



# DEPARTMENT OF HUMAN SERVICES

## Pharmacy benefits in public health care programs

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# Optional vs. mandatory pharmacy benefit

## **Optional:** for members older than 21

- Exception: Medication Assisted Treatment (MAT) for opiate dependence mandatory as of 10/1/2020

## **Mandatory:** essentially for members younger than 21

- Early and Periodic Screening, Diagnostic and Treatment requires states to provide all Medicaid-covered, appropriate and medically necessary services, even optional benefits that aren't covered through the State Plan
- Does not require coverage of experimental or investigatory services or drugs



# What drugs are covered?

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- Any FDA-approved prescription medication manufactured by a drug company that participates in the federal Medicaid Drug Rebate Program. If manufacturers participate in the rebate program, Medicaid must cover their drugs.
  - Limited exceptions exist.
  - All MAT drugs.

# How DHS pays for prescription drugs

## Fee for service

- DHS processes the claims and pays providers directly.

## Managed care organizations

- DHS pays the managed care organizations to provide benefits to their enrollees. The MCO processes the claims and pays providers.



# How pharmacy reimbursement works



**Parts**  
(the cost of the medication itself)



**Labor**  
(the cost of dispensing drugs)

# How people we serve access drugs



## Outpatient pharmacy

- Drugs dispensed by a pharmacy for self-administration or consumption
- Billed by the pharmacy as a pharmacy claim



## Provider administered

- Drugs administered to a member by a provider in an outpatient clinic or facility
  - Many of the drugs require administration by a provider are accompanied by other concurrent treatment or require closer monitoring.
- Billed by the provider as part of the medical claim

# Pharmacy snapshot: calendar year 2019



**862,000:** Medical Assistance members filled at least one prescription



**\$1.27 billion:** Outpatient prescription drug expenditures (excluding rebates)



**\$493 million:** Federal Medicaid drug rebates Minnesota collected

# Federal restriction on sharing information

- Federal law prohibits state Medicaid programs from talking about drug prices and rebate amounts
- Only allows sharing of aggregate information
- Prevents transparency on actual costs of drugs



# How can the pharmacy benefit be managed?

## **Prior authorization**

Ensures drugs are safe, effective and most cost advantageous option (when applicable). Promotes appropriate utilization and program integrity.

## **Preferred drug list**

Similar to prior authorization but generates supplemental drug rebates.



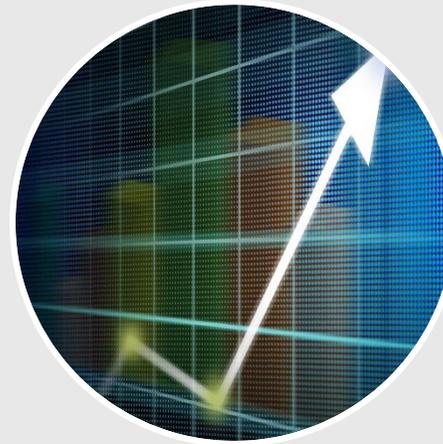
# A uniform preferred drug list



Reduces administrative burden for providers



Decreases disruptions in therapy for enrollees changing health plans or programs



Can generate savings for the state and taxpayers

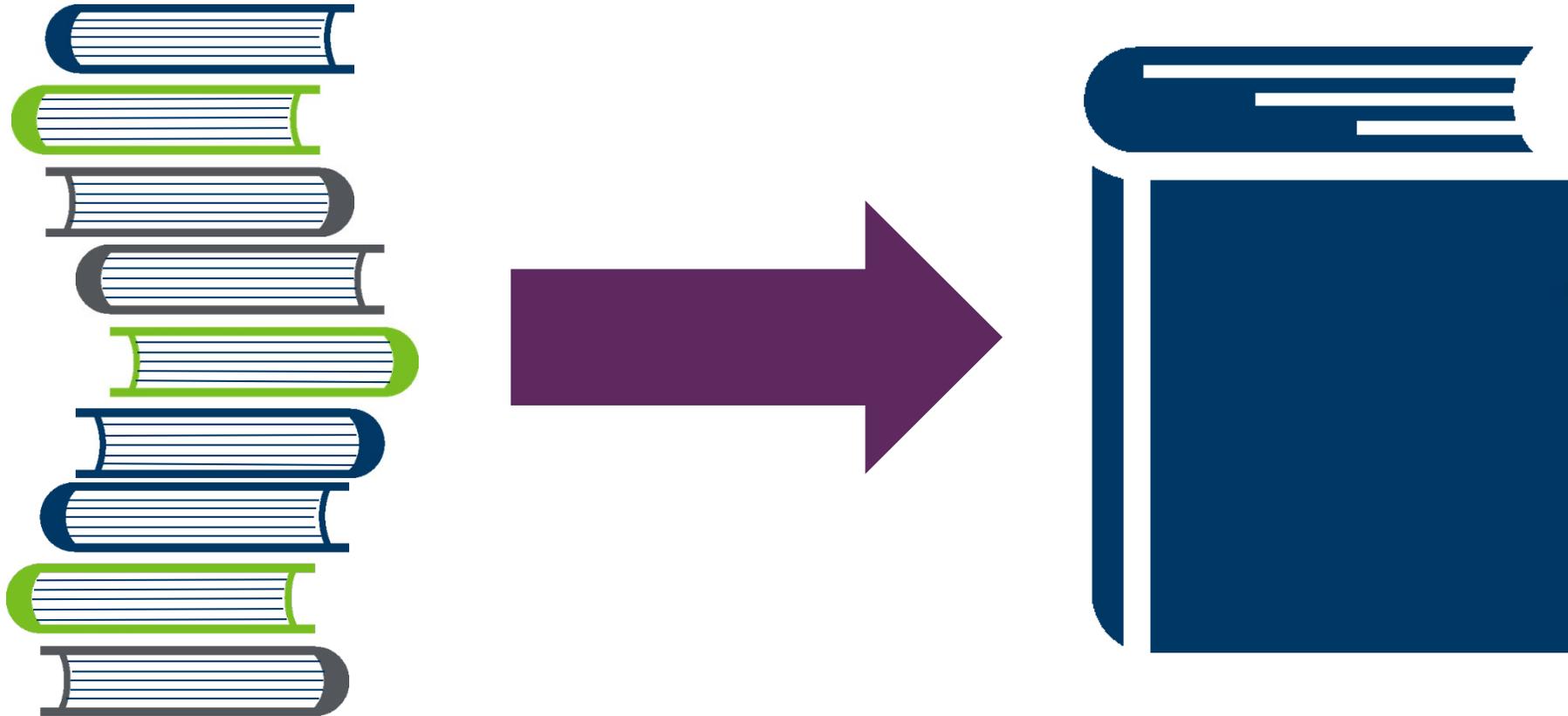


Ensures more transparent, public processes

# Simplifying the pharmacy benefit

Nine different preferred drug lists

One uniform preferred drug list



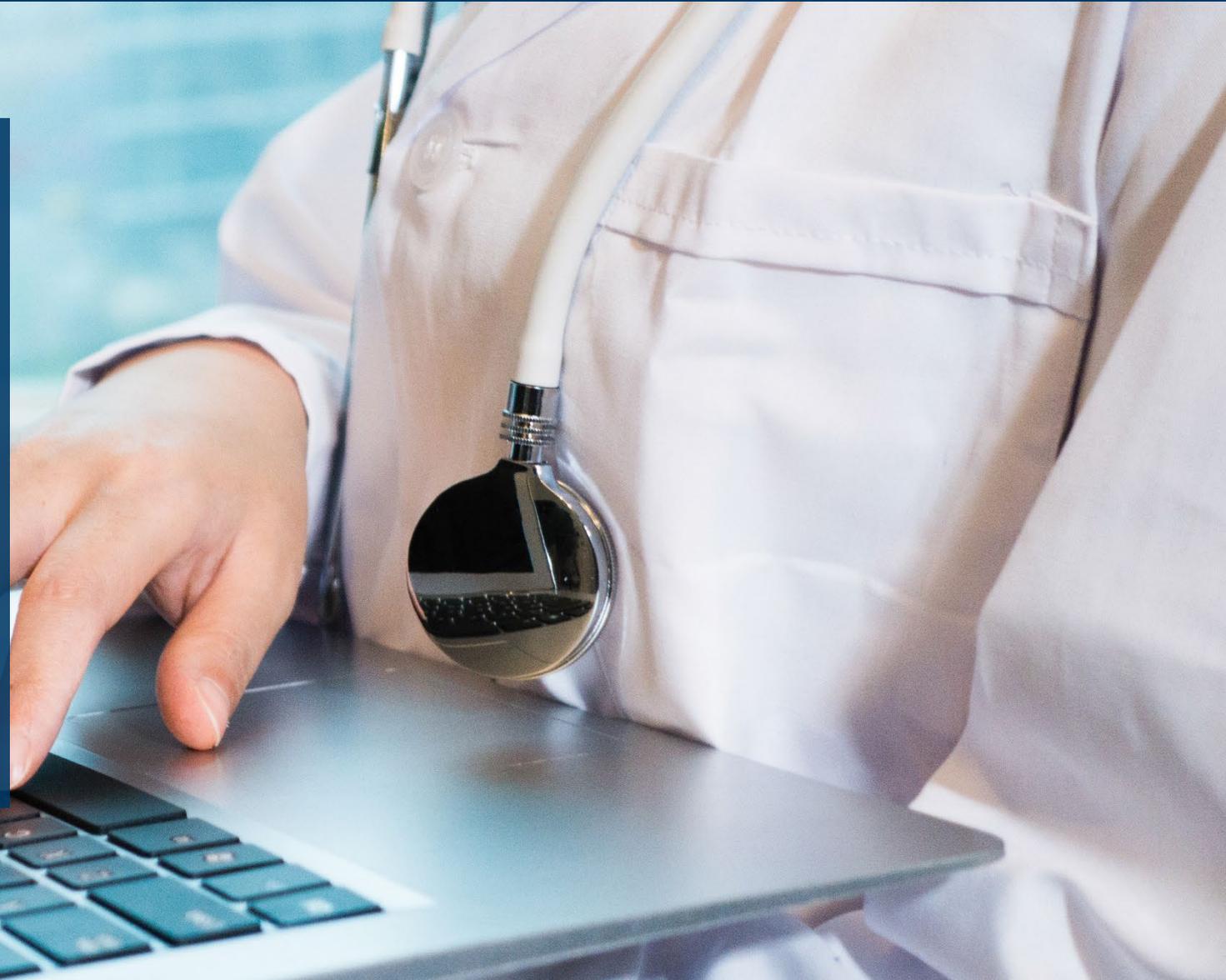
# Who manages the preferred drug list?

- The Drug Formulary Committee manages the preferred drug list through its open, public process.
- Volunteer members include health care professionals and a member of the public.
- The committee reviews drug classes and recommendations for safety and efficacy.
  - Cost information cannot be discussed at the meetings or shared with the members due to the federal restriction.



# The Drug Formulary Committee hosts public meetings

- The meetings transitioned to an online format during COVID-19.
- Committee members accept public comments:
  - In writing before the meetings or up to 15 days after the meetings.
  - Verbally at the meetings.
- The committee makes recommendations to the department.
- The department must provide its contracted managed care organizations with at least 60-days notice of changes to the preferred drug list.



# Department considerations in bringing topics to DFC

The department works with our vendor to assess a number of considerations, such as:

- Member impact (anticipated shifts in utilization vs. impacts on new regimens).
- Current utilization and trends.
- Clinical appropriateness and choice among preferred drugs.
- Availability and access to preferred drugs.
- Financial impacts (e.g., rebates and copayments).



# Federal law establishes standards on prior authorizations



Requires a response within 24 hours



Requires a 72-hour supply in emergency situations



Allows limitations to discourage fraud, waste, abuse



Allows satisfaction of components of a drug use review program to ensure appropriate, medically necessary medications unlikely to produce adverse medical results

# Prior authorization vendor: Kepro

- A CMS-approved Quality Improvement Organization.
- Operationalizes the criteria that the DFC recommends and DHS implements.
  - Receives requests primarily by phone or fax, though a few are received by mail.
  - Reviews requests with clinical staff (technicians, pharmacists, nurses or physicians) as appropriate.



# Uniform pharmacy benefit



Consistency in pharmacy coverage for enrollees



Visibility into drug costs for the State



Public transparency into the pharmacy benefit

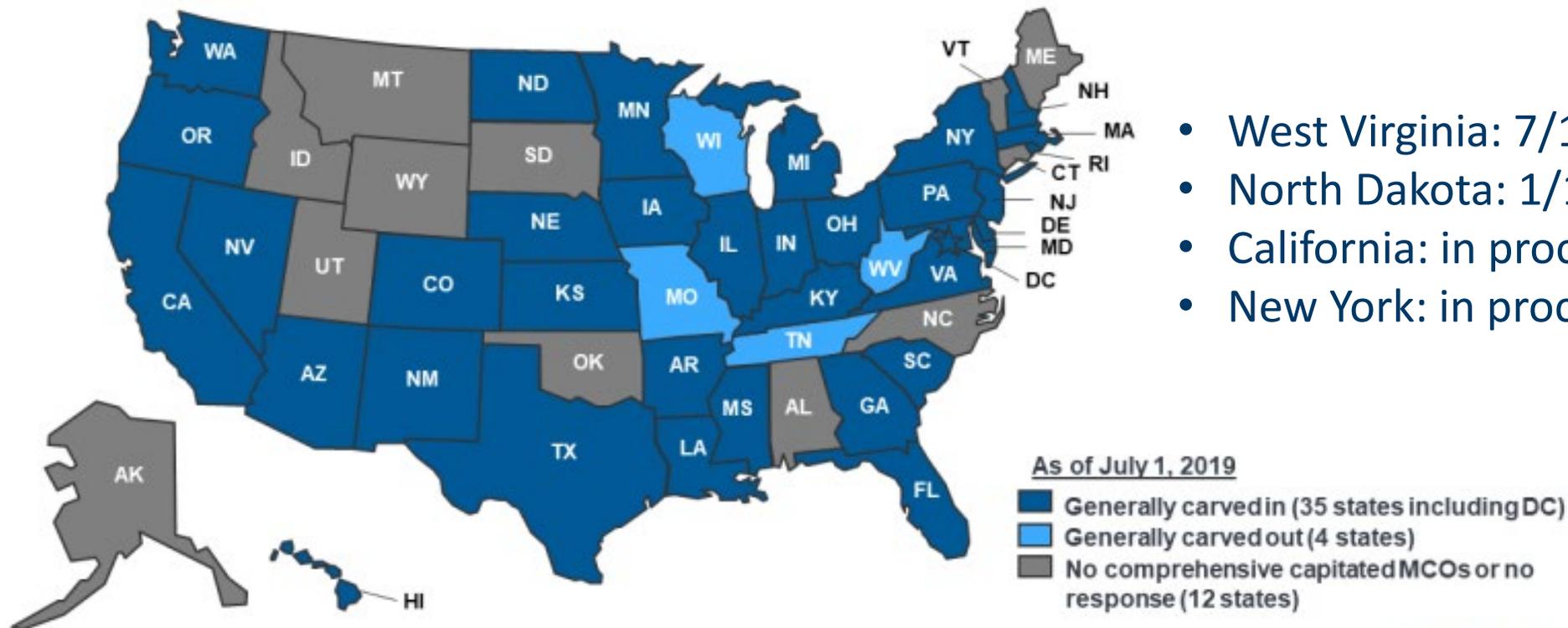


Cost savings for the State

# Uniform pharmacy benefit

Figure 1

## State coverage of pharmacy benefits in MCO contracts, 2019



- West Virginia: 7/1/2017 (\$54M savings)
- North Dakota: 1/1/2020 (>\$6.4M savings)
- California: in process
- New York: in process

NOTES: Responses as of July 1, 2019. WI reported that pharmacy services are carved out with the exception of a small population in the Family Care Partnership program which delivers long term care and acute care benefits, including pharmacy benefits. UT did not respond.

SOURCE: 2019 KFF/HMA survey of Medicaid officials in 50 states and DC, April 2020.

