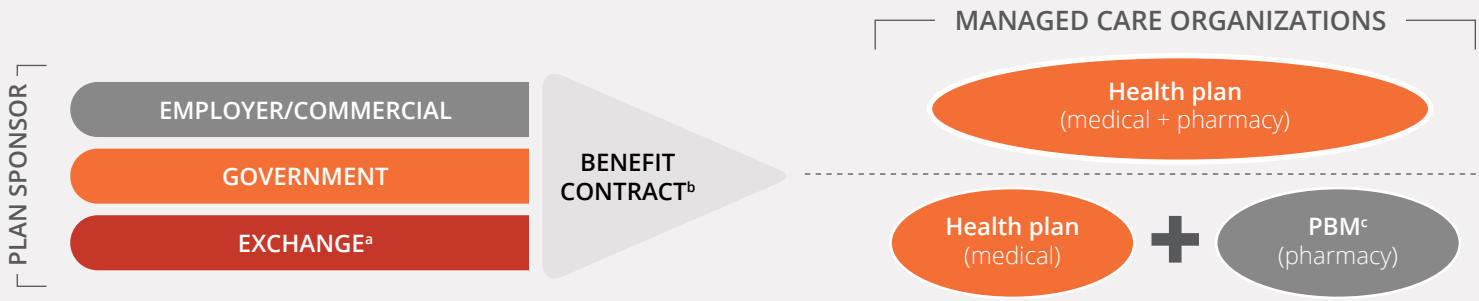
FUNDAMENTALS OF MANAGED CARE

PART 1

Principles of Managed Care

Managed care is a structured approach to financing and delivering healthcare benefits. It is designed to improve the quality of care in a cost-effective manner.

For a general overview, visit ***Managed Care Pharmacy***



*Medicare, Medicaid, Veterans Affairs, Department of Defense (TRICARE), and government employee unions.

Types of Delivery Models

Accountable Care Organizations (ACOs): Managed by Centers for Medicare & Medicaid Services (CMS), these groups of providers provide coordinated care and accept financial risk tied to outcomes to ensure that Medicare patients get the right care while avoiding unnecessary duplication of services and preventing medical errors.

Health Maintenance Organization (HMO): Require members to use approved providers; uses a primary provider as "gatekeeper" to coordinate and authorize care; provides, offers, or arranges for coverage at a fixed, prepaid premium; costs are usually less vs other plan types.

High-deductible Health Plan (HDHP): Insured member pays lower premiums but a higher deductible (average $2500) out-of-pocket before insurance benefits begin.

Integrated Delivery Systems (IDS) or Networks (IDN): Network of healthcare organizations and providers, such as primary care physicians, specialists, hospitals, pharmacies, insurance company; examples include Sutter Health, Cleveland Clinic.

Open Model Plans: Plans contract with independent hospitals, medical groups, pharmacies, etc, who agree to provider-covered services for discounted reimbursement; examples include United Healthcare, CIGNA, Aetna, Humana, Blue Cross/Blue Shield.

Patient Center Medical Health/Homes (PCMH): Organization of primary care designed to meet the majority of a patient's healthcare needs through a team-based approach, coordinated by using electronic health records (EHRs).

Point-of-Service (POS) Plan: Provides different benefits depending on whether the member uses in-network or out-of-network providers; members pay more for out-of-network services.

Preferred Provider Organization (PPO): Patients choose their own network providers; Patient costs (ie, deductibles, coinsurance) are usually higher vs other plan types, such as HMOs.

Key Terms

Health Plans: offer healthcare benefits (eg, medical, pharmacy, dental, vision, chiropractic) to private and public purchasers; examples include United Health Group, Anthem, Aetna, Humana.

Medical Benefits: encompasses inpatient hospital care, outpatient services, home health care, MD-administered drugs, and vaccinations.

Plan Sponsors: purchasers of healthcare benefit products.

Pharmacy Benefits Manager (PBM): organization that exclusively manages pharmacy benefits; examples include CVS Caremark, Express Scripts, OptumRx.

Pharmacy Benefits: encompasses prescription drugs, some nonprescription drugs, medical supplies, vaccinations, and devices.

[a]Health Insurance Marketplace referred to as Insurance "Exchanges".
[b]Medical and pharmacy benefit contract includes Essential Health Benefits (which include pharmacy) with some access customization.
[c]PBM=pharmacy benefit manager provides pharmacy benefits.

Pharmacy Benefit Management Tools

Pharmacy benefits must balance access, quality, and cost. Each organization may use a different combination of strategies to meet the needs of their members in a cost-effective manner

Common Cost Management Strategies

Cost Sharing: Deductibles, copayments, coinsurance

Formulary: Compendium of drugs covered/available in a pharmacy benefit; Updated regularly by a team of clinical and pharmacy experts

- **Open Formulary:** Coverage is provided for most or all formulary and nonformulary medications; patients pay a higher copay or coinsurance for excluded drugs
- **Closed Formulary:** Nonformulary drugs are not reimbursed
- **Tiers:** Coverage varies by type of drug and level of formulary approval; for example:

Tier	Tier Description	Cost Share	
Tier 1	Preferred generic	$5 copay	10% coinsurance
Tier 2	Nonpreferred generic	$10 copay	15% coinsurance
Tier 3	Preferred brand-name	$30 copay	20% coinsurance
Tier 4	Nonpreferred brand-name preferred specialty	$75 copay	30% coinsurance
Tier 5	Specialty	$150 copay	40% coinsurance

Key Terms

Biosimilar Drug: drug with no clinically meaningful differences from the reference biologic in terms of safety, purity, and potency.

Copayment: fixed amount paid for a healthcare service or product.

Coinsurance: portion of the cost of healthcare services/products paid by the consumer; usually a percentage of the total charge (eg, 20%) after a deductible is met.

Deductible: amount consumer must pay for healthcare services/products before health insurance begins to pay; usually an annual amount.

Specialty Drug: drugs priced $670 or higher for a 30-day supply, infused products, and those that require unique storage, handling, or education/support; usually for serious, chronic, or life-threatening diseases.

Drug Utilization Review (DUR): Ongoing review of the PBM claims data to monitor HCP prescribing, pharmacist dispensing, and member use of medications; may address drug-drug interaction, patient precautions (age, gender, pregnancy, etc), and appropriate use of formulary medications

Utilization Management:

- **Quantity Limit:** Limits placed on the amount of medication dispensed at once (eg, 30 tablets for a 30-day supply of a once-daily medicine)
- **Prior Authorization (PA):** Requires prescriber to demonstrate clinical need and obtain preapproval from the managed care organization before prescribing medication or the drug will not be approved for payment; can be done electronically
- **Step Therapy:** The practice of beginning drug therapy with the safest, most cost-effective drug (first-line drug) and progressing ("stepping up") to other more costly or risky therapy only when necessary

Distribution Channels

Pharmacy Types

Inhouse Pharmacy: part of an HMO (eg, Kaiser Permanente), on-site at employer's facility.

Retail Pharmacy: localized retail locations (eg, CVS, Walgreens).

Mail Service Pharmacy: prescriptions supplied via mail order, primarily used for maintenance medications.

Specialty Pharmacy: distribute specialty drugs only.

Source: *American Journal of Managed Care Pharmacy*. Fundamentals of managed care pharmacy [workshop]. 2020.

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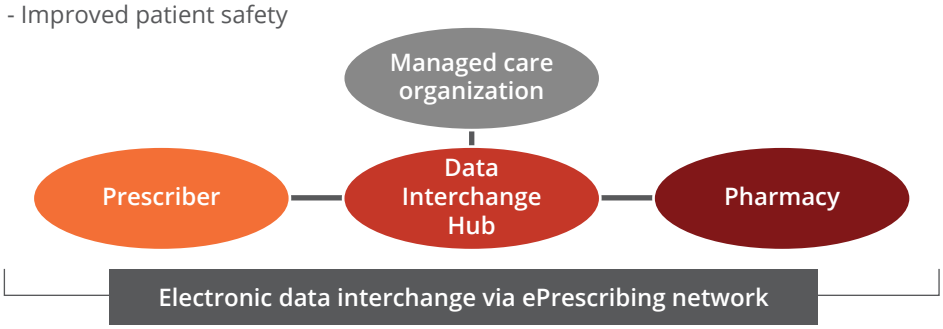
PART 2

Behind the Scenes: Getting Medications to Patients Through the Pharmacy Benefit

Pharmacy benefits may be managed as part of a patient's health plan OR may be managed separately by a pharmacy benefits manager (PBM)

Electronic Prescribing

- ePrescribing has been adopted by 98% of pharmacies and 69% of prescribers (as of 2017)
- 77% of prescriptions are electronic
- CMS requires all providers to use e-prescribing
- Benefits of e-prescribing:
  - Fewer medication errors and more efficient pharmacy workflow
  - Increased patient convenience and may lower costs
  - Improved patient safety
  - Patients better understand coverage
  - Higher prescription fill rates and medication adherence



Edits

Edits are criteria that, if unmet, will cause an automated claims processing system to "reject" a claim for further/manual review. Examples include:

Administrative	• Patient eligibility • Physician/pharmacy authorization • Formulary (eg, drug eligible for reimbursement, availability of lower cost alternative) • Therapy duration/frequency, appropriateness, quantity dispensed
Financial	• Patient responsibility (eg, deductible, copayment, coinsurance) • Reimbursement to pharmacy
Clinical	• Prospective Drug Utilization Review (DUR) • Prior Authorization • Step therapy • Disease management

Key Terms

Certificate of Coverage: a contract between plan sponsor and insurer that defines benefit design (ie, reimbursable products and services, anticipated costs, etc); also called Evidence of Coverage or Summary of Benefits and Coverage.

Claims Adjudication: the process of completing all validity, process, and file edits necessary to prepare a claim for final payment or denial.

National Council for Prescription Drug Programs (NCPDP): nonprofit organization that standardizes the exchange of healthcare information.

NCPDP SCRIPT Standard: standard for transmitting prescription information electronically between prescribers, pharmacies, payers, and other entities.

NCPDP SIG Standard: standard for "Directions for Use" in electronic prescriptions.

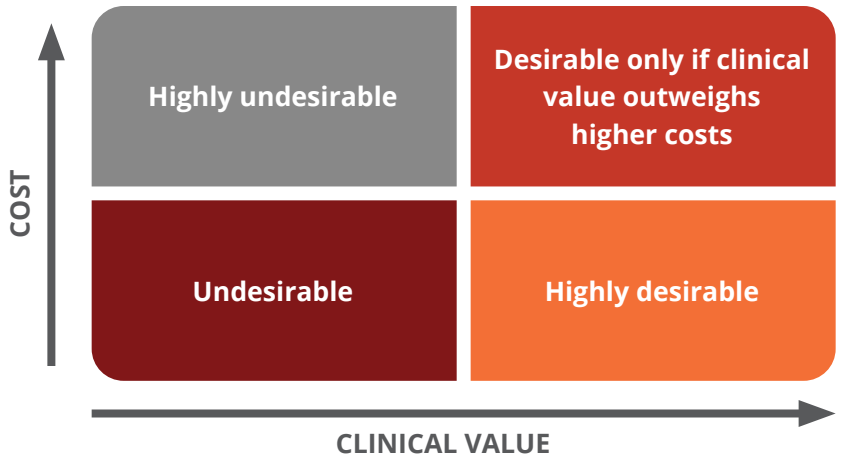
NCPDP Telecommunication Standard: standard format for pharmacy claims transmission and adjudication; enables real-time, point-of-service communication between pharmacies and claim processors.

National Drug Code (NDC): universal product identifier for human drugs; a unique, 10-digit, 3-segment number assigned by the FDA.

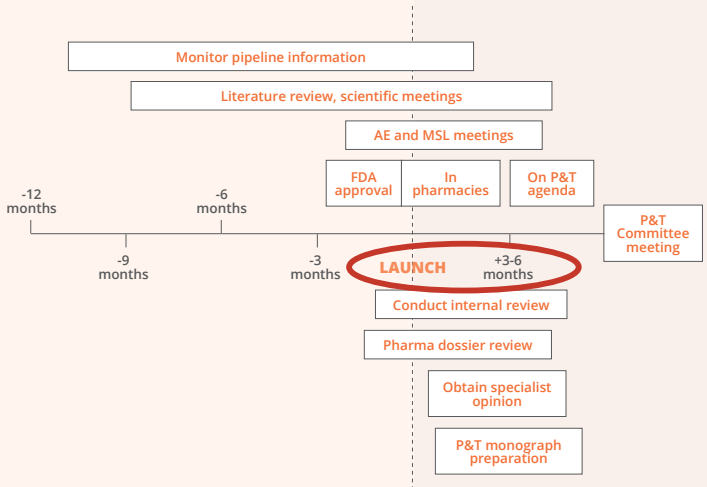
Developing and Managing the Drug Formulary

- Formularies encourage the use of the safest, most effective, and most cost-effective medications
- According to Academy of Managed Care Pharmacy (AMCP), a formulary system is an ongoing process whereby a healthcare organization establishes policies on the use of drugs, related products, and therapies and identifies those that are most medically appropriate and cost-effective to best serve the health interests of a given patient population

NEW DRUG VS COMPETITORS



TIMELINE FOR P&T CONSIDERATION



- A P&T Committee is typically comprised of 10 to 15 physicians, pharmacists, and other members; often includes a plan medical or pharmacy director
  - Responsible for objective appraisal, evaluation, and selection of drugs for a formulary and formulary management tools
  - Meets as often as necessary (usually quarterly) to review and update the formulary when there are new drugs or new indications, uses, or warnings for existing drugs
  - Reviews drug monographs to determine approval
  - Develops and implements policies and procedures for drug use and oversees quality improvement programs

Key Terms

AMCP eDossier System: web-based platform used by manufacturers to disseminate product dossiers.

AMCP Format for Formulary Submissions: guideline for manufacturers and managed care organizations to formalize, standardize, and expand information for P&T Committee review; standardized dossiers from drug companies with information on drug safety, efficacy, and economic value .

Comparative Effectiveness Research (CER): rigorous evaluation of the different options available for treating a given medical condition.

Drug Monograph: A document that summarizes important evidence-based information about a drug; prepared by the health plan/PBM company pharmacy department clinical group for review as part of formulary decisions.

Formulary Management: an integrated patient care process that enables physicians, pharmacists, and other healthcare professionals to work together to promote clinically sound, cost-effective medication therapy and positive therapeutic outcomes.

Pharmacy & Therapeutics (P&T) Committee: responsible for developing, managing, updating, and administering the formulary; also designs and implements formulary system policies on utilization and access to medications.

Source: *American Journal of Managed Care Pharmacy*. Fundamentals of managed care pharmacy [workshop]. 2020.