TAHP
Texas Association of Health Plans

CAPITOL HEALTH BEAT

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Texas Legislature Looks to Increase Efficiency of Medicaid Program While Protecting Enrollees With Pharmacy Carve-in Model

Changes in federal law now make state Medicaid programs eligible for rebates from drug manufacturers for drugs dispensed within an HMO model. Previously, these rebates were only available in the fee-for-service setting, leading many states to "carve out" pharmacy costs from their Medicaid HMO programs. As a result of the change, state Medicaid programs stand to generate significant savings by including, or carving in, pharmacy benefits in the services provided by health plans that are managing Medicaid services for enrollees.

In response to the changes and in an effort to create a more efficient Medicaid program, earlier this year the Texas Legislature voted to "carve in" pharmacy benefits into its state Medicaid program. The move is projected to generate approximately $100 million in cost savings. In adopting the "carve-in" model, legislators also included certain enrollee and pharmacy protections.

Among the protections are network adequacy requirements for health plans to ensure there is reasonable access to pharmacy services for all members enrolled with the HMO. To further ensure access to pharmacy benefits and to protect pharmacies, health plans are also required to contract with any willing pharmacy. Specifically, health plans are required to reach out to all currently enrolled Medicaid pharmacy providers as "significant traditional providers" for potential inclusion in the health plan's pharmacy network.

Birthdays

November
3 – Sen. Brian Birdwell
4 – Rep. Lois Kolkhorst
6 – Rep. Kenneth Sheets
8 – Rep. Mark Shelton
8 – Rep. Paul Workman
9 – Rep. Tracy King
10 – Rep. Connie Scott
13 – Rep. Patricia Harless
15 – Rep. Tim Kleinschmidt
16 – Rep. Jessica Farrar
20 – Sen. Jeff Wentworth
21 – Rep. Marva Beck
25 – Sen. Glenn Hegar
25 – Sen. Robert Nichols

To make certain enrollees have uniform access to prescription drugs, health plans are required to follow the state's Medicaid formulary and preferred drug list. Additionally, to ensure enrollees are able to purchase the drugs they need at a pharmacy in their area, the legislature included a requirement that prohibits health plans from forcing enrollees to use only mail-order pharmacy services. An added benefit for enrollees is the carve-in model's ability to allow for the management of prescription benefits in concert with medical benefits. Such coordination is believed to be an important factor in preventing potentially harmful drug interactions.

With Texas' fee-for-service delivery model having one of the highest dispensing fees in the country, some pharmacists have objected to the state's move toward a more efficient business model for the program. However, state leaders point out that carving pharmacy benefits into managed care will allow Texas Medicaid to align dispensing fees and drug costs with the commercial marketplace and rates paid under other public programs, such as Medicare.

Quality of Hospitals to Be Ranked for Public

Hospitals across the country can now be ranked and evaluated by consumers on a variety of safety issues and patient outcomes. Medicare officials in October began publishing information on the CMS' Hospital Compare website, ranking hospitals on a variety of factors that include rates of surgical complications, infections, medical errors and potentially avoidable deaths. The website, www.hospitalcompare.hhs.gov, allows users to compare hospitals' ratings with national averages for medical complications and hospital-acquired conditions.

A new value-based purchasing program created by the federal government will begin in October 2012, linking payment for services to the quality of care delivered. Hospitals with the lowest quality — including for patient safety and a host of other measures not included on the website, could lose up to 2 percent of their regular Medicare reimbursements.

Many Who Are Overweight Do Not Believe They Are at Risk

Many overweight and obese people do not believe their weight is a health risk, and a significant number said they have never even been told by a doctor that their weight poses a health threat.

Researchers recently asked 450 randomly selected patients at a hospital emergency room if they believe their current weight is damaging to their health, and if a doctor or other health professional ever told them that they are overweight.

According to the Centers for Disease Control, obesity increases the risk of many health conditions, including coronary heart disease, stroke and high blood pressure; Type 2 diabetes; cancers, such as endometrial, breast and colon cancer; high total cholesterol or high levels of triglycerides; liver and gallbladder disease; sleep apnea and respiratory problems; osteoarthritis; reproductive health complications such as infertility; and mental health conditions.

Factors that could influence whether patients discuss their weight with their doctor include whether they have a primary care doctor or a regular source of care, something that researchers didn't ask. It's also possible that people are ashamed of having been told to lose weight and failing to do so, so they lied about being warned.

The study was authored by Dr. Matthew Ryan, an assistant professor of emergency medicine at the University of Florida, Gainesville, and presented at the American College of Emergency Physicians meeting in San Francisco.

Long-Term Care Component of Federal Health Reforms to Be Eliminated

A part of the federal health reform law intended to provide long-term home care for the disabled and elderly will not be implemented because administration officials said they can't figure out a way to make the program pay for itself and still be voluntary.

The so-called CLASS Act was included in the 2010 federal health care reforms, but with a stipulation that it could be eliminated if the Department of Health and Human Services determined it could not be self-sustaining for a minimum of 75 years.

The Community Living Assistance Services and Supports (CLASS) program was to have been voluntary, with participants required to pay into it a minimum of five years before being eligible for benefits. It was intended to provide recipients cash to receive care at home instead of usually more expensive institutional care. Medicare, the federal insurance program for the elderly and disabled, does not cover long-term care.

HHS officials said CLASS would raise billions of dollars of revenue in its early years, when it was taking in premiums and paying out little in claims, but claims were projected to exceed revenue within a couple of decades, requiring taxpayer assistance to keep the program afloat.

A ruling on the constitutionality of the individual mandate component of the reforms is expected from the U.S. Supreme Court in 2012.

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