Carving Pharmacy into Medicaid Managed Care Organization Benefits is Critical for Beneficiary Outcomes

The majority of Medicaid beneficiaries are enrolled in health plans, and enrollment continues to grow as states increasingly come to rely on them to provide an array of coordinated benefits and services. Health plans are in the best position to meet Medicaid beneficiaries’ primary, acute, chronic and long term care needs and to ensure they obtain services in a timely manner. These plans provide:

- Integrated systems of care that promote access to necessary services and improve health outcomes.
- Tailored clinical and care management strategies that improve quality of life.
- Support for adhering to clinical treatment regimens, such as taking medications as prescribed.
- Assistance in coordinating and traveling to medical appointments.

Twenty-eight states and the District of Columbia that use health plans to deliver Medicaid benefits include (or carve in) pharmacy benefits in the coverage, compared to seven states which carve out prescription drugs. However, some states are considering carving out pharmacy benefits. A recent study\(^1\) highlights cost-savings achievable for federal and state governments when pharmacy benefits are carved into MCO benefits. Importantly, carving in pharmacy benefits also helps Medicaid health plans use a variety of benefit management practices that improve beneficiaries’ health and well-being.

**Pharmacy Data Provide Health Plans Critical Beneficiary Information on a Timely Basis.** When MCOs manage medical and pharmacy benefits, their immediate access to pharmacy data allows them to quickly identify and address patient care issues that can significantly improve the health of their members. But when pharmacy services are carved out, incoming data, such as physician claims, can take a month or more to be submitted to the plan thereby negating the effectiveness of monitoring beneficiary health on a real-time basis. The ability to monitor pharmacy data in real-time enables health plans to perform a myriad of activities to improve beneficiary outcomes and access to appropriate services. These include:

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\(^1\) The Menges Group, “Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States”, April 2015.
Improving patient treatment compliance

Medication adherence is critical to treating acute conditions and controlling chronic conditions. It is imperative that patients take their medications as prescribed. Through the monitoring of pharmacy claims, plans can identify beneficiaries who have not filled their prescriptions, remind them of the importance of taking the medications, and inform their prescribing physicians of non-compliance.

- Improved medication adherence often requires more than simply identifying and contacting beneficiaries. Medicaid health plans have developed programs that address cultural barriers to medication usage. These plans commonly work with community-based organizations to support increased medication adherence by developing solutions specifically tailored to local practices. These solutions are improving adherence and health outcomes in the populations served.

Identifying a beneficiary’s chronic condition and initiating coordinated treatment

Health plans use prescription drug data to identify beneficiaries who have chronic conditions such as diabetes, asthma or COPD, and place them into care management programs. These programs ensure each individual has access to an integrated array of preventive, primary, acute, and chronic care services, and providers that can ensure the beneficiary’s condition can be effectively managed. These care management programs improve the beneficiary’s health and reduce the risk of unnecessary visits to the emergency room and hospital admissions.

- Care coordination and medication adherence programs demonstrate measurable results in improving health outcomes. One Medicaid health plan has targeted a program to beneficiaries with diabetes who have not filled prescriptions as recommended. Health plan pharmacists and care managers work with doctors and community pharmacists to address side effects or complex drug regimens that may make it difficult for enrollees to follow care plans. In addition, health plan pharmacists work closely with providers to recommend alternative prescriptions and simplified dosing schedules. The health plan has found inpatient hospital admissions decreased significantly among participants in this program compared to a control group.²

Alerting the beneficiary and physician to potential adverse outcomes

Health plans can monitor utilization patterns of their members to identify potential adverse reactions caused by taking multiple prescriptions or by taking a prescription that is counter-indicated for a patient’s primary or secondary diagnosis. When such potential adverse reactions are identified, the health plan is able to contact the patient’s physician to determine if an alternative prescription should be prescribed.

- These programs have led to reductions in inappropriate use of narcotics or other commonly abused medications. For example, Medicaid health plans have established lock-in programs for enrollees who show a recent history of overusing.

² See Innovations in Medication Therapy Management, AHIP Center for Policy and Research, December 2013, pp. 15-16.
narcotics. Under these programs, pharmacy and case management staff work to identify enrollees who have ten or more controlled substance prescriptions within a three month period. The beneficiary’s primary care or attending physician is contacted to discuss these findings and obtain the physician’s consent to the program. Once the enrollee is notified, the lock-in is entered into the plan’s pharmacy system within several days. Subsequent evaluations are conducted on a quarterly basis to determine whether the enrollee should stay in the lock-in program or be discharged.

- **Ensuring the most clinically appropriate treatment is being delivered**
  Through the monitoring of prescriptions, health plans can better assure that providers within their network follow the optimal treatment regimens recommended by the most current clinical guidelines. When a provider is identified as prescribing medications that are not consistent with clinical guidelines, the health plan may perform outreach to suggest a change in medication accompanied by a clinical rationale.

  - Medicaid health plans commonly use multidisciplinary care teams to identify and address beneficiaries who are not receiving optimal medication therapy. One plan has established a support program for people dually eligible for Medicare and Medicaid in which nurse care managers send patients’ medication lists to pharmacists, who identify gaps in evidence-based care, potential risks to patient safety, and opportunities for cost savings with generics. Pharmacists collaborate with care managers and doctors in making any changes needed to improve care, and they participate in weekly conference calls with care teams to discuss challenges in care and offer recommendations.3

The programs cited above demonstrate the health benefits accruing to low-income populations when prescription drugs are fully integrated with the medical care provided by Medicaid health plans. Given these benefits and the pharmacy cost savings described in the report noted above, it is crucial states continue to allow plans to use their tools to manage prescription drug regimens as a component of their covered benefits.

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3 *Innovations*, pp. 44-45.