



Common Formularies In Medicaid: Implications For Asthma Care Coverage

Introduction

Prescription medications are an important component of guidelines-based asthma care. One approach that a number of state Medicaid programs have taken as they design prescription drug benefits for patients is to use a common formulary. A common formulary refers to a list of preferred medications available to all Medicaid beneficiaries, regardless of the payer (e.g. Managed Care Organization (MCO) or state Medicaid fee-for-service program). This issue brief will describe what common formularies are, why states would consider them, and the implications of common formularies for coverage of guidelines-based asthma care in state Medicaid programs.

A **common formulary** is a state-prescribed list of preferred medications available to all Medicaid beneficiaries regardless of payer (e.g., MCO or state Medicaid program).

While reviewing this information, it is important to remember that different stakeholders in the healthcare community have different motivations for the work each does on asthma medications. When a state Medicaid program creates a common formulary, its primary motivation is to contain costs. It does so by leveraging its purchasing power to negotiate higher rebates for medications used by state Medicaid beneficiaries. Medicaid programs also care about the quality of care their beneficiaries receive, but that is not the motivation for moving to a common formulary. On the other hand, state asthma programs and other asthma stakeholders are usually focused on improving access and adherence to asthma medications. More consistent utilization of asthma medications is part of the National Asthma Education and Prevention Program (NAEPP) Expert Panel guidelines and results in better asthma outcomes. Asthma stakeholders usually recognize that improved access and adherence are likely to lower overall costs of care, but that is not their primary motivation.

By understanding the motivations of different stakeholders for adopting common formularies, state asthma programs and other stakeholders may be able to better engage with their state's Medicaid program and advance improvements in asthma care coverage.

Driving Forces Behind Pharmacy Management

Pharmacy coverage in Medicaid is optional under federal law, but all states have elected to cover prescriptions. In recent years, a combination of rising drug costs, increasing enrollments and utilization, and a shift from less expensive to more expensive drugs have refocused state efforts on controlling pharmacy spending.¹

All state Medicaid programs participate in the federal Medicaid Prescription Drug Rebate Program (MDRP), which provides rebates to the state based on a formula that varies for brand drugs and generics. In return, any drug in the

MDRP must be covered by each state Medicaid program. Most states also negotiate supplemental rebates directly with drug manufacturers. When a state negotiates supplemental rebates, it can create its own Medicaid Preferred Drug List (PDL) which provides preferred access to a more limited number of drugs, but all federal MDRP drugs must still be available to Medicaid beneficiaries. So, in essence, the MDRP is the broad formulary while the state PDL is a preferred subset of that formulary. States can require prior authorization or other criteria for drugs that are on the MDRP but may make drugs on the state PDL available without these barriers to incentivize their greater use.

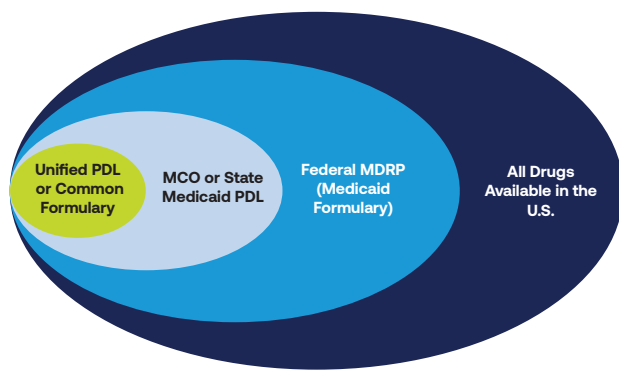
Before the Affordable Care Act, state Medicaid programs only received rebates on the drugs they managed themselves and not those managed by an MCO. This motivated them to “carve out” (or exclude) drug coverage from their contracts with MCOs. The Affordable Care Act extended the MDRP rebates to MCOs. This led more states to shift to a carve-in pharmacy model. This means the drugs are wrapped into – or “carved-in” – the contract Medicaid has with the MCOs, allowing MCOs to manage their own drug coverage without jeopardizing state rebates. Of the 40 states contracting with comprehensive risk-based MCOs in 2018, 35 reported that the pharmacy benefit was carved-in.²

Frequent Types Of Medicaid Preferred Drug Lists

Medicaid PDLs range from very comprehensive with full control exerted by the state Medicaid program to more flexible with full implementation autonomy granted to the state Medicaid MCO or fee-for-service program. The term Unified Preferred Drug

Medicaid Drug Selection Hierarchy

The smaller the oval, the smaller the list of preferred drugs and the higher the rebates



All Medicaid beneficiaries should be able to access all drugs in the Medicaid Drug Rebate Program (MDRP) but may be subject to requirements like prior authorization if there is a PDL or Unified PDL in the state.

Key Definitions

Fee for Service: Payment by a health insurer, Medicare, or Medicaid where providers receive a specific fee for each covered service provided

Managed Care Organization (MCO): A health insurer that provides for the delivery of Medicaid health benefits through a contracted arrangement with the state Medicaid agency.

Medicaid Prescription Drug Rebate Program (MDRP): Federal program that provides rebates to state Medicaid programs based on a formula that varies for brand drugs and generics.

Pharmacy Carve Out/Carve In: Prescription drug benefit that is included in state MCO capitation (payment) is *carved-in*; drug benefits that are excluded from MCO payment is *carved-out*.

Preferred Drug List (PDL): A list of preferred drugs which a payer, including Medicaid, will cover without prior authorization. Inclusion on the PDL is often tied to net cost or the level of rebate negotiated.

Prior Authorization: Process for physicians or other health care providers to receive approval from the payer (in this case, the state Medicaid agency or the MCO) to prescribe a specific medication or perform a specific procedure prior to the patient receiving care.

Rebate: Money paid to Medicaid (or another payer) by the pharmaceutical manufacturer based on the volume used by Medicaid (or other payer’s) beneficiaries.

Unified Preferred Drug List (PDL): A state-prescribed list of medications available to all Medicaid beneficiaries regardless of payer (e.g., MCO or state Medicaid program). Can also be referred to as a *common formulary*. Note: Not all Medicaid common formularies are Unified PDLs, but all Unified PDLs are common formularies.

List (Unified PDL) only applies when the state Medicaid program establishes the entire preferred drug list that ALL payers must use – as is the case under options three and four below.

1. **No Common Formulary**

This is the most liberal policy and allows the state’s Medicaid MCOs and its fee-for-service program to each manage their own formularies and drug costs. In addition to rebates available through the MDRP, MCOs may negotiate additional rebates with drug manufacturers. These supplemental rebates influence if the drug is placed on the MCO’s own PDL. In this case, the MCO’s PDL is narrower than the MDRP. However, by law, the MCO still has to provide a way for its Medicaid members to access all drugs on the MDRP.

2. **Limited Common Formulary**

A limited common formulary generally focuses on the specialty drugs that account for 2% of utilization but 30% of costs.³ Although this is quite common, it is not a Unified PDL because it refers to a small subset of the drugs dispensed to Medicaid beneficiaries. Most asthma medications are not considered specialty drugs and are not among the high cost drugs typically included on such a limited set of preferred drugs. This approach leaves the high volume, low cost drugs (including the vast majority of asthma medications) to the MCOs to manage. Under this strategy, asthma stakeholders would still interact primarily with the state MCOs to address coverage of guidelines-based asthma medications.

3. **Comprehensive Common Formulary with MCO Management Autonomy**

Under this strategy, the state Medicaid program establishes a Unified PDL but does not dictate how the MCOs implement it. This approach provides consistency for providers and patients regardless of which MCO they may be in and enables the MCO to manage drug utilization and provider prescribing patterns to a certain degree. Under this strategy asthma stakeholders would need to interact with both Medicaid and the MCOs. Interacting with Medicaid is important because asthma patients are likely to be impacted by the Medicaid program’s decisions with respect to what drugs are included in the common formulary. However, on an ongoing basis it would still be the MCOs that have the most direct impact on efforts to improve access and adherence to asthma medications.

4. **Carve-Out Comprehensive Common Formulary**

At the far end of the spectrum, the carve-out strategy rests all negotiating power and utilization management with the state Medicaid program. Prescription drug coverage is carved out of the MCO’s contract and managed by the state under one uniform program. Under this strategy asthma stakeholders would interact primarily with Medicaid on issues tied to prescription drugs for asthma.



Pros And Cons Of Common Formularies

For state Medicaid programs there are a number of pros and cons of common formularies associated with maximizing rebates, transparency, and the range of tools available to manage utilization. For patients and providers, some of the pros and cons associated with common formularies include:

Advantages	Drawbacks
<ul style="list-style-type: none"> • Access by all Medicaid beneficiaries to the same set of medications regardless of whether coverage is provided by the fee-for-service program or different MCOs offers beneficiaries consistent coverage for the same medications. This can have a positive impact on quality for patients with chronic conditions on multiple medications. If a state experiences high rates of enrollment changes across its different MCOs this consistency can be particularly valuable. • Eliminates non-medical formulary switching, a tactic that MCOs use to change coverage frequently for similar drugs because they have negotiated a lower price. These changes are often temporary because of a “special” promoted by a manufacturer, causing frequent changes in coverage. For asthma it can be especially problematic because pediatric and age-appropriate medications are often not considered.⁴ • Prescribers and pharmacists do not have to reference multiple different medication lists or formularies for their Medicaid patients, which eases the administrative burden of caring for Medicaid beneficiaries. However, even if all Medicaid MCOs use the same PDL, most prescribers deal with many commercial and Medicare plans so will still have to reference different formularies. 	<ul style="list-style-type: none"> • The exclusion of pharmacy coverage and its associated data limits the MCOs’ ability to monitor medication adherence and integrate medical, behavioral, and pharmacy benefit care management. • Although a common formulary means consistent coverage for beneficiaries it can also mean that a beneficiary may not have easy access to the medication that works for him or her unless comprehensive coverage of all asthma medications exists. The patient also cannot “shop around” with other MCOs. With asthma, children can respond differently to different versions of the same medication, and parents are often advised to stay with what works. • Establishment of a common formulary will be subject to public interest group lobbying which can take precedence over clinical judgement and cost-effectiveness analysis. • Creating a state common formulary can also be more time-consuming than the MCO’s internal formulary process and provide less flexibility to respond quickly when drugs change, or new information emerges.

State Experience

Different states have different experiences implementing common formularies. From a financial perspective the data is mixed. Some state Medicaid programs have reported positive financial benefits as a result of carving out pharmacy from the MCO contracts and moving to a common formulary. Conversely, other research has demonstrated smaller cost increases in states that have given more latitude to MCOs to manage their own formularies.

The state of Ohio adopted a Unified PDL on January 1, 2020. The Ohio Department of Health Asthma Program surveyed its health plan partners regarding the impact of the change in March 2020. MCOs reported challenges with specific drug transitions for beneficiaries, differences in age limits and restrictions for some drugs and some

concerns particularly about epinephrine self-injectors. However, they also reported that the Unified PDL resulted in additional drugs being covered, appreciation from prescribers regarding the alignment of the Unified PDL across MCOs, and a willingness of the Ohio Department of Medicaid to be flexible.

Impact On Asthma Care

A common formulary can impact state asthma programs, Medicaid beneficiaries with asthma, and the providers that treat patients with asthma.

Prior Authorizations

- Prior authorization criteria used for medications for the treatment of asthma often differ among each MCO. A Unified PDL uses the same criteria regardless of the MCO. This streamlines the process for providers and pharmacies.
- If a member changes MCOs or providers, the member will not need to change medications or go through a new prior authorization process which can reduce gaps in coverage.



Establishing the Formulary

- One of the downsides of a common formulary is that the process of establishing what will be on the formulary can be time consuming and political. However, it can create an opportunity for medical societies, groups representing patients with asthma, and other stakeholders to be involved in the process. The Ohio survey responses described above indicated that the opportunity to be involved in the process drove support for the end result.
- In addition to providing subject matter expertise to the drug selection process, state asthma programs can play a role in the transition to a Unified PDL. As a trusted source of information, asthma programs can communicate with providers, MCOs, and patients about the change and help to minimize disruption.
- Although consistency in coverage and authorization can be positive, if a particular inhaler works effectively for an asthma patient and it is no longer on the Unified PDL, the patient has to either change inhalers or get permission to maintain the current inhaler. As long as the inhaler of choice is on the MDRP, the asthma patient is likely to get permission, but the process can cause disruption. The patient's provider may resist going through this process because it is more time-consuming. An asthma program's efforts to educate patients and providers about options for ongoing coverage could be critical.

Innovation

- State asthma programs trying to improve coverage of guidelines-based asthma care can be challenged by the need to work with multiple MCOs and the state Medicaid program. A consolidated decision-making process can make this more streamlined.
- On the other hand, consolidating all decision-making at the state can limit the ability to launch pilot programs with MCOs. This is particularly true if the asthma program does not have a state Medicaid partner that shares common goals.

Acknowledgments

The American Lung Association would like to thank Claire Brockbank and Michele Patarino at Segue Consulting for authoring this issue brief. This issue brief was supported by Grant Number 6NU38OT000292, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

1. Snyder L, Rudowitz R. Kaiser Family Foundation: Trends in State Medicaid Programs: Looking Back and Looking Ahead. June 21 2016. <https://www.kff.org/report-section/trends-in-state-medicaid-programs-section-3-benefits-pharmacy-and-long-term-care/>
2. Kathleen Gifford, Eileen Ellis, Barbara Coulter Edwards, Aimee Lashbrook, Elizabeth Hinton, Larisa Antonisse, and Robin Rudowitz, States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019 (KFF, October 2018), <https://www.kff.org/medicaid/report/states-focus-on-quality-and-outcomes-amid-waiver-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2018-and-2019/>
3. America's Health Insurance Plans (AHIP). High-Priced Drugs: Estimates of Annual Per-Patient Expenditures for 150 Specialty Medications. April 2016. October 19, 2019 at <https://www.ahip.org/wp-content/uploads/2016/04/HighPriceDrugsReport.pdf>
4. Policy Lab, Children's Hospital of Philadelphia. When Medication Switching Threatens Care of Children With Asthma. Summer 2018. https://policylab.chop.edu/sites/default/files/pdf/publications/When_Medication_Switching_Threatens_Care_Of_Children_With_Asthma.pdf