards.*
- *Fully integrating benefits so that all tools are available to improve health quality outcomes for consumers.*

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Issues with the current Vendor Drug Program:

- The current VDP is developed to sustain rebate dollars, versus being primarily focused on evidence-based clinical algorithms familiar to providers and critical to improved outcomes and decreased costs. This is administratively counter-intuitive and complex for clinicians to administer. It also continues reliance on more costly brand versus generic prescription drug options.
- Focusing on rebates as the driver of the Medicaid and CHIP prescription drug options works against opportunities to look at the full continuum of health care. A fully integrated approach favors true-cost and outcomes improvement. Federal law now allows states that carve prescription drugs into an MCO's capitated rates to collect rebates.
- Health Plans have a number of resources to ensure that prescribers and enrollees are aware of generic therapeutic options and the need to increase use of these less costly, effective prescription drug resources.

Supporting Literature

Milliman

TAHP asked Milliman to evaluate the expected impact of moving from a single statewide formulary in the Texas Medicaid and CHIP program to formularies specified by each Texas Medicaid MCO. The report estimated the potential savings of moving from the current partial carve-in to full carve-in, allowing multiple formularies, and giving the plans the ability to apply other pharmacy management tools.

- Projected Impact of Formulary Carve-In for Texas Medicaid and CHIP Programs, Milliman, 2013 (funded by the Texas Association of Health Plans)
- Milliman Letter: Revised Pharmacy Savings Estimates. April 1, 2013

Experience in Other States

The Lewin Group

A February 2011 report by the Lewin Group sponsored by the Medicaid Health plans of America estimated the saving that may result for each state if they had full carve-in of prescription drugs.

The study found that "considerable evidence exists" demonstrating MCOs manage pharmacy benefits more efficiently than occurs in the Fee for Service setting.

- Projected Impact of Adopting a Pharmacy Carve-In Approach Within Medicaid Capitation Programs, the Lewin Group, 2011

New York:

The state of New York carved prescription drugs into its Medicaid capitation on October 1, 2011, including MCO-specified formularies.

2011 Mercer Study:

"This study considers policy options and identifies best practices in the purchasing and management of prescription drugs in the 2011 Medicaid environment; the study also examines New York's Medicaid prescription drug program- including pharmacy program carve-out."

A September 2012 analysis by Mercer reviewing the first six months of carve-in experience concluded, "health plans have achieved GDRs that far exceed the assumptions used to develop the regional average premiums during the first six months of the carve-in."

- Medicaid Prescription Drugs: Purchasing and Management, Mercer Government Human Services Consulting, 2011.
- Mercer, Katherine Long, ASA, MAAA, Ton Ogborne, FSA, CERA, MAAA, Mike Zucarelli, BS, PharmD September 11, 2012. FISCAL YEAR 2011-12 MEDICAID MANGAGED CARE AND FAMILY HEALTH PLUS PHARMANCY REVIEW.

Savings Generated by New York's Medicaid Pharmacy Reform, Prepared by Special Needs Consulting for the Pharmaceutical Care Management Association, 2012

The Study's major findings include:

- New York Medicaid saves $425 million in 2012, four times greater than expected.
- The federal government saves more than $212 million.
- The vast majority of savings is from greater use of generics and lower-cost brands.
- Dispensing fees are no longer higher than those paid by Medicare and private insurers.
- There is even greater savings potential since New York has yet to tap into the savings available through affordable pharmacy networks and targeted use of mail-service pharmacy.

Data on States' Collection of Rebates for Drugs Paid through Medicaid Managed Care Organizations:

Effective March 23, 2010, the ACA expanded the Medicaid rebate requirements to include drugs dispensed to beneficiaries by a Medicaid MCO. As a result, States contracting with MCOs that carve prescription drugs into the MCOs' fixed payments are now required to collect rebates. The rebate expansion has the potential to provide these states with a significant source of additional funds.

- *"States' Collection of Rebates for Drugs Paid Through Medicaid Managed Care Organizations", Department of Health and Human Services, Office of the Inspector General, 2012.*