

Unified Formulary: The Good, The Bad, and How to Drive Savings



Mckenzie McVeigh, PharmD, MS
Clinical Pharmacy Manager, MassHealth
Office of Clinical Affairs, Commonwealth Medicine
University of Massachusetts Chan Medical School

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Conflicts of Interest

- Mckenzie McVeigh has no relevant conflicts of interest to report.

Learning Assessment Questions

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**All state Medicaid
programs have a Unified
Formulary?**

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What is the main purpose of a Unified Formulary?

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What are potential ways to assess managed care adherence to a Unified Formulary?

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Learning Objectives



Identify the purpose and benefits of a unified formulary



Discuss the challenges with implementing a unified formulary



Describe the unified formulary efforts in Massachusetts

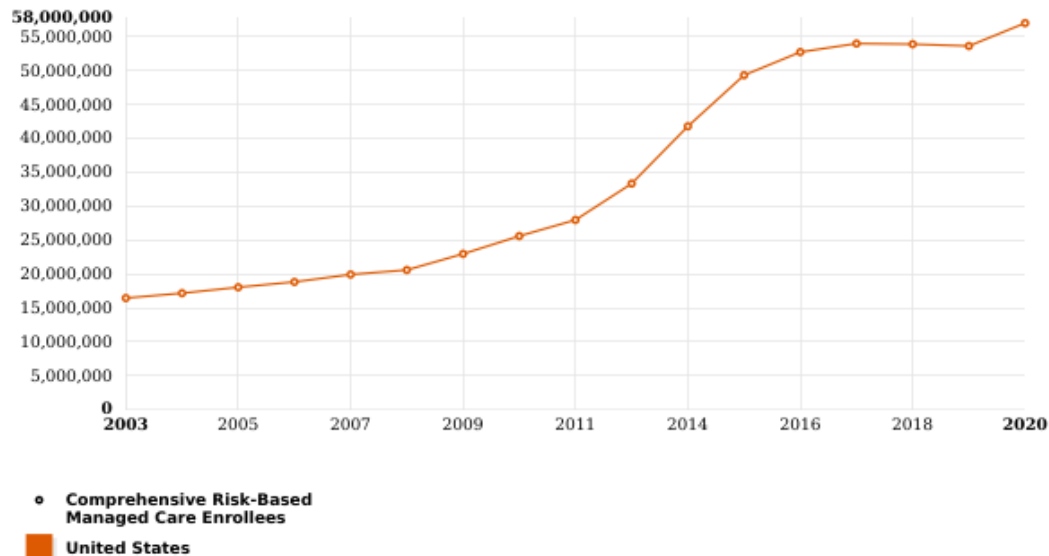


Understand strategies to measure managed care performance

Why do states have managed care organizations?

- Since the Affordable Care Act (ACA) authorized expansion in 2014, Medicaid enrollment has risen by ~24 million people
 - In response to increased enrollment, states have relied on managed care organizations (MCOs)
 - **MCOs generally have been allowed to oversee their own drug formularies**

Total Medicaid MCO Enrollment: Comprehensive Risk-Based Managed Care Enrollees, 2003 - 2020



SOURCE: Kaiser Family Foundation's State Health Facts.

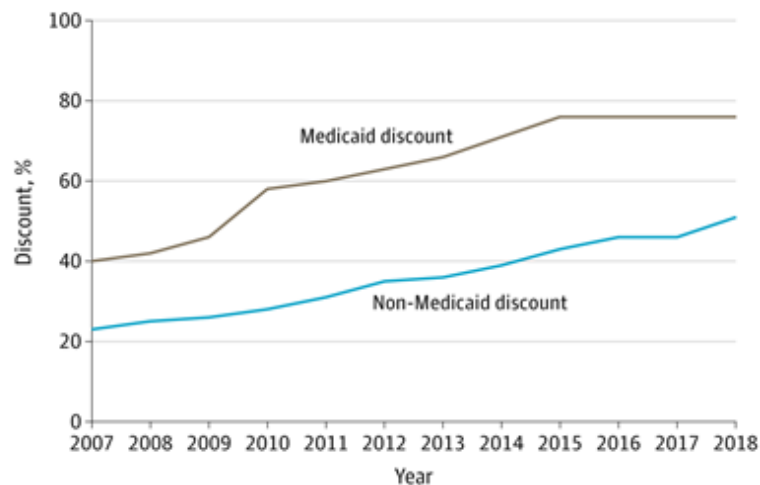
How does managed care affect pharmacy spend?

- Drug prices continue to rise contributing to growth in pharmacy budgets

A Changes in list and net prices for branded drugs



B Mean discounts in Medicaid and other payers



- MCOs do not collect federal rebate for outpatient drugs, therefore are incentivized to use drugs that are lower cost to MCOs
 - Lower list (gross) prices
 - Collect their own rebates from manufacturers

How can states curb increasing drug costs?

1. Unified preferred drug lists with managed care plans
2. Contract with manufacturers to increase rebates

Both aim at reducing total net spend to states

What is a Unified Formulary?

- Uniform Formulary
- Single Preferred Drug List (PDL)
- Unified Pharmacy Product List (UPPL)

- The objective is to align drug management across fee-for-service (FFS) and managed care programs
 - Distinguishes between preferred and non-preferred drugs

Purpose of Unified Formulary



Simplifies experience
for providers and
members

- Same clinical criteria for all therapeutic classes



Improve administration
efficiency

- MCOs do not need to manage their own formularies
- Easier for coordination for members transitioning between plans



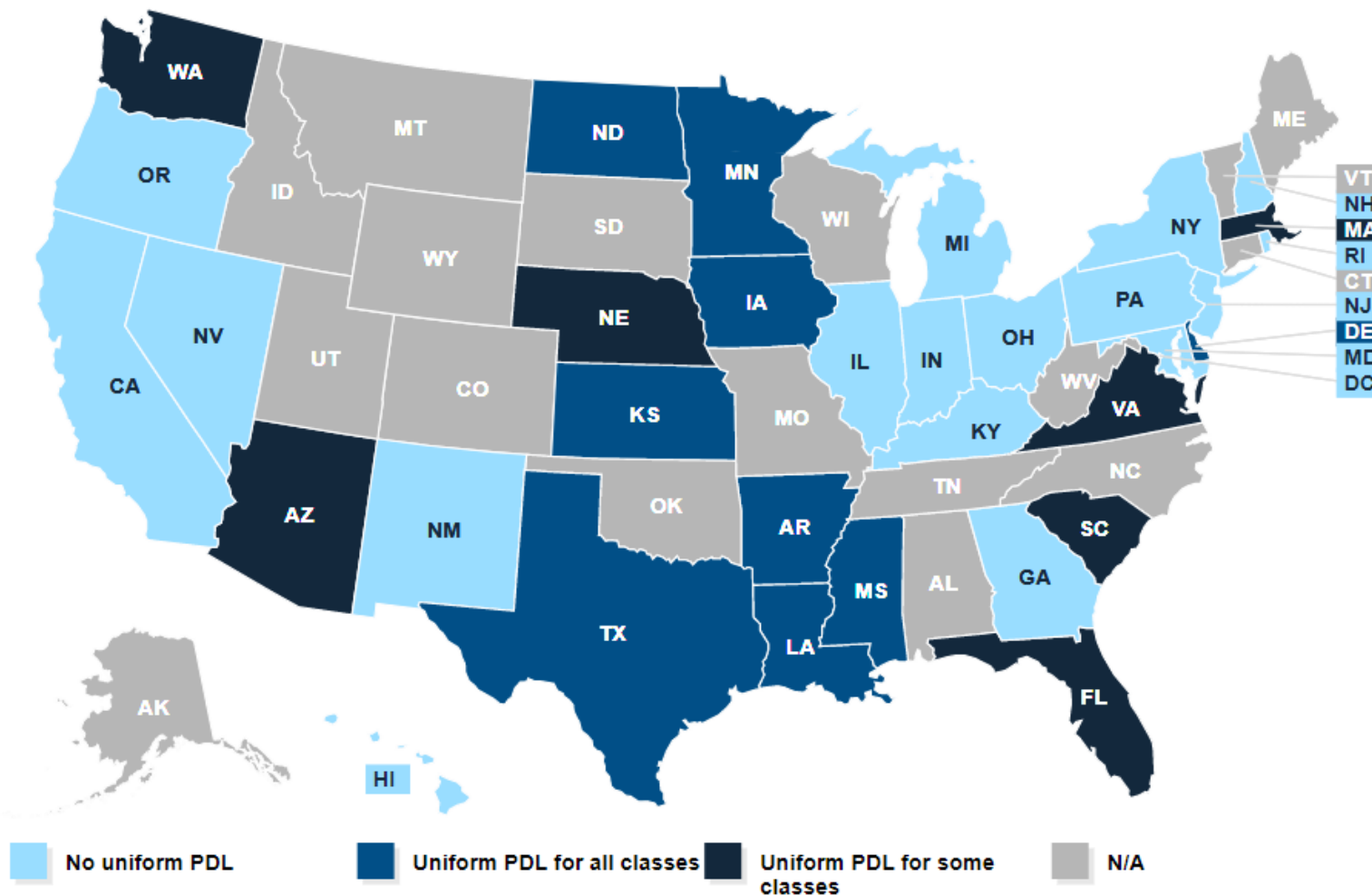
Maximize supplemental
rebate collection and
increase negotiating
power

- Same preferred drugs for entire population
- Larger populations when including total (FFS and managed care) lives

Pharmacy Carve-Out

- Currently, only a handful of states have carved the pharmacy benefit out of MCO contracts
- Benefits of carve-out:
 - Centralize the decision making
 - Improve negotiations for supplemental rebates
 - Less strict pharmacy networks
 - Overall simplification
- However, it increases the administrative burden (claims processing, prior authorization review, etc) to the state and limits data for use by managed care plans

States with Unified Formulary for Managed Care*



*As of July 2019 (there have been additional states that have implemented a single PDL since 2019)

States with pharmacy carve out: MO, TN, WI, WV

Source: <https://files.kff.org/attachment/How-State-Medicaid-Programs-are-Managing-Prescription-Drug-Costs.pdf>

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Unified Formulary: Considerations for implementation



Clinical

- Efficacy
- Safety
- Baseline utilization



Financial

- Gross vs net cost
- Contracts



Operational

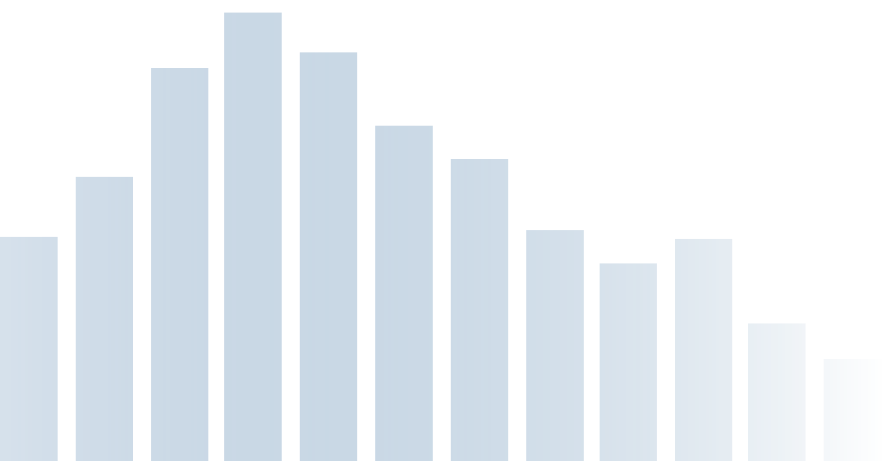
- What level of unification?
- Coding details to provide to MCOs

How will managed care be measured on adherence/performance to PDL?

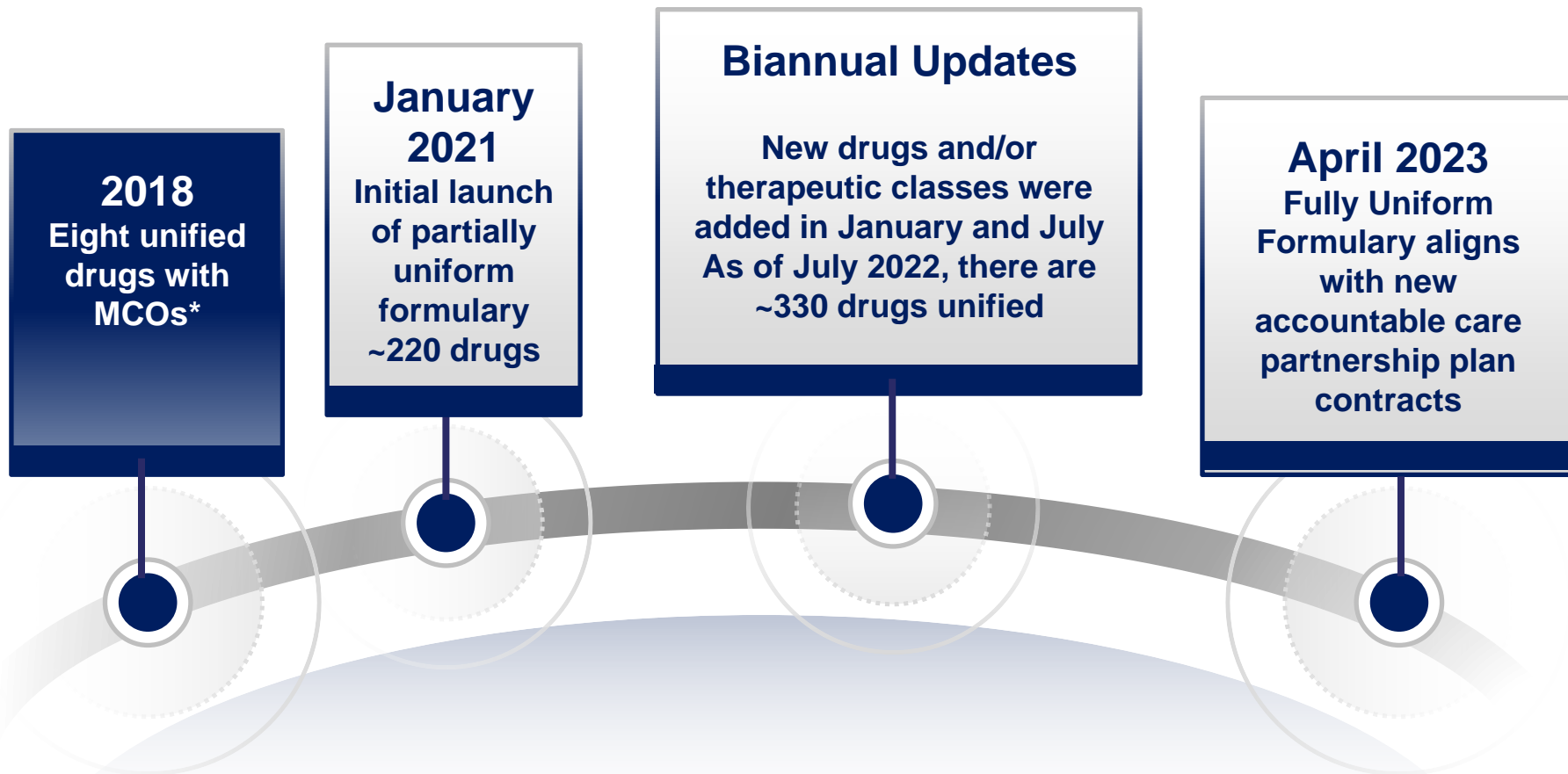
Measuring MCO Performance

- States can measure adherence to the unified formulary using:
 - **Prospective targets** comparing preferred/non-preferred drug utilization with penalty/reward for each script above/below target range
 - **Retrospective reconciliation** comparing managed care actual utilization to FFS utilization and penalty/reward based on actual vs expected rebates
 - **% compliance** to PDL (e.g., >95% of claims for preferred drugs)
- States can align financial incentives with MCOs by sharing a percentage of supplemental rebate revenues or reward for adherence to the single PDL

The Massachusetts Experience



Uniform Formulary Implementation Timeline



*Therapeutic classes included cerebral stimulants, growth hormones, hepatitis c antivirals, long-acting injectable antipsychotics, opioid use disorder, and anti-TNF agents

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Notable Successes

- Increased negotiation leverage
 - Larger population leads to additional negotiation leverage when contracting with manufacturers
- Increased rebate collection
 - Optimization of uniform formulary drives utilization to lowest net cost drugs
 - Embedded misalignment with managed care capitation rates which incentivizes plans to use the lowest list (gross) drugs which often differ from the lowest net cost drugs

* Based on drug volume and utilization distribution from Q4 CY2020 for each therapeutic class

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Encountered Challenges

- Communicating changes with multiple parties
- Timing
 - Frequency of changes
 - When are MCOs expected to implement the changes?
- Operational challenges
 - Drug database
 - Formulary file
- Determining the scope of a unified formulary
 - Pharmacy vs medical benefit, over the counter drugs, non-drug products, etc.
- Monitoring compliance to unified formulary and MCO performance

Measuring Performance: Prospective Targets

Methodology

1. Set target ranges for preferred utilization in each therapeutic class
 - Target range is based on FFS experience
 - Accounts for clinical considerations such as stability
2. Compare each managed care plans ‘% preferred’ to the target
3. Apply penalties or rewards for each script above/below that target range

Measuring Performance: Prospective Targets

Benefits

- Drugs are categorized as either preferred and non-preferred
- Clear targets for each therapeutic class
- 'Reward' payment for outperforming the targets

MCO expectations are clear

Challenges

- Target ranges are static for the entire year and does not account for variances in drug landscape and net pricing

Measuring Performance: Retrospective Reconciliation

Methodology

1. Compares managed care actual utilization on the NDC level to the FFS actual utilization (retrospective ‘target’)
2. Penalty/reward based on actual rebate differences between the managed care plan’s performance with that of FFS

Measuring Managed Care Performance

- Retrospective reconciliation

Benefits

- Based on **actual** utilization which accounts for clinical and policy changes and/or market dynamics throughout the year

Challenges

- Operationally more complex

Conclusions

- A single, unified formulary allows state Medicaid programs to achieve significant savings
- Unified formularies allow for a simplified, consistent pharmacy benefit for providers and members
- States should consider measuring managed care performance
 - Provide incentive payments for over performing or require penalty payments for lost rebates to states

Learning Assessment Questions

All state Medicaid programs have a Unified Formulary?

1. True
2. False

Learning Assessment Questions

What is the main purpose of a Unified Formulary

1. Simplify the experience for providers and members
2. Improve administration efficiency
3. Maximize rebate collection
4. All of the above

Learning Assessment Questions

What are potential ways to assess managed care adherence to a Unified Formulary?

1. Compare managed care plan utilization to prospective targets for therapeutic classes
2. Retrospectively compare rebates collected based on actual managed care utilization to expected rebates collected based on FFS utilization
3. Assess compliance to the unified formulary based on % preferred vs non-preferred claims
4. All of the above
5. None of the above



Mckenzie McVeigh

Clinical Pharmacy Manager, MassHealth
Office of Clinical Affairs
mckenzie.taylor@mass.gov

Commonwealth Medicine

University of Massachusetts Chan Medical School
333 South Street, Shrewsbury, MA, 01545