

JMOC Update:

# Managed Care and Pharmacy Benefits

Barbara Sears, Director  
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March 15, 2018

# Perspective

- Recent events have highlighted opportunities to gain better transparency with Pharmacy Benefit Manager (PBM)
  - » Drug prices
  - » PBM spread
- Impacts all health insurance programs
  - » Public
  - » Commercial
- All states

**It is not simply an Ohio Medicaid issue**

# Medicaid Managed Care & Pharmacy Benefits

Ohio Medicaid includes pharmacy benefits in its comprehensive managed care package. Managed Care Plans contract with Pharmacy Benefit Managers (PBM) for program administration.

- Four of the Plans use CVS Caremark as its PBM, one uses Optum.
- Fee for Service uses a National Average Drug Acquisition Cost (NADAC) pricing model, which is published weekly by CMS. Fee for Service also pays a tiered dispensing fee.
- Managed Care uses Maximum Allowable Cost (MAC) pricing model, which is variable and based on the lowest average cost of acquisition for a specific drug.

# Pharmacy and the Fiscal Environment

- In a managed care environment, Managed Care Plans assume the financial risk of rising drug prices and utilization. 2017 Medicaid pharmacy spend was approximately \$3 billion.
- Returning pharmacy to the Fee for Service program will result in a *sizeable increase* in spend for Ohio Medicaid.
- **Transparency requirements** set to take effect in July will allow Ohio Medicaid to determine the “PBM spread” and manage accordingly. Resulting contractual changes would be based on real – and not perceived – data.

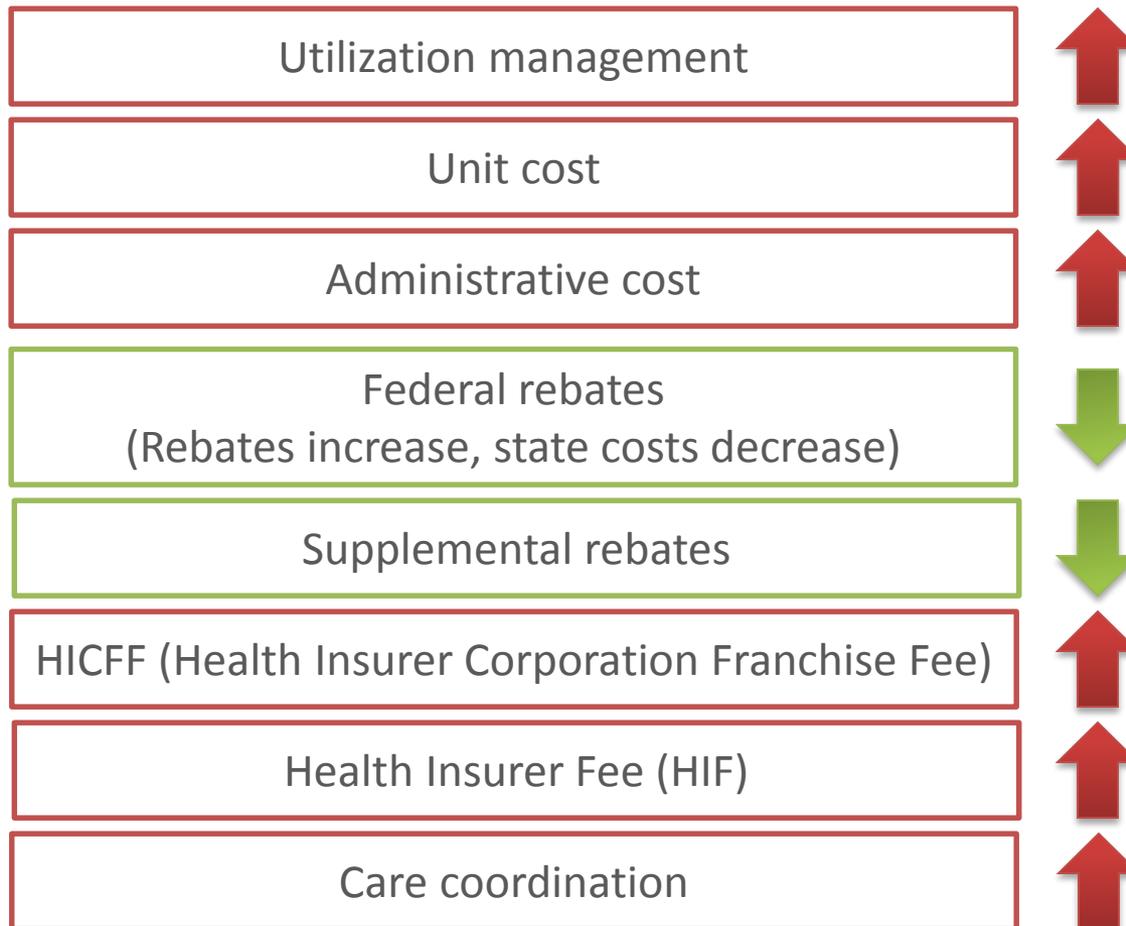
# Fiscal Impact of Pharmacy Carve-Out

	Annual Impact (\$ millions)
<b>Fiscal Savings</b>	
Increase in Pharmacy Rebates	\$286.9
<b>Total Estimated Fiscal Savings</b>	<b>\$ 286.9</b>
<b>Fiscal Costs</b>	
Increase in Paid Claims and Utilization	\$ (234.9)
Loss of Managed Care Plan Savings	(157.6)
<b>Total Estimated Fiscal Costs</b>	<b>\$ (392.5)</b>
<b>Composite Fiscal Costs</b>	
State Share of Fiscal Cost $((\$286.9 - \$392.5) * 31\%)$	\$ (32.7)
Loss of Managed Care Fees and Taxes	(100.0)
<b>Estimated Net Fiscal loss to State</b>	<b>\$ 132.7</b>

**Notes:** Values have been rounded. Excludes impact of Utilization Management, Care Coordination, and Administrative Costs. Assumes average State Share of 31%.

# Pharmacy carve out considerations

By carving the pharmacy benefit out of the managed care delivery system the state of Ohio assumes full risk for the cost of the outpatient drug benefit.



# Returning Pharmacy to Fee for Service: Member Benefit Implications

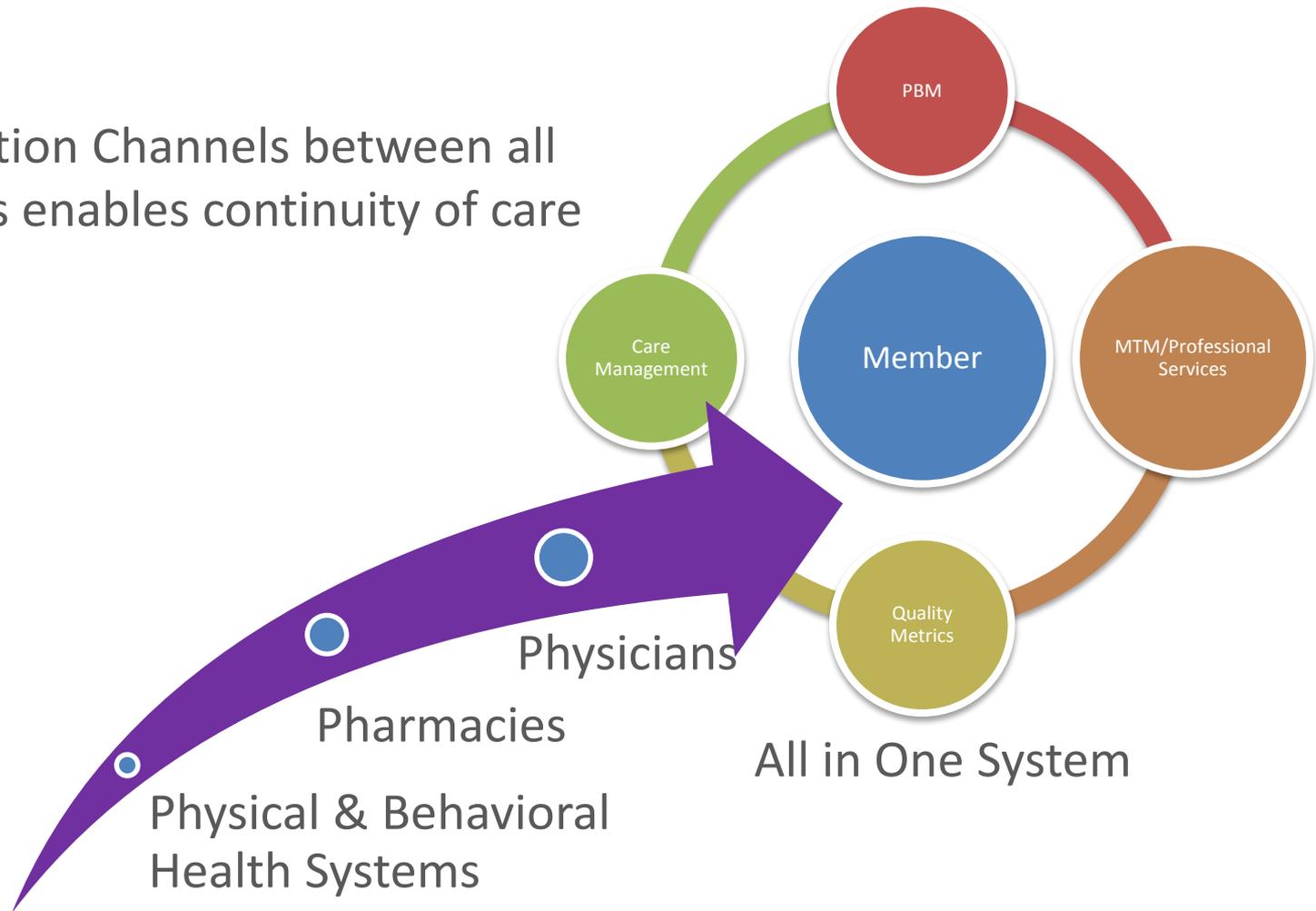
Managed care allows:

- Greater flexibility
- Additional benefits
  - » Value based contracting
  - » Medication Therapy Management

Care coordination and integration is lost in Fee for Service model

# Benefits of Managed Care:

Communication Channels between all stakeholders enables continuity of care



## Ohio Medicaid commitments:

Ohio Medicaid has been working on this issue with interested parties since the fall of 2017 – including a collaborative meeting with Ohio Pharmacists Association (OPA) and Ohio Association of Health Plans (OAHP) last week.

- Worked with the plans and CVS Caremark on a MAC pricing solution that took effect in January 2018. Managed Care Plans have also been working on additional solutions.
- New Provider Agreement language will take effect July 2018.
  - » Improve MAC pricing appeals and notification requirements, and
  - » Enhanced data transparency reporting, providing transactional access to what PBMs are paying pharmacies.

## Ohio Medicaid commitments:

- Ohio Medicaid strengthened its network standards across the state to help improve pharmacy access for members in January 2018.
- New Provider Agreement language will take effect July 2018 to enhance and expand requirements associated with the Medication Therapy Management (MTM) program.
- Collaboratively work with OPA and OAHP on potential approaches to allow pharmacists to bill for new services
- Committed to discussing further OPA's concern with access to Specialty Pharmacy
- Continue to seek-out and examine additional options



Department of Medicaid

Department of Mental Health  
and Addiction Services

JMOC Update:

# Behavioral Health Redesign

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## Implementation Data as of March 13, 2018

**508** unique providers have submitted claims for services under redesign, and of those, **94%** have been paid for claims.

**\$138.7** million cumulative total of claims paid.

Of the **49** agencies that received contingency payments, **16** agencies are beginning to repay the advance.

**6** agencies approved for contingency plan after date extension.

# Implementation Update

**100%** of prior authorizations are being processed within 72 hours.

Bi-weekly EDI meetings will offer a forum for providers to ask technical questions and engage with ODM staff.

ODM and OhioMHAS are working with IT vendors to provide technical assistance.

ODM Rapid Response Team continues to provide real-time technical assistance for behavioral health providers.

# MyCare Implementation Update

**182** unique providers have submitted claims for services under redesign, and of those, **87%** have been paid for claims.

**\$2.1** million cumulative total of claims paid.

Individual claims monitoring via Rapid Response Teams and outreach augmented with all Managed Care Plan meetings to determine opportunities for training and outreach.

Plans communicate actively with providers via MITS BITS, EDI meetings, and Trade Association newsletters.

Through the BH Collaborative, Plans have created a standardized prior authorization form, proactively identified provider challenges and solutions, and created a comprehensive provider resource document\*.

\*All provider resources can be found at: <http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans>

# Preparations Leading to July 1, 2018

Hosted **7** winter regional provider forums and planning spring forum series.

- Forums provide a great opportunity to connect with BH providers to address questions.

Individually, Plans continue to provide webinars, testing opportunities, and consultations for providers.

Plans will present to the BHR Benefit & Service Development Work Group on March 28<sup>th</sup>.

Credentialing teams are prioritizing applications for BH providers in advance of the carve-in.

- Managed Care Plans must complete the contracting process within 90 days.
- Transition of care requirements are in place for 3 months.
- May execute a single case agreement with the provider or suggest in-network providers.
- Managed Care Plans are meeting with OACBHA on April 6<sup>th</sup> to discuss contracting processes.