UNDERSTANDING MANAGED CARE AND ITS TRENDS

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Topic Overview

The evolution of managed care spans over 100 years. The infrastructure of managed care is complex, including diverse participants and processes. Participants include wholesalers, manufacturers, hospitals, clinicians, pharmacy teams, the government, and pharmacy benefit managers, among many others. The role of managed care is to apply clinical and scientific evidence, support the appropriate use of therapeutics, enhance patient and population health outcomes and optimize the use of limited healthcare resources. Formularies, utilization management tools, quality, safety, and cost-sharing programs are tools to manage outcomes and costs. By 2023, the country's medication spending is expected to rise to $420 billion, fueled predominantly by new products. Value-based managed care systems are a trend and a challenge. Innovative approaches to managed care are underway. Creating payments that tie provider financial success to high-quality patient care, and 'gold card' projects are poised to lead to further advances in managed care strategies. Pharmacy teams are ideally positioned to contribute to a broad range of managed care solutions.

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Target Audience: This educational activity is for pharmacy technicians.

How to Earn Credit: From January 21, 2023, through January 21, 2026, participants must:

1) Read the "learning objectives" and "author and planning team disclosures;"
2) Study the section entitled "educational activity;" and
3) Complete the Course Test and Evaluation form. The Course Test will be graded automatically. Following successful completion of the Course Test with a score of 70% or higher, a statement of participation will be made available immediately. (No partial credit will be given.)

Learning Objectives: Upon completion of this educational activity, participants should be able to:

1. **Define** managed care
2. **Identify** managed care models, plans, and characteristics
3. **Describe** the roles of managed care pharmacy team members
4. **Apply** knowledge of managed care to answer patient or health team questions

Disclosures

The following individuals were involved in the development of this activity: Pamela Sardo, Pharm.D., B.S., and Susan DePasquale, MSN, PMHNP-BC. Pamela Sardo, Pharm.D., B.S., was an employee of Rhythm Pharmaceuticals until March 2022, and she has no conflicts of interest or relationships regarding the subject matter discussed herein. There are no financial relationships relevant to this activity to report or disclose by any of the individuals involved in the development of this activity.

Introduction

The infrastructure of managed care is complex, and it includes diverse participants and processes. Participants include wholesalers, manufacturers, hospitals, clinicians, pharmacy teams, the government, and pharmacy benefit managers, among many others. Managed care applies clinical and scientific evidence, supports the appropriate use of therapeutics, enhances patient and population health outcomes, and optimizes the use of limited healthcare resources. Pharmacy teams are ideally positioned to contribute to a broad range of managed care solutions.

History of Managed Care

The history of managed care principles began over 100 years ago in the United States.[1] In 1929, Dr. Justin Kimball at Baylor Hospital in Texas established The Baylor Plan, a prepaid hospitalization plan that first used the Blue Cross logo. In 1938, Henry J Kaiser established a prepaid clinic and hospital care during the Grand Coulee Dam construction in Washington. In 1950, the Joint Commission on Accreditation of Hospitals (JCAH) encouraged the formation of a Pharmacy and Therapeutics (P&T) committee and the development of a list of drugs covered by a health insurance plan called a formulary. By 1965, P&T committees were required before a hospital could receive accreditation.[2,3]

In 1960, expenditures on healthcare totaled $26.8 billion; by 1994, this amount grew to $949.4 billion. Spending on pharmaceuticals accounted for 8.2% of this total. Increasing medical spending caused a shift in healthcare insurance from fee-for-service reimbursement to a managed care environment.[3]

In 1968, the first pharmacy benefit manager, Pharmaceutical Card System (PCS), was formed. This was followed by the Health Maintenance Organization (HMO) Act of 1973 was signed into law by President Richard Nixon. These developments advanced managed care and the importance of managed pharmacy benefits.[2]

Health Maintenance Organizations drew on the skills and expertise of pharmacists, giving them a greater role in managed care. Pharmacists in HMOs participated in "evaluating evidence, developing formularies and clinical programs, optimizing patient outcomes, designing benefits, and negotiating contracts."[4]

In 1976, six million people were enrolled in HMOs, which increased to 58.2 million in 1995.[3] In 2011, the Centers for Medicare and Medicaid Services (CMS) established the Shared Savings Program to reward Accountable Care Organizations (ACOs) that lowered the growth of healthcare costs while meeting quality of care standards. Accountable Care Organizations are groups of doctors, hospitals, and other healthcare providers who work together to improve the quality and experience of care. In 2014, the Health Insurance Marketplace began.[1,5]

What is Managed Care?

"Managed care is an organized way to deliver healthcare services by efficiently utilizing healthcare resources to provide quality patient care."[1] The goal of managing care is to provide optimal healthcare at an affordable price, using diverse resources. Many people use the terms managed care organization (MCO) and health plan interchangeably to describe a managed care delivery system. Insured managed care individuals may pay a deductible, copay, or coinsurance for certain covered services that are delivered to the patient. To receive coverage, many individuals pay a monthly premium. Employers often pay a portion of the premium. Copays, premiums, and co-insurances are implemented to share the financial risk with the insured individual in an effort to encourage the use of only services that are needed.[1]

Employer groups, Medicaid, and Medicare are called plan sponsors, or payers because these are the entities that are purchasing health insurance. They determine what insurance benefits and limitations. Money is exchanged for services that are determined in a contract with a healthcare plan or insurance company. For example, an employer group may contact several health plans to get competing bids from health plans before they finally select

a health plan to provide medical and pharmacy benefits. The healthcare plan has a network of physicians, hospitals, and other providers that the covered individuals can use for their healthcare needs. These are called "networks."[1]

Some health-related services and products require prior authorization before access. Heavy users of services are sometimes provided case managers to manage access to specific therapeutics for the patient's condition. Providers submit claims for payment for services using specific codes, and the payers review the claim submissions.[6,7]

Including hospitals within the managed care plan's network provides the ability to treat a larger population of patients than if fewer benefits were offered. Many health insurance plans limit the number of hospitals a patient can visit under their health plan, which limits the freedom of the patient in terms of where they receive their care. Managed care plans also cover many extended healthcare benefits, including prescription drugs, dental plans, hearing aids, vision care, acupuncture, home care, hospital rooms, and physician visits.[6]

Within the managed care infrastructure are interdisciplinary teams, including pharmacy professionals. The critical role of managed care pharmacy is to apply clinical and scientific evidence, support the appropriate use of medications, enhance patient and population health outcomes, and optimize the use of limited healthcare resources.[1]

Managed care companies may hire pharmacy technicians for customer service or other diverse roles. Their job descriptions may be broad. They may resolve questions from members about whether certain services are covered (such as vision care or acupuncture), which medication is on a formulary, or whether there are quantity limits.[4,8]

Managed care pharmacists apply their unique skills to formulary and medication utilization management, clinical programs, benefit design, and implementation. Managed care pharmacists may participate in contract negotiations to support patient access to therapies, while also ensuring cost-

effective use of limited healthcare resources. They also participate in quality and safety program management.[4,8]

Prescription drug plans incorporate utilization management tools, including prior authorization, step therapy, and quantity limits. Prior authorization occurs when the patient and/or prescriber contact the plan before certain prescriptions (or other treatments) can be provided. Quantity limits are restrictions on the amount of medication or treatment that can be provided at one time. Step therapy occurs when plans may require patients to try a lower-cost, or similar therapeutic, before covering the prescribed drug being requested.[1,9]

The prescription formulary is developed as a management tool. The objective is to enable control of inventory and for physicians to have an adequate and consistent supply of medication for their needs. Determining which products should be included in the formulary is based on the evaluation of efficacy, safety concerns, and cost considerations. Outpatient formularies also consider ease of use for the patient, patient compliance rates, dosage forms, taste, and stability. The primary goal of a formulary is to provide safe, appropriate, and effective prescription therapy. Decisions are based on evidence-based literature, the current standard of care regarding how diseases are currently treated, risk evaluation mitigation strategies (REMS), and treatment guidelines. If other factors are equal, economic considerations may be the deciding factor.[3]

A formulary is an ever-changing list of drugs, usually reviewed annually. Changes occur to the formulary as new medications are approved, older ones lose their patent protection, or if the FDA approves a new indication. Changes also may occur if new clinical information becomes available regarding safety or efficacy. New manufacturer contracts can also restore coverage of products that had previously been restricted.[3]

Therapeutic interventions are a method to encourage adherence to a plan's formulary. When a physician prescribes a medication that is not on the formulary, the dispensing pharmacy team usually receives a computer-

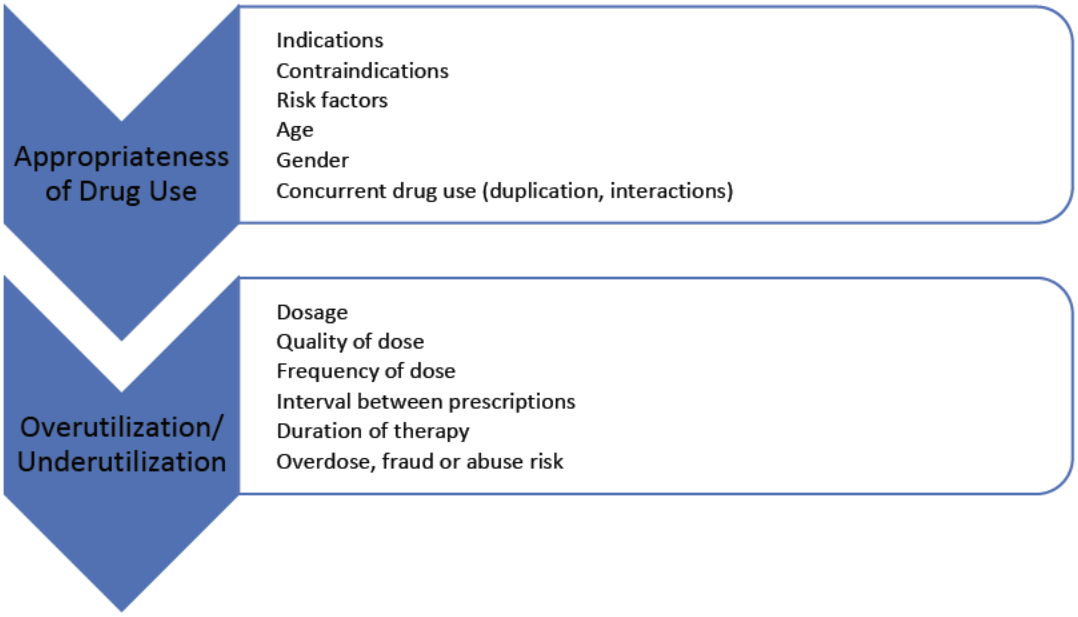
generated message that the medication is nonpreferred, and the message usually educates the pharmacy team regarding the preferred product or other next steps. Instruction to contact the physician or attempt to change the prescription usually follows the notice of restriction.[3]

The P&T formulary committee occasionally decides if there are to be limitations on who may prescribe a medication. Plans may limit dispensing to one-month or another limitation period. Reasons include limits to avoid the purchase of large supplies that might be changed or discontinued before the supply is exhausted. Reasons may also include limits to prevent stockpiling of medications. MCOs may also place dispensing limitations on medication supplies for conditions that are acute and self-limiting. Most plans offer members a process to receive up to a 90-day supply of maintenance medication at one time.[3]

An adjunct to the formulary system is a drug utilization evaluation (DUE) program. It is also referred to as drug use review (DUR). This may be overseen by the P&T committee that includes pharmacists, or an independent managed care committee. The committee evaluates the effectiveness, safety, and appropriate use of drugs for a patient.

A well-designed DUR program will have specific criteria to measure the appropriateness of drug use and measure possible over or underutilization of drug therapy. It will look at both the usage and the outcomes to determine if medication is being properly utilized. It can be implemented prospectively, concurrently, or retrospectively.[3] One example may involve a medication that is only FDA-approved for adults; however, the DUR review reveals it is being used in children. A managed care technician can inform the DUR committee of the next steps. Often, pharmacists are members of the DUR review process and can propose action plans to the DUR team from the findings. Figure 1 reveals elements of a DUR program.

Figure 1. Elements of a Comprehensive DUR Program[3,10]



Managed care processes include quality and safety assessments by reporting on quality measures that accreditation agencies, the government, or employers require. Assessing drug shortages and safety programs are also undertaken within managed care.[8]

Treatments are also evaluated based on pharmacoeconomics, which encompasses an assessment of effectiveness and cost. Outcomes-based formularies evaluate pharmacoeconomics and quality-of-life issues. Outcomes incorporate the overall impact of treatment to determine the effectiveness of a treatment in clinical, social, and economic terms.[3]

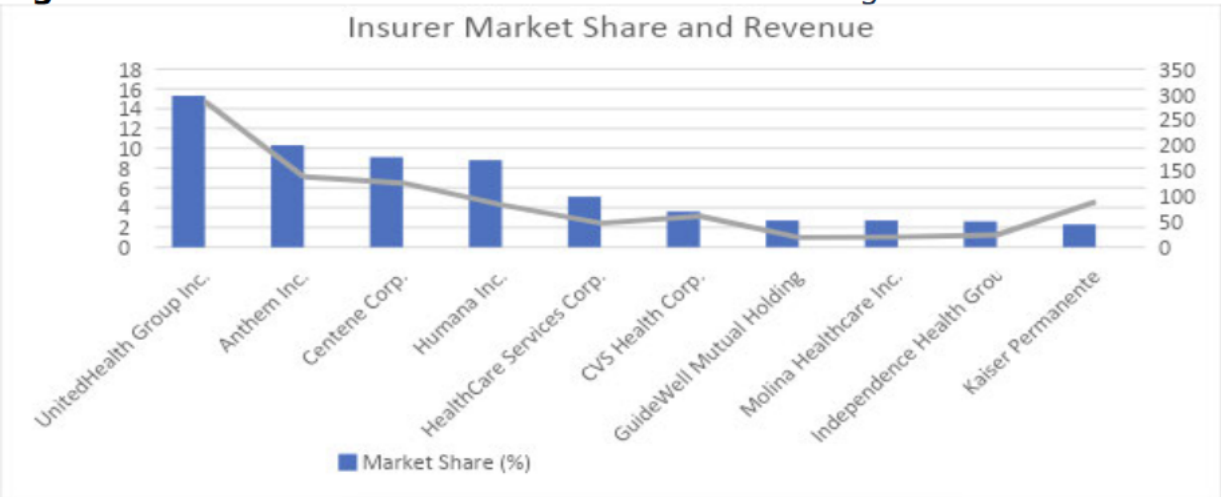
The growing importance of Healthcare Employer Data and Information Set (HEDIS) and the National Committee for Quality Assurance (NCQA) evaluations of managed care plans is causing a greater awareness of outcomes data. HEDIS scores, for example, are available for public review. As a standard is developed to compare institutions based on data, outcomes-based formularies consider the entire cost of care as opposed to just medication cost. There is also a tremendous focus on disease state management (DSM).[3]

Understanding the Managed Care Participants

Over 300 million Americans receive prescription benefits. Managed care participants who plan and execute the benefits include health plans, pharmacy benefit managers (PBMs), government-sponsored plans, and emerging models of care.[4] They also include purchasers of healthcare insurance, such as private employers, managed Medicaid and Medicare programs, and Department of Defense TRICARE programs (for uniformed service members, retirees, and their families). Managed care participants also include integrated delivery systems (IDNs) and ACOs. The most common types of MCOs include HMOs and Preferred Provider Organizations (PPOs).[8]

Employer groups, Medicaid, and Medicare are three of the largest insurance programs.[8] Centers for Medicare and Medicaid Services is the largest payer for healthcare. In 2019, Medicare had over 60 million beneficiaries. Its enrollment is projected to go over 80 million by 2030.[11] Figure 2 contains a graph of the market share and revenue of some top health insurance companies.

Figure 2: 2021 Market Share and Revenue of Leading Health Insurers[12,13,14]



Available GuideWell revenue data is from 2019

Multidisciplinary team members engage in the formulary development and maintenance processes. Nurse practitioners, physician assistants,

actuaries, internal medicine, pediatrics prescribers, and specialty practice providers (such as behavioral health, pulmonary, or cardiology) are often P&T committee members. Medical directors, pharmacy directors, and clinical pharmacists (often with drug class review responsibilities) are usually members of the P&T Committee. The participants strive to optimize patient care through the safe, appropriate, effective, and economical use of drugs. They decide the amount of control, the form the formulary will take, and the design and coordinate aspects of the formulary benefit. The P&T committee is a significant communication link between the organization's medical staff and the pharmacy network providers.[4,15]

Additional managed care participants are the PBM companies. Today, there are approximately 66 PBM companies. The three largest are Express Scripts (an independent publicly-traded company), CVS Caremark (the pharmacy service segment of CVS Health), and OptumRx (the pharmacy service segment of UnitedHealth Group Insurance). These three PBMs control approximately 89% of the market and serve about 270 million Americans. PBMs work with drug manufacturers, wholesalers, pharmacies, and health insurance providers. They negotiate payments within the supply chain. When a new drug becomes available, the manufacturer negotiates with wholesalers or corporate distribution centers. The wholesalers and distribution centers may then sell and distribute drugs to pharmacies. PBMs negotiate agreements with drug manufacturers on behalf of insurers and are paid rebates by drug manufacturers based on complex calculations.[16]

Managed Care Trends and Challenges

Managing the high cost of new and innovative therapies is a challenge for managed care and the healthcare system. By 2023, the country's medication spending is expected to rise to $420 billion, driven mostly by new products.[17]

Trends and challenges include healthcare companies' searches for ways to reach beyond cost to achieve value for managed care participants, employer groups, and patients. The value formula frequently utilized is as follows:[18]

$$\text{Value} = \frac{\text{Patient Outcomes}}{\text{Costs expended to achieve those outcomes}}$$

Healthcare institutions are adopting new trends incorporating patient outcomes. Examples include processes that affect patients, such as satisfaction with care or measuring the proportion of patients with diabetes who receive a diabetic foot exam. Patient outcomes also include clinical or functional outcomes, such as the number of procedures completed without complications, whether a patient's functional level was improved, or whether lower hospitalization rates can be identified.[19]

Value-based care removes incentives to care that do not have the ability to measure a positive impact on patient outcomes. Costs include <u>all</u> costs, including opportunity costs incurred in the healthcare delivery process. Improving value includes improving outcomes measures at a faster rate than cost increases.[20]

Managed care trends include quality-based initiatives and reporting where data-driven quality measures are balanced with cost. Incentives may grant rewards for services provided to the right patient at the right time in the most effective setting. One challenge is establishing methods to align provider, payer, and patient incentives to reward quality, effectiveness, and efficiency. Some quality measures may change annually, based on newly identified gaps in optimal care. One example of a measure may be a patient's hospital length of stay for a specific diagnosis, with targets to keep it below a specified number of days. Prophylactic antibiotics being discontinued within 24 hours after surgery might be another measure.[20]

Value-based performance reform is a trend and a challenge. This objective is to create payment structures that tie a provider's financial success to the patient receiving high-quality patient care. This is referred to as payment for performance (P4P). It encompasses measuring and comparing the results of key processes and services with those of the best performers in the network, for example.[21]

Trends and challenges include bundled payment models for episodes of care or buckets of care. For example, only one payment is provided for a full range of services associated with a specific event, such as a knee replacement or dialysis. It also places providers at some financial risk. The challenge is that bundling does not generally offer incentives to prevent the illness proactively.[22]

New treatments, devices, and procedures are drivers of healthcare costs. Comparative effectiveness is a trend and challenge to evaluate new therapeutics**.** Payers and institutions review therapeutics for cost effectiveness and outcomes assessments. The Institute for Clinical and Economic Review (ICER) and the Patient Centered Outcomes Research Institute (PCORI) create comparative effectiveness reviews. Another example of clinical and economic evidence for formulary consideration is the Academy for Managed Care (AMCP) Format for Formulary Decisions. These three strive to provide data to determine if a new therapeutic has characteristics that are better than current care, which usually has an increase in cost. The reviews use economic modeling and systematic reviews, and they evaluate clinical trials and observational studies.[23-25]

Another surprising trend is that as the FDA evaluates investigational therapeutics, the FDA staff are inviting managed care medical leaders to Washington, D.C. The purpose of the joint meeting is to provide managed care insight to the FDA and to discuss the pipeline therapeutics before an approval or denial decision is made.[26,27]

What Is Next?

Drug therapy is centered around effectiveness and safety of a drug but this is not the end of the process when managed care is implemented. Healthcare employees, including pharmacy teams, must strive to increase access to needed treatment options while also controlling costs. Managed care pharmacy teams can use published evidence, innovation, and clinical skills to advance healthcare.[4]

Some health plans are trying novel incentives. One new law explains that physicians who have a 90% prior authorization approval rate over a six-month period on certain services will be exempt, or considered to be "gold carded," from prior authorization requirements for those services. Some prescribers say that health plans should restrict utilization management programs to 'outlier' providers whose prescribing or ordering patterns differ significantly from their peers.[28]

Managed care processes will continue to evolve. Pharmacy team members will need to educate themselves on the changes in managed care in order to provide patients with optimal healthcare.

Summary

Managed care delivers healthcare services to a patient in an organized, efficient way. The goal of managed care is to provide optimal healthcare at an affordable price, using diverse resources.

Pharmacy team members are well-positioned to keep patient healthcare needs in the forefront. Clinical decision-making, in all practice settings, must be driven by evidence. This requires team members to review published evidence, keep current on innovations, and advance clinical skills in healthcare. Pharmacy teams can support the appropriate use of therapeutics and direct resources toward interventions that demonstrate value.

Course Test

1. **Which of the following is true about managed care?**

    a. The goal of managing care is to provide optimal healthcare at an affordable price, using diverse resources
    b. The terms managed care organization (MCO) and health plan describe an unmanaged care delivery system
    c. Insured managed care individuals may pay a deductible but co-insurance is fee-for-service, not managed care
    d. Employers often pay a portion of the premium, but if individuals pay a monthly premium, it is called unmanaged

2. **Which is a possible pharmacy technician role involving managed care?**

    a. A managed care pharmacy technician can inform the DUR committee if they discover an FDA-approved medication for adults is being used in children
    b. When a physician prescribes a medication that is not on the formulary, the dispensing pharmacy technician tells the patient they always must pay cash
    c. Pharmacy technicians employed in a managed care office setting are not permitted to respond to member questions about whether there are quantity limits or if acupuncture is covered
    d. Managed care pharmacy employees will hear the word pharmacoeconomics and quality-of-life issues, but those aspects are only for physicians.

3. **A new pharmacy employee approaches the pharmacy technician and asks about the benefits. The employee, reading that the facility has a formulary as part of its drug benefit, asks: "What is a formulary?" Which of the following options is a correct response?**

    a. The primary goal of a formulary is to limit access to generic medications but provide safe, appropriate, and effective brand name prescription therapy.
    b. A formulary is a list of medications available to employees based on evidence, or current standards of care regarding how diseases are treated.
    c. A formulary is a list of drugs for employees that are not re-reviewed. New medication in that therapeutic class can be included only if step therapy is implemented.

d. A formulary is a list of medications only available to employees if there is a manufacturer contract and it has never been considered restricted in the past.

4. A college student approaches the pharmacy technician and asks, "What is a P&T Formulary Committee?" Which of the following is the best response?

a. Medical directors, sales directors, and human resources leadership are usually members of the P&T Committee
b. MCOs have P&T Committees because the FTC mandates them to may also place dispensing limitations on medication
c. A group of prescribers and others who select products for the formulary based on efficacy, safety, and cost
d. The P&T formulary committee visits congress monthly and decides how much drugs will cost and who may prescribe

5. Which of the following is correct about managed care and its participants?

a. Independence Health is the largest payer for healthcare
b. By 2030, UnitedHealth enrollment is expected to be >80 million
c. The 3 large PBMs are Express Scripts, OptumRx and CVS Caremark
d. Congress plans and executes all medical healthcare benefits

6. With healthcare costs rising, which of the following best describes objectives in a model of managed care?

a. Increase therapeutics needing prior authorization and ration care
b. Optimally control costs by limiting the formulary to outpatients
c. Include clinical or functional outcomes and cost effectiveness
d. Exclude value-based performance because it is a challenge

7. Which are examples of utilization management tools?

a. Prior authorization
b. Step therapy
c. Quantity limits
d. All of the above

8. Which statement is accurate for a new managed care pharmacy team employee to know about comparative effectiveness?

a. The Institute for Clinical and Economic Review (ICER) and the Patient Centered Outcomes Research Institute (PCORI) create comparative effectiveness reviews
b. Clinical and economic evidence for formulary consideration is available within the UnitedHealth but not Academy for Managed Care (AMCP)
c. Actuaries are the only staff qualified to provide data to determine if a new therapeutic has characteristics that are better than current care
d. The reviews of generics use economic modeling, systematic reviews, and rely on Bloomberg and Wall Street for decision-making

9. Which of the following is a managed care trend?

a. In 2020, the country's medication spending was $490 billion
b. Determining how to achieve value for managed care participants
c. Low costs have priority over aligning provider-payer quality incentives
d. They will learn that bundled payments prevent risks to doctors

10. What is a bundled payment?

a. It is a model that places nurses, not doctors, at financial risk
b. It is a managed care payment model for episodes of care
c. It is a model for payment for dehumidifiers and antibiotics together
d. It is a managed care payment model for clinical trials

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