

Chapter 9: Prescription Drugs

Texas Medicaid and the Children’s Health Insurance Program (CHIP) cover most outpatient prescription drugs either through a managed care organization (MCO) or through the Vendor Drug Program (VDP).

The Texas Medicaid drug benefit is an optional service that has been available to all Texas Medicaid clients since September 1971. In state fiscal year 2016, an average of 3.8 million clients per month were eligible to receive medications through the program. Texas Medicaid paid approximately \$3.7 billion for over 48 million prescriptions, with an average cost per prescription of \$75.32.

Adults enrolled in traditional fee-for-service (FFS) Medicaid are limited to three prescriptions per month. All other Medicaid-eligible individuals are allowed an unlimited amount of prescriptions.

Outpatient Drug Benefit in Fee-for-Service

The Health and Human Services Commission (HHSC) directly contracts with over 4,900 dispensing pharmacies to provide prescription

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drugs to clients in Medicaid FFS and managed care. Texas pays for all Medicaid FFS outpatient drug coverage through VDP, with the exception of some medications provided as part of outpatient physician services.

Clients who are dually eligible for Medicaid and Medicare receive most of their prescription drugs through the Medicare prescription drug benefit known as Medicare Part D (see **Chapter 2, Medicaid and CHIP in Context**).

Outpatient Drug Benefit in Managed Care

Most Medicaid clients and all CHIP clients obtain their prescription drug benefits through an MCO as required by S.B. 7, 82nd Legislature, First Called Session, 2011. Outpatient prescription drugs are a benefit of CHIP and the STAR, STAR+PLUS, STAR Health, and STAR Kids managed care programs.

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Pharmacy providers must enroll with HHSC prior to participating in any managed care pharmacy network. Each MCO builds its own pharmacy network to allow local pharmacies to dispense pharmaceuticals to managed care members. The MCO contracts with a pharmacy benefits manager (PBM) to process prescription claims. The PBM contracts and works with pharmacies that actually dispense medications to CHIP and Medicaid managed care members. MCOs must allow any pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

MCOs and PBMs are required by state law to adhere to the Medicaid and CHIP formularies and the Medicaid preferred drug list (PDL) until August 31, 2018. Prior authorization (PA) is required for non-preferred drugs and drugs subject to clinical PA. MCOs/PBMs

may implement any of the state's approved clinical PA, but no more. Clinical PAs may vary between plans because not all MCOs may choose to implement each clinical PA; however, there are some clinical PAs that all MCOs and FFS are required to implement.

If a drug is neither preferred nor non-preferred on the PDL, the MCO/PBM cannot establish a drug as non-preferred and implement a PDL PA.

Federal Drug Rebate Program

Among other provisions, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) required the implementation of a federal Medicaid drug rebate program, effective January 1, 1991. Under this law, drug manufacturers are required to pay rebates for drugs dispensed under state outpatient drug programs in order to be included in state Medicaid formularies. States are required to cover all of the drugs for which a manufacturer provides rebates under the terms of the law. The basic drug rebate provisions of OBRA 90 are as follows:

- States must maintain an open formulary (except for a few categories listed in the law) for all drugs of manufacturers that have signed a federal rebate agreement.
- States may require PA of drugs to limit the use of covered drugs, but

must provide PAs within 24 hours of receipt of the request. States must also provide up to a 72-hour emergency supply of drugs if a PA cannot be granted within 24 hours.

- Rebate amounts per unit are determined by the Centers for Medicare & Medicaid Services (CMS).
- States perform the rebate billing and collection functions.

Two subsequent pieces of federal legislation further updated the rebate provisions. The Deficit Reduction Act of 2005 extended the rebate program to outpatient drugs administered in a physician's office or another outpatient facility. The Affordable Care Act (ACA) increased the minimum federal rebate percentages drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount. The ACA also expanded the rebate program to cover claims paid by Medicaid MCOs.

VDP manages the federal manufacturer drug rebate program and collects rebates for medications dispensed by pharmacies and administered by physicians to Medicaid clients in FFS and managed care. Texas negotiates additional state rebates for preferred drugs. HHSC also collects rebates for drugs provided to clients in CHIP and three state health programs, including

the Healthy Texas Women program. The 2016-17 General Appropriations Act (GAA), H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 23), requires HHSC to submit an annual report to the Legislature on rebate revenues and outstanding balances. The 2016-17 GAA (Article II, HHSC, Rider 5) also establishes collected rebates as the first source of funding for Medicaid and CHIP prescription drug services, before general revenue. HHSC collected approximately \$2.1 billion all funds in Medicaid rebates in calendar year 2015.

Preferred Drug List and Supplemental Rebate Program

A PDL is a tool used by many states to control growing Medicaid drug costs while also ensuring program recipients are able to obtain medically necessary medicines. States have taken different approaches to developing PDLs based on federal and state law. In Texas, H.B. 2292, 78th Legislature, Regular Session, 2003, provided direction to HHSC on how to implement the Medicaid PDL.

The PDL contains medications in various therapeutic classes that are designated as "preferred" or "non-preferred" based on safety, efficacy, and cost-effectiveness. Prescribers who choose non-preferred medications for their patients must

obtain PA. The Texas Drug Utilization Review (DUR) Board reviews drugs and drug classes and recommends to HHSC which pharmaceuticals should be listed as preferred or non-preferred status on the PDL.

With a PDL, Medicaid clients have access to all of the drugs Medicaid is required to cover under federal law, including those covered before the PDL was established. The PDL controls spending growth by increasing the use of preferred drugs. Unless Texas Medicaid has historical paid claims information indicating a patient meets the state's authorization criteria, a physician's office must call to obtain approval before a non-preferred drug can be reimbursed. By containing drug costs, the PDL helps preserve Medicaid's ability to meet clients' increasing prescription drug needs, as well as other health care needs.

The MCOs implemented the state's PDL and do not have PA requirements more stringent than those in place for FFS as required by S.B. 7 and the 2012-13 GAA, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, HHSC, Rider 81).

Supplemental rebates are collected under the PDL provisions of H.B. 2292. These rebates are in addition to the rebates collected under the federal drug rebate program on products selected as preferred drugs for the Texas Medicaid formulary. These

rebates are based on competitive negotiations that are performed by a contractor that specializes in optimizing rebate offers for supplemental rebates. The rebate offers are used in determining cost-effectiveness for possible placement on the PDL. Rebates are collected on both FFS and MCO prescription drug claims. Supplemental rebate revenue is shared with CMS at the same federal medical assistance percentage used to pay the claims.

HHSC estimates receiving a total of \$828 million in Medicaid VDP rebates in state fiscal year 2016. This amount includes \$79.1 million in supplemental VDP rebates.

Drug Utilization Review

Prospective and retrospective DURs play a key role in how HHSC understands, evaluates, and improves the prescribing, administration, and use of medications.

Prospective DUR evaluates each client's drug history before medication is dispensed to ensure appropriate and medically necessary utilization. Advisory messages concerning clinically significant drug interactions, ingredient duplication, or therapeutic duplication are part of the point-of-sale claim adjudication process.

Retrospective DUR reviews the drug therapy after the client has

received the medication. Reviews examine claims data to analyze prescribing practices, medication use by clients, and pharmacy dispensing practices. HHSC conducts multiple reviews each calendar year that focus on patterns of drug misuse, medically unnecessary prescribing, or inappropriate prescribing. Intervention letters are sent to physicians to help better manage clients' drug therapy.

The Texas DUR Board is an HHSC advisory board composed of 17 physicians and pharmacists who provide Medicaid services and represent different specialties, two representatives from Medicaid MCOs as nonvoting members, and a consumer advocate representing Medicaid recipients. Members are appointed by the HHSC Executive Commissioner. The board reviews and approves the therapeutic criteria for prospective and retrospective DUR and clinical PA criteria. Board meetings are held quarterly in Austin.

e-Prescribing

To reduce adverse drug events and costs incurred in providing prescription drug benefits, HHSC upgraded its pharmacy benefits system to provide electronic prescribing (e-prescribing) functionality. The following functions became available to pharmacies and providers in December 2011.

- The Medicaid/CHIP drug formulary and PDL are available to FFS and MCO prescribers electronically. Prescribers' electronic health records (EHR) systems can download regularly updated formulary information that is seamlessly integrated into their prescribing interface.
- Client prescription benefit eligibility is also integrated into prescribers' electronic health record (EHR) systems as well as pharmacies' management software. Medicaid/CHIP client eligibility can be verified in a timely manner by providers and pharmacies, ensuring clients receive the full benefit of their enrollment and timely access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

The federal Drug Enforcement Administration issued rules in 2010 allowing the e-prescribing of controlled substances (ePCS). The rules included a requirement for the certification of both the prescriber software system and pharmacy software system by an independent third party auditor. The Texas Department of Public Safety has adopted the same requirements and updated their rules and regulations in October 2013 to allow controlled substances, including Schedule II,

to be prescribed and transmitted electronically. By September 2016, 94.8 percent of pharmacies in Texas were capable of accepting ePCS. Texas Medicaid has organized a statewide effort to raise awareness and use of ePCS in Texas. With ePCS, prescribers spend less time on the phone, and improve security and confidentiality. Pharmacies decrease phone calls, eliminate verbal misinterpretations and increase prescription accuracy. Patients benefit from improved safety. Texas Medicaid providers can learn how to start using ePCS and which EHR systems are ePCS enabled by going to www.getEPCS.com.