Managed Medicaid
Impact, Trends and Challenges

February 29, 2012
Las Vegas, NV
Learning Objectives

• Recognize the impact of the Affordable Care Act on Managed Medicaid

• Contrast trends in Fee for Service and Managed Medicaid

• Examine the unique Managed Medicaid challenges and opportunities for various stakeholders – Mfrs, States, State Intermediaries
Managed Medicaid Panel

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   Director of Pharmacy
   MassHealth

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   Johnson & Johnson Healthcare Systems

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   Goold Health Systems

Mark Wiseman
   Senior Principal
   IMS Health
Agenda

• Managed Medicaid Overview
• State Medicaid Perspective
• Pharma Industry Perspective
• State Intermediary Perspective
• Panel Round Table
Medicaid Drug Rebate Program

- Federal Drug Rebate Program
  - FFS Only
  - Base Rebate 15.1%

1991

- FFS Medicaid Federal Rebate

March 23, 2010

- Managed Medicaid Commercial Rebate Negotiations
- ACA Drug Rebate Equalization
  - Base Rebate 15.1% to 23.1%
- New Formulation Rebates
  - Line Extensions
Medicaid Vs All Prescriptions

- Total Medicaid: 91%
- Medicaid: 9%
New Jersey

**FFS Medicaid, Managed Medicaid Trends**
New York

FFS Medicaid, Managed Medicaid Trends

Vector One®: Payer (VOPA)
MassHealth Overview (FY12)

• Members

  - 1.35M Members (↑4.6% > FY11)
    • 512K members Contracted MCO (38%)
    • 330K members Primary Clinician Care Plan (In-house Managed) (25%)
    • Fee-for-Service Members (Mostly Other Insurance) (37%)
      - 270K Medicare Dual Eligible members
      - 200K members with other insurance
      - 30K members “true” FFS
MassHealth Overview (FY12)

• Dollars
  – State Budget - $30.5B
  – EOHHS Budget - $14.95B
  – MassHealth Budget - $10.1B
  – MCO Capitation - $3.98B
  – Pharmacy
    • PCC / FFS - $539M
    • Medicare D “Clawback” – $229M
    • MCO Rx Spend ~ $330M (FY11)
Organizational Structure

- Medicaid Director
  - Chief Medical Officer
  - Pharmacy Director
  - Director, Managed Care Plans
  - Deputy Medicaid Director, Providers and Plans
Pharmacy Director
Roles and Responsibilities

• Manage Pharmacy Benefit for PCC Plan and all wrap-around and secondary Rx payments

• Managed Medicaid Entities
  – Develop, modify, review Pharmacy section(s) of MCE contracts
  – Convene Quarterly MCE Pharmacy Director Meetings
  – Collect drug rebate (post ACA implementation)
Managed Care Entities

• “Traditional” Medicaid MCOs
  – 5 Plans – most have public “connection”
  – Healthcare Reform expansion (2006) population absorbed exclusively by current MCOs

• Behavioral Health carve-out for PCC Plan

• Senior Care Options (SCO) Plans for Elderly Duals

• ASO-like vendor sought for new care coordination model for PCC Plan/Behavioral Health

• New Duals (18-64y/o) Demonstration seeks MCE-like vendor
### Rebate Collections

*Pre and Post ACA*

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<th>FY10</th>
<th>FY11</th>
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<td>PCC/FFS</td>
<td>PCC/FFS/MCO</td>
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<td><strong>Claims Paid Amount</strong></td>
<td>$503,716,821</td>
<td>$782,682,220</td>
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<td><strong>Rebate Collected</strong></td>
<td>$167,683,602</td>
<td>$326,476,141*</td>
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<td><strong>Ratio Rebate$:$Claims$</strong></td>
<td>33.3%</td>
<td>41.7%</td>
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*Not including Rebate Offset Amount of $35.2M*
J&J Overview:

- Johnson & Johnson (J&J), which celebrated its 125th anniversary in 2011, is the world's most comprehensive and broadly based manufacturer of health care products, as well as a provider of related services, for the consumer, pharmaceutical and medical devices and diagnostics markets.

- J&J has more than 250 operating companies in 60 countries around the world, employing approximately 118,000 employees and selling products in more than 175 countries.

- Johnson & Johnson Health Care Systems (JJHCS) provides contracting and supply chain services to key health care customers.

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Managed Medicaid Concerns
Manufacturer’s Perspective

• Consistency (or lack thereof) with invoicing methods
  – Separate out MCO Utilization into one MCO Invoice, rolled up by labeler
  – Separate out MCO utilization and submit per MCO, per labeler
  – MCO Utilization blended with FFS

• “Completeness” of Claim Level Detail (CLD)

• Quality Controls
  – Between the MCO and the State, what measures are taken to ensure that the data are accurate and complete?
  – 340B scrubbing methodology?

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JJHCS Experience

Analysis of Managed Medicaid Data

• JJHCS was able to gather Managed Medicaid data
  – 10 states
  – 15 plans
  – 5-6 quarters of data

• Areas of analysis
  – Inventory of raw data
  – Dispensed dates of claims prior to March 23, 2010
  – Outliers within the Managed Medicaid data
  – Duplicates across FFS Medicaid claims
  – Duplicates across Commercial MCO claims

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Challenges

Managed Medicaid Data Inventory

• Many iterations of data files
  – Worksheets were often broken up by Labeler and sometimes NDC
  – Duplicated worksheets were provided

• Many iterations of data formats
  – All states had more than one format
  – Different formats for different quarters and different labelers

• Several data elements missing or encrypted

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Challenges

Q1 2011 Data Elements

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<th>Entire Inventory Grid</th>
<th>Other</th>
<th>Core Elements</th>
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<td>Quarter</td>
<td>Pharmacy ID</td>
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<td>Rx Number</td>
<td>Utilization Quantity</td>
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Each Column Represents a Data Element (31)
Each Row Represents a State (10)

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Challenges
Q1, Q2 2011 and Core Data Elements

Of the six core data elements, Pharmacy ID and Rx Number were typically missing or encrypted.

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Other Challenges

• Found some claims dispensed prior to March 23, 2010.

• Found duplicates and outliers within the data and duplicates across commercial plans.

• 340B Claims (match to Medicaid Exclusion file)
GHS at a glance

- Facilities in Augusta, Maine; Des Moines, Iowa; Cheyenne, Wyoming; and Atlanta, Georgia
- 37+ years experience in the healthcare management and data services business, focusing on State Medicaid pharmacy benefit services
- Approximately 200 employees
- Presently provide diverse, value-driven pharmacy services in 16 states
- 5 Business lines: Medicaid PBSA, Long Term Care Assessments, Medical PA’s, Recovery Audit Contractor, Business Process Outsourcing.
- GHS partners with our clients to perform vendor services that are primarily geared towards Fee for Service programs
Patient Protection and Affordable Care Act Effect on States

• **Extended rebates on MCO claims**
  – States & CMS no longer equal partners

• Drove States to consider MCO pharmacy “carve in”

• “A recent national study found that the impact of mandatory MMC on Medicaid spending is a function of how generous a state’s Medicaid FFS payment rates are compared to commercial rates. Where Medicaid FFS payment rates are very low, it is difficult for states to negotiate capitation rates that garner plan participation but also yield savings, and the study showed that MMC contracting in such states did not reduce spending. On the other hand, in states with relatively high Medicaid FFS rates, MMC did reduce spending below what it would have otherwise been.”

Impact

• MCO entities cannot manage formularies in the best interest of a State due to;
  – No RPU information
  – No Federal participating manufacturer reference tool
  – No rebate offset amounts
  – No guidance on “line extension” products

• State Fee for Service programs cannot design MCO formularies due to;
  – Lack of understanding of the MCO rebate structure
  – Lack of understanding of “capitated” rate setting
Potential Solutions

• Is it likely that CMS will make all rebate information available to MCO entities?
  – Not likely to occur

• Is it likely that MCO entities will take formulary direction from States?
  – More likely to occur

• States/ MCO entities need to work together to design a formulary that can be utilized by both and addresses/ supports both organizational needs
For More Information

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Questions
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Thank You!

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