The Menges Group

State Policies Regarding Medicaid MCO Preferred Drug Lists

March 2014

I. Introduction

Medicaid capitation programs have several state-specific design features related to the prescription drug benefit. At the highest level, states must decide whether to include or exclude pharmacy services in the capitated benefits package. While most capitation programs include, or carve-in, the pharmacy benefit, several states still utilize a carve-out approach. Several prior ACAP-sponsored reports have demonstrated the relative programmatic advantages of the pharmacy carve-in model.[1]

Within the carve-in approach, several important design issues and options exist, particularly with regard to the latitude that capitated MCOs have regarding which medications are on its preferred drug list (PDL). MCOs promote the use of the least expensive, clinically effective medication through the PDL mechanism. Drugs placed on the PDL can be prescribed without authorization by the MCO. Non-preferred drugs can still be accessed by MCO enrollees, but only through prior authorization from an MCO. Some of the key programmatic dynamics related to PDLs are described below.

- Large price differentials often exist between medications that are deemed by prescribers to be similarly clinically appropriate and effective. These prices can range from less than $25 for one medication to several hundred dollars for another. While particularly wide price differentials often exist between brand and generic medications in a given therapeutic class, substantial price differences also often exist within alternative brand medications – and/or within generic medications.

- While the Medicaid program obtains large rebates on most brand drugs, MCOs have been highly adept at achieving minimal net (post-rebate) costs. Conversely, state-operated PDLs have in many instances secured large-scale rebate revenues on high-cost medications but failed to achieve an optimal net cost. As an example, an 80% rebate on a $300 medication creates a net cost of $60, which would still have a net cost three times above a generic alternative that has an initial ingredient cost of $22 and a 10% rebate.

- The price differentials between medications – both the pre-rebate costs and particularly the net, post-rebate costs -- are rarely visible to the prescribing physicians or the Medicaid recipient.

- Neither the prescribing physician nor the Medicaid recipient typically has a financial incentive to utilize relatively low-cost medications (even if they were aware of the price differences). Significant copayment differentials are typically used in the commercial insurance and Medicare Part D settings to encourage patients to select relatively low-cost products. However, only nominal copayments can be used in the Medicaid arena due to

[1] One such study is "Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs," sponsored by ACAP and prepared by The Lewin Group, October 2007. This report is available at: http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/AssessmentCarveinCarveOut.pdfCite lewin reports

the covered population's poverty, and in many Medicaid MCOs no copayment is charged whatsoever.

Given these dynamics, the most important pharmacy cost containment tool available to MCOs involves optimal management of the mix of drugs. A recent study indicated that the majority of the Medicaid savings derived through optimal management of the pharmacy benefit accrue through impacts on drug mix.[2] The remainder of this paper describes state policies in this area, focusing on the degree to which Medicaid MCOs can configure their PDLs as they deem most appropriate.

It is important to note that MCOs with relatively restrictive PDLs do provide access to *all* Medicaid-covered, FDA-approved drugs. These health plans do not, however, allow relatively high-cost medications to be accessed equally easily when lower-cost alternatives exist. Techniques such as "generics first," prior authorization, and step therapy are used by MCOs to steer volume towards relatively low-cost products – where appropriate – while also ensuring access to higher-cost medications where medically necessary.

II. State Policies Regarding PDLs

A wide continuum of regulatory policies exists across states with regard to the Medicaid MCOs' latitude to determine their own PDL content. Because prescription drugs are an optional benefit for states in terms of Federal Medicaid program requirements (even though all states have elected to cover prescription drugs in their Medicaid programs), there are no Federal requirements regarding states' PDL content.

In most states with capitated MCO programs (and which use a pharmacy "carve-in" model), there are no requirements regarding the degree to which a Medicaid MCO PDL must align with the state's Medicaid fee-for-service PDL. Some examples of states that essentially delegate full control over PDL content to their Medicaid MCOs include Arizona, Illinois, Kentucky, Maryland, Massachusetts, New York and Oregon. Some quotes from health plan executives in these states are provided in the text box below.

"Massachusetts allows us to manage our own PDL. They keep us informed about changes that they are making so that we can consider how that might impact the plan."

"We have full latitude to control our formulary. This is important because a formulary integrates with the overall population based strategy to care for our members and must remain flexible to meet the needs of various quality projects that are often informed by multiple obligations."

[2] "Medicaid Pharmacy Savings Opportunities: National and State-Specific Estimates," sponsored by PCMA and prepared by The Menges Group, May 2013. The report is available at: http://www.pcmanet.org/images/stories/uploads/2013/final%20medicaid%20savings%20report%20menges%20group%20may%202013.pdf

At the opposite end of the latitude continuum, in some states Medicaid MCOs are required to exactly match up their PDLs with the Medicaid fee-for-service PDL. Examples of these states are Florida and Texas.

A middle ground policy has been established in several states (e.g., Ohio), where a Medicaid MCO's PDL is required to be largely aligned with the Medicaid fee-for-service PDL. In these states, not all medications on the state's PDL have to be covered, but there are requirements regarding the percentage of products on the state's PDL that must be also be on the MCO's PDL. Therefore, Medicaid MCOs are permitted to tailor their PDL content within a drug class. Within this type of regulatory situation, MCOs must typically submit their PDLs for state review and approval at least annually.

Exhibit A summarizes the nature of PDL regulations in each ACAP member state.

PDL latitude is not always identical across all therapeutic classes – specific restrictions sometimes apply in certain therapeutic classes (e.g., classes involving behavioral health medications and/or anti-retroviral medications). Some states require that unrestricted access must occur to all medications in certain therapeutic classes.

III. Arguments in Favor of PDL Consistency Across Medicaid MCOs

Arguments offered as to why a single statewide Medicaid MCO might be most appropriate are presented below.

1. **Administrative Ease.** An argument in favor of a single Medicaid PDL is that it creates administrative advantages for prescribing physicians and pharmacies, as providers would have an easier time knowing what products are covered without prior authorization and special justification.

2. **Consistent Access.** When a single formulary is used by all Medicaid MCOs within a state, all Medicaid beneficiaries have comparable access to the same set of medications.

3. **Rebate Maximization.** A single statewide Medicaid formulary drives more volume to certain brand medications where the percentage rebate is highest. In some instances, these rebates can result in the net (post-rebate) cost for the brand drug being lower than most or all generic alternatives.

4. **Minimizing Disenrollment.** An MCO noted that some persons will switch plans in order to access the specific pharmaceutical product they desire. While this is a small group, such disruptions would not occur in a consistent PDL situation.

Exhibit A. PDL Regulatory Overview, ACAP Member Health Plan States

	State Restrictions on Medicaid MCO Preferred Drug List Content				
ACAP Member Health Plan State (excluding states using pharmacy carve-out model)	State Does Not Restrict Medicaid MCO Formulary Content	States Requires MCOs to Use a Single PDL	State Imposes Some Formulary Restrictions or Requirements	Does State have a "Prescriber Prevails" Requirement?	Comments
Arizona	X				
California	X			No	Currently, MCO's formulary should be comparable to the State's Medi-Cal PDL. Some plans may have certain medications carved out -- e.g., HIV & psychiatric drugs. However, State is seeking to require all Medi-Cal MCOs to use its FFS PDL.
Colorado		X			
District of Columbia	X				Antiretroviral medications are carved out.
Florida		X			
Hawaii			X		Protected classes of drugs include: oral anti-neoplastic, attention deficit/hyperactive disorder, antidepressants, anxiolytics, antipsychotics, anticonvulsants, and antiretrovirals.
Illinois	X				
Kentucky	X			No	
Massachusetts	X			Not Yet	
Maryland	X				Behavioral health medications are carved out.
Minnesota			X	Yes, but only for antipsychotics	Required to cover drugs which are contained in the Medical Assistance Drug Formulary OR that are the therapeutic equivalent to Medical Assistance formulary drugs. The MCOs must cover antipsychotic drugs regardless of the MCO's formulary if the prescribing provider certifies in writing that the prescribed drug will best treat the Enrollee's condition
New Hampshire		X		No	NH requires plans to incorporate the NH Medicaid PDL, as developed by DHHS; MCOs may offer additional drugs on their formulary.
New Jersey			X	Yes, but only for behav. health medications	No more than four restrictive changes permitted per year.
New York	X			Yes	Prescriber prevails currently applies to 8 categories: anti-depressant, antiretroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes.
Ohio			X		Health plans are required to work with other plans to maintain a match of at least 80% of medications with one another and State Medicaid FFS PDL.
Oregon	X			No	State offers some "strong recommendations" as to what products should be included in certain areas (e.g., all birth control medications)
Pennsylvania			X	No	State approval required for all formulary changes (positive and negative). Coverage required of at least one medication in every drug class on state's PDL.
Rhode Island			X	No	Generic First programs require that most brand name drugs be step edited with 2+ generics in the same class. Multiple classes of drugs are exempt from generic first program.
Texas		X			MCOs must use Medicaid FFS PDL
Virginia			X	No	Full coverage of contraceptive medications is required
Washington			X		MCOs have recently become responsible for coverage of and payment for behavioral health medications, and several rules/restrictions apply to these drugs

IV. Arguments in Favor of MCO PDL Latitude

The arguments conveyed for providing MCO latitude over the PDL are described below. These arguments also entail "counter-arguments" for some of the previously-described potential advantages of using a single statewide Medicaid PDL.

1. **Minimizing Politicization.** A uniform PDL at the state level allows drug manufacturers to achieve successful product placement by succeeding in a political arena in which they are often adept. MCOs expressed concern that a uniform state-determined PDL is likely to be overly inclusive of high-cost products that are not delivering adequate marginal clinical value in return for their often large marginal cost difference. Drug mix data comparisons between the Medicaid FFS and Medicaid MCO settings strongly support this argument.[3] A Medicaid MCO executive, describing a state with a single statewide PDL, noted that "We see some of the products the State places on its PDL and we just have to scratch our heads and wonder what they are doing."

2. **Overcoming Lack of Co-Pay Barrier.** With the large price differentials and without meaningful copayments or copayment differentials, there simply is no mechanism within a uniform and broad statewide Medicaid PDL to prevent unnecessarily high-cost medications to occur. MCO latitude to enforce use of the lowest-cost, clinically appropriate medication is a critical (and in many cases the only) means of achieving cost-effective prescribing practices.

3. **Optimizing Cost Savings.** MCOs and in turn the Medicaid program experience unnecessarily high net pharmacy costs due to the loss of the ability to guide evidence-based prescribing. As noted in the Introduction section, wide price differentials exist between clinically effective medication options, and an MCO's ability to steer volume to the lower-cost therapy has significant financial ramifications.

4. **Integration of Complex Priorities.** The arguments for a single statewide PDL suggest that the Medicaid pharmacy benefit operates in a silo. However, the Medicaid PDL is inter-related with the prescription drugs used in other coverage programs, and medications are strongly interwoven with broader health care needs. A drug manufacturer may provide valuable disease management and adherence support to a health plan's enrollees or a supplemental rebate, for example, which justifies a health plan's decision to add certain products to the PDL (and perhaps remove some competing products). A single statewide Medicaid PDL does not allow MCOs the flexibility to best balance the wide array of priorities associated with "whole person" care coordination for large and diverse populations. Uniform state requirements run counter to allowing MCOs the flexibility to be innovative. Also, an MCO executive

[3] "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-For-Service and Capitated Setting," sponsored by the Center for Health Care Strategies and prepared by The Lewin Group in collaboration with ACAP, January 2003. The report is available at:
http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/MedicaidPharmacyCosts.pdf

emphasized that what works best for one MCO or population group might not be optimal for others.

5. Administrative Ease Counterpoints. Widespread concerns have been raised with the argument that a single statewide Medicaid PDL has significant value in reducing the administrative burdens of prescribing physicians and pharmacists. Medicaid does not operate in a vacuum, and the program pays for less than 20% of all US prescriptions. The wide array of commercial insurance entities and Medicare Part D plans that serve a given community create dozens of different PDLs that the physician and pharmacy community must navigate – regardless as to what occurs with Medicaid PDLs. While there is some administrative advantage to Medicaid moving to a single PDL, the "selling" of this policy makes it sound like providers will move from several PDLs to one when in fact they will move from something more in the vicinity of 35 PDLs to 31. It is also important to note that information technology is greatly improving providers' ability to ascertain and accommodate different PDLs. One MCO executive noted that "With electronic prescribing and electronic submission of authorization requests, the burden [of multiple Medicaid PDLs] should not be too great."

6. **Rebate Maximization Counterpoints.** Concerns were also raised that the pursuit of maximum rebates often tends to be counter to the need to achieve the lowest net cost for the medications prescribed. While there are situations where securing a large rebate on a brand medication will yield the most attractive net (post-rebate) cost among the clinically effective alternative products, the pursuit of rebates has generally been a key reason why the Medicaid FFS setting has not accessed anywhere near the cost efficiencies that Medicaid MCOs have achieved. A further concern with rebates is that supplemental rebates are much smaller than used to be the case. Because the ACA has increased the statutory Medicaid rebate percentages and extended these rebates to medications paid for by Medicaid MCOs, manufacturers are offering states and MCOs far smaller supplemental rebates. Medicaid MCOs have generally indicated that the additional rebates they are accessing have declined by at least half of where they were prior to the ACA's enactment, and in many cases have almost entirely disappeared.

V. Summary

Prior to passage of the ACA, the states' key pharmacy policy issue within their capitated programs involved whether to carve in or carve out the prescription drug benefit. Due to the ACA's drug rebate equalization provisions, states are increasingly using the carve-in model. The most important pharmacy policy issue has become the level of latitude MCOs are afforded to manage the mix of drugs provided.

This paper has summarized each ACAP state's policy stance regarding Medicaid MCO PDL content, and delineated the advantages of different policy approaches. Broad MCO latitude to establish their PDLs is commonly afforded by these states, with many additional states placing

PDL restrictions in certain therapeutic classes. Colorado, Florida, New Hampshire and Texas are the only states that require all MCOs to use the Medicaid FFS PDL, although California has indicated an intention to adopt this approach.

In assessing the arguments for and against PDL latitude, the advantages of affording MCOs with wide latitude appear to be both more numerous and more compelling than the arguments for adopting a single statewide PDL.

Thus, both in terms of the number of states adopting certain PDL latitude approaches and in terms of a review of the pros and cons of each approach, affording relatively wide PDL latitude appears to be the most constructive policy stance for states to adopt. In managing the drug mix as they view most appropriate, MCOs are best able to perform their role of maximizing the clinical effectiveness and cost-effectiveness of Medicaid coverage.

Managing drug mix effectively yields significant cost savings at no clinical detriment, and it is important for states to encourage this to occur. States providing this latitude do need to provide adequate regulatory oversight to ensure that access to costlier, effective medications is occurring when necessary and appropriate.