

# MCAC Access Subcommittee Presentation

Wednesday, June 9, 2021



# PHARMACY DIVISION



Government of the District of Columbia

Department of Health Care Finance

For Official Government Use Only



# Presentation Outline

- ▶ CPAPS Pharmacists Roles in Fee-for-Service (FFS) & Managed Care Medicaid
- ▶ Similarities and Differences between FFS and MCO Rx Programs
- ▶ Pharmacy and the Alliance Program
- ▶ HIV Medication Carve-out and Coverage
- ▶ Meet the CPAPS Pharmacy Team
- ▶ Questions



# CPAPS' ROLE IN FFS PHARMACY VS. MANAGED CARE PHARMACY

Presented By: JONAS TERRY, PHARM.D, CMTM  
HCDMA/CPAPS



# Fee-for-Service vs. Managed Care Medicaid

- ▶ States deliver Medicaid and CHIP benefits by directly paying providers – called “**fee-for-service**” payments

OR

- ▶ through contracted arrangements with “**managed care organizations**” that oversee benefit delivery.





# Medicaid Prescription Drug Program

- ▶ includes the management, development, and administration of systems and data collection necessary to operate:
  - the Medicaid Drug Rebate program,
  - the Federal Upper Limit calculation for generic drugs, and
  - the Drug Utilization Review program.



# CPAPS' Role in FFS Medicaid

- ▶ **Beneficiary satisfaction**
  - ❖ Improve quality of and patients' access to care
  - ❖ Protect safety
  - ❖ Customer Service and Complaint management
- ▶ Agency's sole pharmaceutical technical expert
- ▶ Members of the DUR Board and P&T Committee
- ▶ Responsible for DC Medicaid PBM Oversight - clinical
- ▶ Claim Processing and Payment for pharmacy benefit drugs
- ▶ Monitor drug utilization for fraud, waste and abuse
- ▶ Application of appropriate policy, rules, clinical management (i.e., prior authorization, quantity limits, and step therapy etc.)
- ▶ Develop and implement pharmacy benefit policies



# CPAPS' Role in FFS Medicaid (cont'd)

- ▶ Perform cost benefit analyses on certain drugs
- ▶ Research scientific literature on drugs to determine efficacy of prescription drugs
- ▶ Implement & Manage Clinical Pharmacy Programs & Services (i.e., Pharmacy Lock-in Program, Opioid-MME Program, MTM services, etc.)
- ▶ Review and Determine the approval or denial of prior authorization for medical benefit drugs
- ▶ Interagency Consultations, e.g.
  - ❖ Assist the Office of the Ombudsman & Bill of Right on pharmacy-related matters and cases
  - ❖ Policy formulation, State Plan Amendments
  - ❖ Legal Issues and Fair hearings
- ▶ Other duties as assigned





# CPAPS' Role in MCO Medicaid

- ▶ **Oversight Responsibilities** – governing regulations for Medicaid Managed Care Pharmacy
  - **Affordable Care Act** (effective March 2010) - expanded federal rebate program into managed care
  - **Medicaid & CHIP Managed Care Final Rule** (pharmacy related components effective for contracts starting on or after July 2017)
  - **Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act** (October 2018)- addresses the national opioid overdose epidemic with Medicaid program specific mandates for pharmacy



# Pharmacy Areas of MCO Oversight

- ▶ Implementation of Federal and District Laws, Regulations and Policies
- ▶ Prescription Drug Coverage
- ▶ Drug Formulary approval
- ▶ Exclusion of 340B Drug Utilization Data and Reporting
- ▶ Drug Utilization Review (DUR) Program Requirements
- ▶ DUR Annual Report
- ▶ Prior Authorization
- ▶ Complaint Resolution



# Prescription Drug Coverage

- ▶ MCOs whose contracts include **covered outpatient prescription drugs** are required to meet federal Medicaid FFS standards regarding the **availability** and **prior authorization** of these drugs as if the standards applied directly to the health plans. These provisions are effective for plan contracts starting on or after July 1, 2017.
  
- ▶ In accordance with sections 1902 and 1903 of the Social Security Act (the Act):
  - **Prescription drug coverage** under Medicaid MCOs should demonstrate coverage consistent with the **duration**, and **scope** as described by Medicaid FFS.
  
  - MCOs cannot have medically necessary criteria for prescription drugs that are **more stringent** than Medicaid FFS.



# Drug Formulary Information

- ▶ Each MCO must make information about its **drug formulary** available **electronically** or in **paper form**. The formulary information must include which **generic** and name **brand** medications are covered and which **tier** each medication is on.

**\*DHCF/CPAPS Pharmacists review and approve each MCO's drug formulary as changes are proposed.**



# Exclusion of 340B Drug Utilization Data and Reporting

- ▶ § 438.3(s)(3) requires that the managed care plans must have procedures in place to **exclude** utilization data for drugs subject to discounts under the **340B Drug Pricing** Program when states do not require submission of managed care drug claims data from covered entities directly.
- This provision extends to managed care organizations as Section 2501 (c) of the ACA modified section 1927(j)(1) of the Act to specify that covered outpatient drugs are not subject to the rebate requirements if such drugs are both subject to discounts under section 340B of the PHS Act and dispensed by HMOs, including Medicaid MCOs.
- Under 438.3(s)(3), managed care plans must **exclude 340B drug utilization** in their reporting to the states to **avoid** manufacturers paying duplicate discounts.



# Drug Utilization Review (DUR) Program Requirements

- ▶ Section 438.3(s)(4) requires managed care plans that provide coverage of covered outpatient drugs to also operate a **DUR program** that complies with the requirements at 1927(g) of the Act.
- ▶ The managed care plan does not have to adopt the same DUR activities that the state's FFS program enacts.
- ▶ Section 1927(g)(1)(A) of the Act requires that the state's DUR program assures that prescriptions are:
  - **appropriate;**
  - **medically necessary;** and
  - **not likely to result in adverse medical results.**



# Drug Utilization Review (DUR) Program Requirements (Continued)

- ▶ The **DUR program** shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.
- ▶ 42 CFR 456, Subpart K further defines the DUR program in three sections:
  - **Prospective DUR**
  - **Retrospective DUR** and
  - **An Educational Program**
- ▶ **DUR** helps to ensure appropriate prescribing of medications and improves the quality of care of the beneficiary.
- ▶ States need to ensure MCO contracts **beginning July 1, 2017 and thereafter** include language on the above DUR requirements.



# DUR Annual Report

- ▶ Section 438.3(s)(5) requires managed care plans to provide a **detailed description** of its DUR program activities to the state on an annual basis.
- ▶ The purpose of the **DUR Annual report** is to ensure that managed care plans (MCOs, PIHPs and PAHPs) meet the parameters of section 1927(g) of the Act.
- ▶ States need to ensure that their MCO **contracts beginning July 1, 2017 and thereafter** include language on their DUR annual reporting requirements.





# Prior Authorization

- ▶ Section § 438.3(s)(6) stipulates that MCOs conduct the **prior authorization** process for covered outpatient drugs in accordance with section 1927(d)(5).
  
- ▶ **Prior authorization** process:
  - Ensures drugs of known safety and efficacy are used first- New drugs may lack adequate safety and efficacy data.
  - Intends to monitor drugs associated with severe adverse effects
  - Helps to limit the duration of use to FDA approved indication
  - Impart cost savings by preventing unnecessary prescribing of medically inappropriate drugs
  
- ▶ Managed care plans are required to provide a response to a prior authorization request for a covered outpatient drug by **telephone** or **other telecommunication device** within **24 hours** of the request AND the dispensing of **at least a 72 hours supply** of a covered outpatient drug in an emergency situation.
  
- ▶ Managed care plans have the flexibility to maintain their own prior authorization procedures in accordance with the standards of section 1927 (d)(5) of the Act.



# Reporting

## ▶ Monthly

- Templates are submitted to DHCF by MCO and placed on shared drive
- Pharmacy Lock-in Program status
- PA Denials Report

## ▶ Quarterly

- DUR Program statistics report to DUR Board

## ▶ Annually

- **DUR Annual Report: Due June 30<sup>th</sup>.**
- CMS now requires Annual DUR report to include MCO DUR activities and assessment.

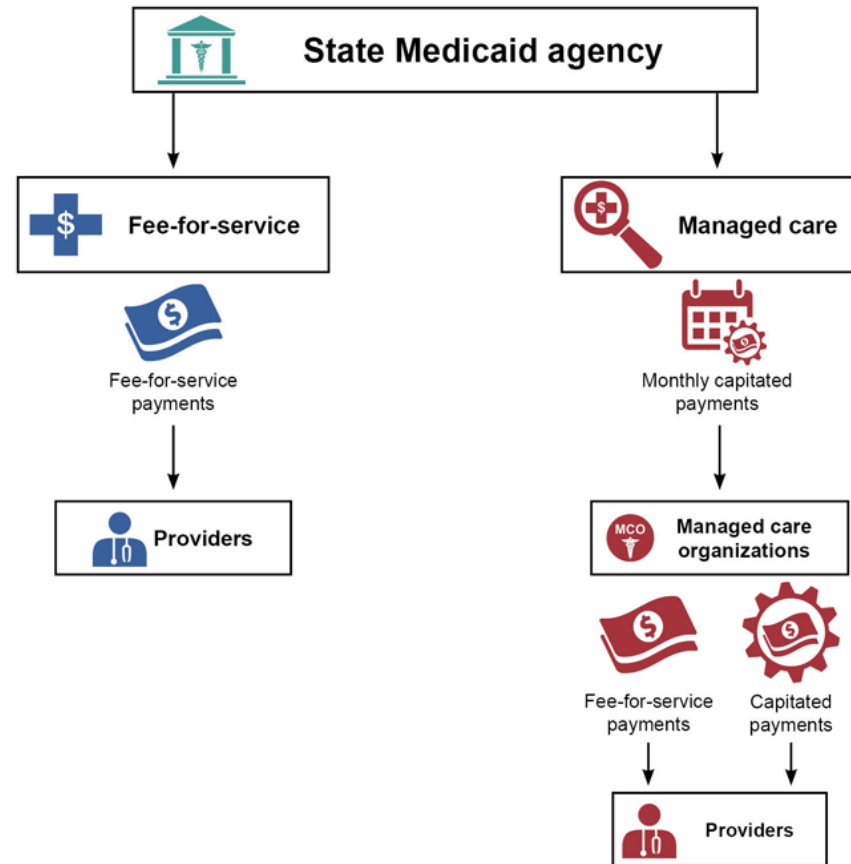


# DIFFERENCES BETWEEN FFS MANAGED CARE RX PROGRAMS

Presented By: GIDEY AMARE, PHARMD, MS  
HCDMA/CPAPS



# FFS & MCO Rx Program

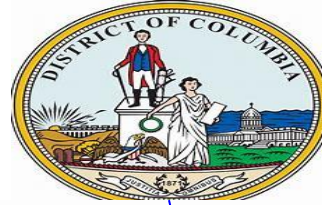


Source: GAO. | GAO-18-528

Note: Managed care organizations may also pay providers through other payment approaches in which the provider assumes some risk for covered services.



# FFS and MCO Medicaid Hierarchy



Government of the District of Columbia

Department of Health Care Finance



# FFS and MCO Rx Program Similarities

## FFS & MCO

- ▶ Benefit Operations (PBM, DUR Board & P&T Committee)
- ▶ Beneficiary Satisfaction
- ▶ Pharmacy Lock-in Program
- ▶ Opioid-MME Program
- ▶ Medication Therapy Management
- ▶ Uniform DHCF Pharmacy Policies (Hep C, HIV & PrEP/PEP, MAT, SUPPORT Act, etc.)

## PBM

- ▶ Claims processing
- ▶ Reporting
- ▶ Eligibility Maintenance
- ▶ Network Maintenance
- ▶ Custom PDL or Formulary Implementation
- ▶ Pharmacy Help Desk
- ▶ Safety Notifications
- ▶ DUR and System Edits (step therapy etc.)
- ▶ Clinical Programs (drug interaction alert etc.)
- ▶ Prior Authorization



# FFS and MCO Rx Program Differences

## ▶ FFS

- **50,000 beneficiaries**
  - Mainly disabled adults ages 19-64 in EPD or DDI Waiver Programs
  - Children in foster care through age 26
- 
- ▶ Open access to any enrolled provider
  - ▶ Preferred Drug List – not a formulary
  - ▶ High utilization/high cost



# FFS and MCO Rx Program Differences

## ▶ MCO

### ▶ **226,000 beneficiaries (the majority of Medicaid enrollees)**

- Mostly children and women of child-bearing age
- Childless Adults via Medicaid expansion under ACA (Obamacare)
- Former FFS adults transitioned in October 2020

### ▶ Capitation (Per member per month)

### ▶ Closed Formularies

### ▶ Provider networks

### ▶ Four Managed Care Plans under DC Medicaid

- **AmeriHealth Caritas DC**
- **CareFirst Blue Cross Community Health Plan DC**
- **MedStar Family Choice DC**
- **Healthcare Services for Children with Special Needs**





# FFS and MCO Rx Program Differences

## ▶ Alliance

DC provides health insurance coverage for uninsured District residents not eligible under federal Medicaid guidelines

- **using local dollars** through the Healthcare Safety Net Alliance program

In FY20 average monthly enrollment was **16,500 beneficiaries**.

**Alliance beneficiaries** are assigned to one of three current Medicaid Managed Care Plans to receive most services:

- **AmeriHealth Caritas DC**
- **CareFirst Blue Cross Community Health Plan**
- **MedStar Family Choice DC**



# PHARMACY AND THE ALLIANCE PROGRAM

## *ACCESS AND COVERAGE CHANGES AND EXPANSIONS*

PRESENTED BY: CHARLENE FAIRFAX, RPH, CDE  
HCDMA/CPAPS



## In the Beginning....

- ▶ Pharmaceutical data for the Alliance Program came from two sources, as Alliance members' prescriptions are filled and processed in two different ways:
- ▶ **UNITY HEALTH CARE PHARMACIES**
- ▶ Alliance members were generally required to have their prescriptions filled at Alliance pharmacies run by Unity Health Care Clinics in the District. These Alliance pharmacies only dispense medications on the Alliance formulary during scheduled business hours.
- ▶ The replenishment cost for the medications used to fill these formulary prescriptions was reported by the Department of Health Pharmaceutical Warehouse which provided inventory and formulary management services and replenished medications to the Alliance pharmacies on a weekly basis.
- ▶ Each year the FFS Medicaid program signed a Memorandum of Understanding (MOU) with the Department of Health to fund the cost of formulary medications for Alliance members



## Still In the Beginning.....

- ▶ MCO NETWORK PHARMACIES filled Alliance member prescriptions when:
- ▶ Medications prescribed for Alliance members were not on the Alliance Formulary; *OR*
- ▶ Prescriptions needed to be filled when the Unity Health Care pharmacies were closed (in the evening and during weekends)
- ▶ MCO PBMs kept track of these “non-formulary” prescriptions and MCO plans reported them to Medicaid monthly to be accounted for in capitation rate calculations



# ALLIANCE TRANSITION TO MCO

- ▶ In early 2016, the District lost access to discounted drug prices on the Federal Supply Schedule
- ▶ This loss eliminated the ability of the “Replenishment” model used by the DOH Pharmaceutical Warehouse to service the Unity Health pharmacies
- ▶ THEREFORE: Effective July 1, 2016
- ▶ Alliance members assigned to MCOS began to obtain their prescription medications from the MCO network pharmacies (instead of Unity Health pharmacies which were closing)
- ▶ The limited Alliance formulary was still in effect, so
- ▶ MCOs had to manage two separate formularies:
  - Medicaid MCO members
  - Alliance MCO members



# ALLIANCE TRANSITION TO MCO

- ▶ To eliminate confusion for prescribers, pharmacies and Alliance members over separate formulary coverage, a contract modification allowed the MCOs to provide Alliance members the same pharmacy coverage as their Medicaid members
- ▶ So effective on January 12, 2017:
- ▶ **MCO MEDICAID FORMULARY = MCO ALLIANCE FORMULARY**
- ▶ Alliance Claims are reported separately to DHCF to avoid invoicing for Federal Rebates



# Alliance Program

- ▶ Beneficiaries receive medications found on the MCO formulary from pharmacies enrolled in their respective Managed Care plan network.

**However,**

**there is an exception for HIV medications.**





# Alliance Program and HIV coverage

- ▶ Alliance members diagnosed with HIV must receive their HIV medications from the DC Health AIDS Drug Assistance Program (**ADAP**)
- ▶ ADAP receives special federal funding intended to treat any patient diagnosed with HIV
- ❑ Diagnosed Alliance members must enroll in ADAP **and** receive their HIV medications through pharmacies participating in the AIDS Drug Assistance Program (ADAP) program administered by DC Health
- ▶ Neither FFS Medicaid nor the Medicaid MCOs are responsible for HIV medication coverage for diagnosed Alliance patients





# Fee for Service

- ▶ Beneficiaries diagnosed with HIV receive their HIV medications through pharmacies enrolled with FFS Medicaid.
- ▶ Pharmacy submits HIV claims to FFS Medicaid for reimbursement through Magellan PBM.
- ▶ There is a \$1.00 co-pay.





# Managed Care HIV “Carve-out”

- ▶ Beneficiaries **diagnosed with HIV** receive their HIV medications through pharmacies enrolled with the Managed Care Plan.

**\*HOWEVER** (This is the “**carve-out**” part)

- ▶ **Pharmacy must submit these HIV claims to FFS Medicaid for reimbursement through the Magellan PBM.**

**BIN: 018407**

**PCN: DCMC018407**

**Group ID: DCMEDICAID**

- ▶ There is **NO** co-pay.





# What about PrEP & PEP coverage?

- ▶ **Truvada®**(emtricitabine and tenofovir disoproxil fumarate) and **Descovy®**(emtricitabine & tenofovir alafenamide) are currently the only FDA approved HIV medications indicated for **pre-exposure prophylaxis**.
- ▶ **PEP** is a combination of anti-retroviral medications prescribed for **HIV post-exposure prophylaxis** (within 72 hours of possible HIV exposure) to be taken daily for 28 days.
- ▶ **PrEP** and **PEP** are covered by DC Medicaid.
- ▶ **How will pharmacy providers know the difference?**
  - Unlike PEP, PrEP is a single drug regimen.

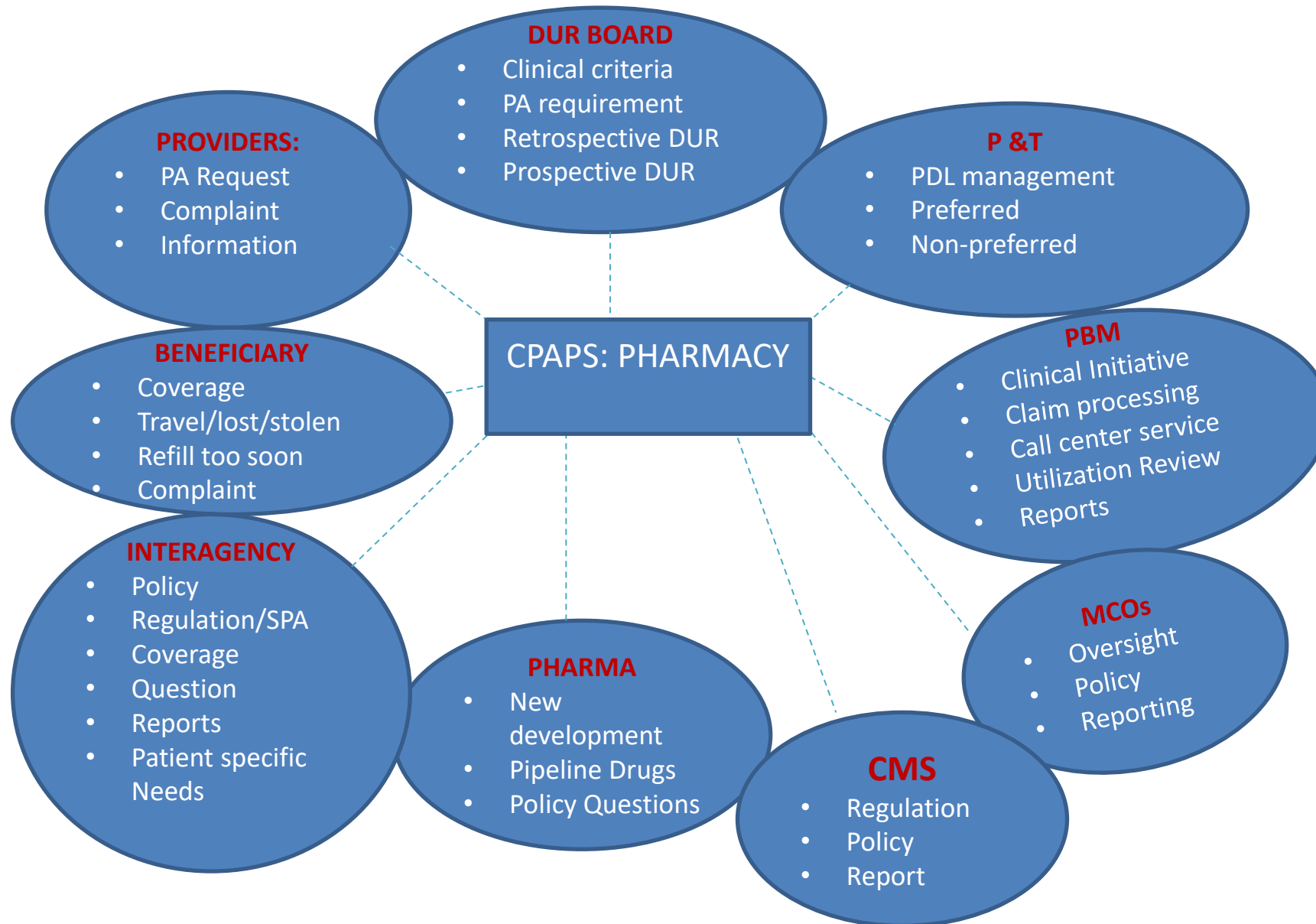




# PrEP & PEP Coverage

- Truvada® and Descovy®** when written for PrEP for a **Medicaid beneficiary whether enrolled in FFS or in a MCO** must be submitted to the **FFS Medicaid PBM (Magellan)** for reimbursement.
  
- Truvada® and Descovy®** when written for PrEP and for an **Alliance beneficiary** must be submitted to the respective **Managed Care Plan** for reimbursement.
  
- Antiretrovirals when written for PEP for a **Medicaid beneficiary whether enrolled in FFS or in a MCO** must be submitted to the **FFS Medicaid PBM (Magellan)** for reimbursement.
  
- Antiretrovirals when written for PEP for an **Alliance beneficiary** must be submitted to the respective **Managed Care Plan** for reimbursement.

# Pharmacy Program Work Relationship & Interaction





# PHARMACY STAFF



# Cavella Bishop: Program Manager

- Manages the Medicaid Pharmacy program
- Contract Administrator for Comagine (QIO)
- Member of the Pharmacy and Therapeutics (P&T) Committee
- Drug Utilization Review Board Member





# Charlene Fairfax: Senior Pharmacist

- ▶ Serves as the lead pharmacy consultant for the Department of Health Care Finance.
- ▶ Develops, implements, and revises necessary policies and procedures.
- ▶ Contract Administrator for the Preferred Drug List vendor.
- ▶ Co-Chairs the Pharmacy and Therapeutics Committee meeting.
- ▶ Coordinates Industry day presentations.
- ▶ Participates in pharmacy-related Fair Hearings.
- ▶ Point of Contact for Managed Care Pharmacy issues and coordinates MCO monthly and quarterly meetings.







# Gidey Amare: Clinical Pharmacist

- ▶ Serves as the lead clinical pharmacy consultant for the Department of Health Care Finance.
- ▶ Develops, implements, and revises necessary policies and procedures.
- ▶ Works with the Health Care Ombudsman's Office to resolve pharmacy issues.
- ▶ Main Point of Contact for medical benefit prior authorizations and clinical criteria development.
- ▶ Develops presentations for the quarterly Pharmacy Forums.
- ▶ Reviews pharmacy procedure codes and coordinates updates with ORRFA and Conduent.





# Jonas Terry: MTM Pharmacist

- ▶ Develops, implements, and manages the Medication Therapy Management (MTM) program.
- ▶ Develops, implements, and revises necessary policies and procedures.
- ▶ Oversees the Pharmacy Lock-In Program for both FFS and Managed Care.
- ▶ Provide MTM to FFS patients and providers as identified through the FFS Pharmacy Lock-In Program and the PBM, Magellan.
- ▶ Reviews FFS patient profiles provided by Conduent for the DUR Board and follow-up with targeted outreach to beneficiaries and providers.
- ▶ Participates in pharmacy-related Fair Hearings.





# Marie Dorelus: Management Analyst

- ▶ Creates and updates policies and procedures, guidelines, transmittals, and memos for the Division.
- ▶ Attends meetings related to new projects or State Plan Amendment changes in preparation for writing the subsequent policy and procedure transmittals.
- ▶ Develops power point presentations for division meetings.



# Contact Information

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