

# **Assessment of Common Core Formulary Impacts on Virginia Medicaid Managed Care Drug Spending**

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# I. Executive Summary

## A. Project Overview

During the first quarter of 2019, Virginia's Medicaid Managed Care Organizations (MCOs) paid for 95.1% of the Commonwealth's Medicaid prescriptions.<sup>1</sup> Virginia began implementing a Common Core formulary (CCF) in August 1, 2018 for Medallion 4.0 members with full implementation completed by December 1, 2018.<sup>2</sup> The CCF was implemented more than a year earlier (in August of 2017) for CCC Plus plans.

We have been engaged by Virginia's Association of Health Plans to estimate the fiscal impacts of this switch to a uniform PDL in Virginia, and to also assess the programmatic advantages and disadvantages of this policy change. Our financial impact assessment focused on the Medallion population, for whom all Medicaid prescriptions are covered by Medicaid. Costs and usage during a six-month period before CCF was implemented (January through June of 2018) were compared with a six-month period after CCF was fully implemented (January through June of 2019). During the interim six-month period, July through December of 2018, CCF was in the process of being phased in.

## B. Key Findings

The most significant findings from our analyses are summarized below.

- **The change to a uniform PDL has led to increased net (post-rebate) costs in Virginia's Medicaid program.** Our tabulations indicate that the Common Core Formulary (CCF) will result in increased Virginia Medicaid costs of \$13.2 million during CY2019, with \$5.5 million of these added costs being borne by Virginians and the remainder constituting increased Federal outlays.
- **Larger adverse fiscal impacts are expected to occur over time.** The additional costs of the CCF are currently softened by continuation of drug therapies that were instituted prior to CCF implementation. As time passes, the CCF drug list will dictate the entire mix of drugs being utilized by Virginia's Medicaid population, leading to further cost increases.
- **Pre-Rebate Costs are far higher under the CCF.** Costs per prescription pre-rebate increased 14.9% from the first half of 2018 to the first half of 2019 for the Medallion population. The national average increase in pre-rebate costs per Medicaid prescription over the past few years has been 4.36%.
- **Generic usage has decreased under the CCF.** For the Medallion population, the generic percentage of all prescriptions dropped from 88.3% to 86.3% from the first half

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<sup>1</sup> CMS State Drug Utilization Data published on July 23, 2019

<sup>2</sup>CCF Timeline information sourced from DMAS Presentation on June 14, 2018

of 2018 to the first half of 2019. This two percentage point decrease is a key driver in the overall cost increases that occurred, given that the average generic cost per prescription has been 15 times lower than the average cost per brand in Virginia's Medicaid program on a pre-rebate basis.

- **Brand drugs' share of program costs has increased rapidly.** During the first half of CY2018, brand drugs represented 64.3% of Medallion drug expenditures. This percentage increased sharply to 71.7% during the first half of 2019.
- **Other states have struggled to achieve cost-effective outcomes with a "top-down" uniform PDL model.** The nation's two largest states with longstanding experience using the uniform PDL approach, Florida and Texas, rank on average 32<sup>nd</sup> in net costs per Medicaid prescription and 43<sup>rd</sup> in generic usage. These states' approach closely resembles Virginia's CCF design. Conversely, Michigan uses a common formulary across all of the state's Medicaid MCOs, but this PDL is largely determined by the health plans and Michigan had the nation's 2<sup>nd</sup> lowest net costs per Medicaid prescription during 2018. The experience of other states is consistent and compelling in that the strategy of managing front-end drug mix optimally is outperforming the strategy of utilizing more brands and negotiating additional rebates on these brand drugs.
- **Therapeutic class level analyses demonstrate the adverse drug mix impacts the CCF is creating.** This report includes "drill-down" assessments of several therapeutic classes showing the specific drug mix changes that have occurred under CCF and the adverse costs these shifts are causing.
- **The programmatic arguments in support of moving to a uniform PDL tend to be misleading and/or over-stated.** For example, the administrative simplicity associated with moving to a single Medicaid PDL is not a major factor for most practices given Medicaid's modest share of overall Virginia prescription volume and the large number of PDLs in use in the non-Medicaid sectors. Similarly, the CCF focus on accessing supplemental rebates and consolidated purchasing power are dependent on "playing the wrong" game by steering volume to brand drugs. In addition, Medicaid MCOs have demonstrated the ability to act more nimbly than the Medicaid fee-for-service sector in addressing ongoing pharmacy benefits management dynamics such as drug price changes, introduction of new drugs, and patent expirations.

Taking all of our analyses into account, we encourage Virginia policymakers to restore the Medicaid MCOs' latitude to operate their own PDLs and utilize their full set of cost management tools. Maintaining the Common Core Formulary is not in the best interests of DMAS nor the Commonwealth's taxpayers.

## II. Data Analyses Methodology

The Menges Group created a data template and requested data from each of Virginia's six currently contracted Medicaid MCOs. We designed the template to ensure claims were captured in the exact same structure for the same populations across the same timeframes, which allowed us to analyze the pre- and post- fiscal impact of the Common Core Formulary (CCF) implementation.

The six MCOs are Aetna, Anthem, MCCVA (Magellan), Optima (Sentara), United, and Virginia Premier. We received data on CCC Plus, Medicaid Expansion, and Medallion populations. We focused our analyses on prescriptions dispensed to Medallion beneficiaries which enabled us to isolate a singular pair of pre- and post- CCF timeframes for comparison as well as focus on a population whose prescriptions are entirely Medicaid-covered. The CCC Plus population includes many dual eligibles, whose prescriptions are primarily covered under Medicare Part D. The Medicaid expansion population began enrolling during CY2019 and was not covered by Medicaid during the pre-CCF implementation timeframe.

We requested data for two timeframes:

- The pre-CCF timeframe comprised the first two quarters of CY2018 during which Medallion plans had full latitude over their PDLs.
- The post-CCF timeframe included the first two quarters of CY2019, a period immediately following the completion of rolling out the CCF for Medallion which occurred throughout the second half of CY2018.

Once we received the data, we ensured that NDC structure was consistent across MCOs and combined plan level data to produce statewide analyses. This required, for example, making the NDC field consistent across MCOs for NDCs with leading zeroes.

We then mapped the MCOs' NDC level data to an internal crosswalk of NDC level Brand or Generic categorizations and therapeutic classes. For drugs with high spending and utilization that did not receive a categorization, we researched their brand/generic classifications. After this process, 0.6% of prescriptions and 0.4% of Medallion spend remained uncategorized as brand or generic.

Finally, we analyzed third party liability (TPL)-paid claims. TPL paid claims only accounted for 0.50% of Medallion-paid prescriptions and 0.58% of Medallion's pre-rebate spend across all timeframes, an amount small enough that we did not view TPL claims to cause any meaningful distortions in our pre-post comparisons. We have provided our cost impact estimates inclusive of TPL claims; however, due to the small volume of TPL claims, they had a negligible effect on the fiscal impact estimates.

### III. Data Tabulations

#### A. Cost Per Prescription Trends

While Virginia’s Medallion program began a new contract term between 2018 and 2019 (with the program’s name changing from Medallion 3.0 to Medallion 4.0), the covered population and prescription volume were nearly identical between these timeframes. However, pharmacy costs for this subgroup rose sharply between the first half of 2018 prior to implementation of the Common Core Formulary (CCF) and the first half of 2019 (under full implementation of the CCF). Exhibit 1 conveys the specific figures, aggregating the claims level data provided by each of the six Medicaid MCOs as described in Section II.

**Exhibit 1. Medallion Pharmacy Costs and Prescription Volume Pre- and Post-CCF**

	Jan-Jun 2018	Jan-Jun 2019	Percent Change
Prescriptions	2,705,116	2,704,178	-0.03%
Amount Paid (pre-rebate)	\$179,074,186	\$205,877,778	14.97%
Cost Per Prescription	\$66.20	\$76.13	15.01%
Cost Per Prescription Excluding Claims with Third Party Liability	\$66.19	\$76.03	14.87%

Medallion’s average costs per prescription rose by 14.9% statewide and increased by double-digits within all six of the MCOs’ Medallion members. The national average annual rate of increase in Medicaid costs per prescription from 2016-2018, derived by working with a CMS database containing all Medicaid prescriptions, is 4.36%

Taking all of this information into consideration, there is strong evidence that the CCF has led to significant increases in pharmacy benefits payments. If Virginia’s costs per prescription had increased at the derived annual norm of 4.36% from 2018, payments per prescription would have been \$69.08 during 2019, or \$6.95 per prescription less than the payments which were made under CCF. Note that this differential is on a pre-rebate basis; rebates are factored into the impact estimates later in this report.

#### B. Drug Mix Impacts

A second key analytical metric involved in comparing the brand/generic mix of drugs during the pre-CCF timeframe and the first six months of CCF implementation. These findings are presented in Exhibit 2.

The percentage of Medallion-paid prescriptions which were generics decreased by 2.00% from the pre-CCF timeframe to the initial CCF implementation timeframe. While perhaps a seemingly modest change, this shift in the mix of drugs towards brands is a significant contributor to the overall cost increases described above. As shown in Exhibit 3, the average brand drug cost was approximately *15 times* that of the average generic, and the percentage of spending attributable to brands rose 7.4 percentage points between the two timeframes (from 64.3% to 71.7%).

### Exhibit 2. Medallion Brand/Generic Mix Pre-CCF Versus Under CCF Model

Medallion Program Data	Jan-Jun 2018	Jan-Jun 2019	Percent Change
<b>Prescriptions</b>			
Generic	2,388,338	2,333,555	-2.29%
Brand	301,069	355,618	18.12%
Uncategorized	15,709	15,005	-4.48%
Total	2,705,116	2,704,178	-0.03%
			<b>Percentage Point Change</b>
<b>Share of Prescriptions</b>			
Generic	88.29%	86.29%	<b>-2.00%</b>
Brand	11.13%	13.15%	2.02%
Uncategorized	0.58%	0.55%	-0.03%
Total	100.00%	100.00%	

### Exhibit 3. Average Pre-Rebate Costs for Brands and Generics in Virginia Medallion Program

Average Cost Per Medallion Prescription	Jan-Jun 2018	Jan-Jun 2019	Percent Change
Generic	\$26.46	\$24.60	-7.0%
Brand	\$382.16	\$415.02	8.6%
Uncategorized	\$51.69	\$58.61	13.4%
Total	\$66.20	\$76.13	15.0%
<b>Ratio, Average Brand Cost to Average Generic Cost</b>	<b>14.4</b>	<b>16.9</b>	
<b>Brand Share of Pharmacy Payments</b>	<b>64.3%</b>	<b>71.7%</b>	

A further assessment of how drug mix is affected by PDL policies was conducted by a Virginia Medicaid MCO that operates in many states with uniform PDL requirements and many other states where the MCO has PDL latitude. A generic dispensing rate analysis of plan-managed Medicaid PDLs versus state-managed Medicaid PDLs across the first five months of CY2018, showed a 4.7 percentage point differential in the generic dispensing rate (GDR). The aggregated GDR across the plan-managed PDLs was 87.5 percent versus 82.8 percent under the state-managed PDLs.

### **C. State Performance with Uniform PDLs**

The Menges Group annually tabulates Medicaid prescription drug performance statistics in each state, with all Medicaid prescriptions and rebates factored into these tabulations. The performance of states using the uniform preferred drug list (PDL) model within their Medicaid MCO programs largely supports preserving PDL latitude at the MCO level.

The two largest states using the uniform PDL approach, Florida and Texas, ranked 39<sup>th</sup> and 26<sup>th</sup> respectively in terms of net Medicaid cost per prescription during 2018, despite ranking 15<sup>th</sup> and 7<sup>th</sup> respectively in the percentage of Medicaid prescriptions paid by Medicaid MCOs. Nationwide during FFY2018, the average net (post-rebate) cost of a Medicaid prescription in the fee-for-service setting (\$48.46) was 37.2% above the average for MCO-paid prescriptions (\$35.32). Florida ranked 40<sup>th</sup> in 2018 in the generic percentage of Medicaid prescriptions, and Texas ranked 46<sup>th</sup>. These performance statistics are not encouraging regarding the cost-effectiveness of the uniform PDL model.

However, Michigan has used a uniform PDL model for several years and had the nation's second-lowest net cost per Medicaid prescription during 2018. Michigan also ranked well (14<sup>th</sup>) in the state's generic percentage of Medicaid prescriptions. This favorable outcome (in terms of Michigan's uniform PDL efficacy) likely differs from Florida's and Texas' experience due to the collaborative nature of Michigan's uniform PDL model. Michigan's health plans play a significant role in shaping the Medicaid MCO PDL content, which is an entirely separate PDL from Michigan's fee-for-service (FFS) Medicaid PDL. Conversely, Florida and Texas use a single Medicaid PDL across the FFS and MCO settings, with this PDL content being overwhelmingly determined by the Medicaid agency. This "top-down" model of determining the PDL content more closely describes how Virginia's CCF is currently structured. This approach provides few opportunities for MCOs to partner with the Medicaid agency to shape the PDL content.

### **D. Virginia Net Cost Figures Including Rebate Data**

State Medicaid programs receive large statutory rebates, particularly on brand drugs. Based on statutory rebate information for Virginia contained in the annual CMS FMR reports, as well as pre-rebate costs reported for Virginia in the CMS Drug Utilization File dataset, we have derived an average statutory rebate of 61.0% on Virginia's brand drugs in FFY2018. The statutory rebate on generic drugs is 13%.

Using these percentages, statutory rebates on MCO-paid drugs are derived as shown in Exhibit 4 for January – June 2018 and in Exhibit 5 for the January – June 2019 timeframe. Data provided by Virginia's MCOs indicate that supplemental rebates averaged approximately 4.0% on brand drugs during 2018, with no supplemental rebates secured on generics. For 2019 under the Common Core Formulary (CCF), we have assumed that a larger average supplemental rebate average of 5% on brand drugs will occur. The largest percentage of supplemental rebates in any state in FFY2018 was 6.9% in Vermont, which consistently has one of the nation's highest



overall net costs per prescription (after factoring in these supplemental rebates). These figures are also shown in Exhibits 4 and 5.

Comparing the two timeframes, net costs per MCO paid Medallion prescription increased 5.17% from the first half of 2018 (\$35.48) to the first half of 2019 (\$37.31). This increase was much larger than the national average increase in MCO costs per Medicaid prescription, which we have tabulated to be 2.97% per year during the 2016 – 2018 timeframe working with CMS Drug Utilization File datasets and the rebate data available in the CMS FMR reports.

#### Exhibit 4. Net Cost Estimate, January – June 2018

MCO Paid Prescriptions, Medallion	January - June, 2018			
	Brand	Generic	Uncategorized	Total
Prescriptions	301,069	2,388,338	15,709	2,705,116
Initial Payments to Pharmacies	\$115,055,656	\$63,206,567	\$811,963	\$179,074,186
Statutory Rebate Percentage	61.0%	13.0%	13.0%	43.8%
Statutory Rebates	\$70,183,950	\$8,216,854	\$105,555	\$78,506,359
Supplemental Rebate Percentage	4.0%	0.0%	0.0%	2.6%
Supplemental Rebates	\$4,602,226	\$0	\$0	\$4,602,226
<b>Net Costs</b>	<b>\$40,269,480</b>	<b>\$54,989,713</b>	<b>\$706,408</b>	<b>\$95,965,600</b>
<b>Net Cost Per Prescription</b>	<b>\$133.75</b>	<b>\$23.02</b>	<b>\$44.97</b>	<b>\$35.48</b>

#### Exhibit 5. Net Cost Estimate, January – June 2019

MCO Paid Prescriptions, Medallion	January - June, 2019			
	Brand	Generic	Uncategorized	Total
Prescriptions	355,618	2,333,555	15,005	2,704,178
Initial Payments to Pharmacies	\$147,590,073	\$57,408,228	\$879,478	\$205,877,778
Statutory Rebate Percentage	61.0%	13.0%	13.0%	47.4%
Statutory Rebates	\$90,029,944	\$7,463,070	\$114,332	\$97,607,346
Supplemental Rebate Percentage	5.0%	0.0%	0.0%	3.6%
Supplemental Rebates	\$7,379,504	\$0	\$0	\$7,379,504
<b>Net Costs</b>	<b>\$50,180,625</b>	<b>\$49,945,158</b>	<b>\$765,146</b>	<b>\$100,890,928</b>
<b>Net Cost Per Prescription</b>	<b>\$141.11</b>	<b>\$21.40</b>	<b>\$50.99</b>	<b>\$37.31</b>

### E. Fiscal Impact Estimates

As derived in the above section, Virginia’s net costs per prescription for MCO-paid Medallion prescriptions increased by 5.17% between the first half of CY2018 and the first half of CY2019. Working with all MCO-paid prescriptions nationally (comprising more than 500 million prescriptions per year), we have quantified an average annual increase in net costs per prescription of 2.97% from 2016 to 2018 (encompassing the most recent available three years of

data). This adverse differential of 2.20 percentage points is the net cost we attribute to the implementation of Virginia’s Common Core Formulary.

Our overall fiscal impact estimate of the CCF is shown in Exhibit 6. The first row applies the 2.2% adverse cost impact to all net (post-rebate) Medallion pharmacy costs, showing a monthly increased Medicaid cost of approximately \$370,000 during 2019, with these additional costs split evenly between federal and Commonwealth of Virginia funds. This same percentage cost impact is applied to the net MCO pharmacy expenditures in the other two Medicaid subgroups – CCC Plus and Medicaid Expansion – in the next rows of Table 6. CCC Plus has the largest pharmacy spending of the three eligibility groups, and Medicaid Expansion the smallest. The 90% Federal match rate for Medicaid expansion leads to a relatively modest additional Commonwealth of Virginia fund impact (approximately \$20,000 per month) in this subgroup.

Taken together, we estimate monthly additional costs attributable to the CCF to be \$1.1 million with the Commonwealth of Virginia’s additional monthly costs being \$463,000. Table 7 translates these figures to annual cost impacts (multiplying the monthly figures by 12). These estimated additional costs throughout CY2019 are \$13.2 million in overall Medicaid funds, and \$5.6 million in Commonwealth of Virginia funds.

**Exhibit 6. Net Monthly Costs Attributable to CCF Implementation During CY2019**

	Monthly Net Cost, MCO-Paid Prescriptions in Virginia During CY2019	Additional Monthly Cost Attributable to Common Care Formulary (2.2%)	Federal Match Rate	Additional Monthly State Fund Cost Attributable to CCF
Medallion	\$16,815,155	\$369,933	50.0%	\$184,967
CCC Plus	\$23,327,320	\$513,201	50.0%	\$256,601
Medicaid Expansion	\$9,755,503	\$214,621	90.0%	\$21,462
<b>Total Monthly Impact</b>	<b>\$49,897,978</b>	<b>\$1,097,756</b>	<b>57.8%</b>	<b>\$463,029</b>

**Exhibit 7. Net Annual Additional Costs Attributable to CCF**

	Medicaid Total	State Funds
Estimated Additional Annual Cost Attributable to CCF	\$13,173,066	\$5,556,352

The adverse fiscal impacts of the CCF shown above, while applied to all population groups, were derived based on detailed pre-versus-post CCF analyses of the Medallion population’s usage and costs. These analyses were based on the first six months of full implementation of the CCF for the Medallion program. Given that drug mix dynamics are driving the increased costs of the CCF, and that many Medallion enrollees have maintained their pre-CCF drug regimens for continuity of care purposes once the CCF went into effect, we expect that the adverse cost impacts of the CCF will worsen over time. As time passes fewer of the drugs being accessed will

reflect the pre-CCF preferred drug list policies of the MCOs, with ultimately all drugs reflecting the less cost-effective mix of drugs placed on the CCF.

Additional analyses suggest that the added costs of the Common Core Formulary could be much higher than the figures estimated above. A comparison of per prescription costs was conducted by one of the Virginia MCOs between states where it operates under a uniform PDL versus states where the health plan directly manages the PDL. During CY2017, this organization’s costs per Medicaid prescription were 15.0% lower in the plan-managed PDL states than in the uniform PDL states. During 2018 this differential widened to 18.0%. These tabulations further suggest that the Virginia estimated impacts of the Common Core Formulary may be much larger than the annual \$5.5 million figure derived in Exhibit 7.

## IV. Therapeutic Class Analyses

We conducted “drill down” assessments on three therapeutic classes that experienced the largest increase in raw dollar cost increases (pre-rebate) generated by cost per prescription increases occurring between the pre- and post- CCF implementation timeframes. These three therapeutic classes are Antirheumatics, Atypical Antipsychotics, and CNS Stimulants. Our tabulations are summarized in Exhibits 8 - 10.

We calculated raw dollars generated by multiplying the difference in cost per prescription from pre- to post- CCF timeframes by the number of prescriptions in the first six months of 2019. Within the top three therapeutic classes as ranked by this metric, we see overall cost per prescription percent increases as high as 49.8% (Antirheumatics) and generic dispensing rate (GDR) decreases as low as -30.2% (CNS Stimulants). These figures are shown in Exhibit 8.

### Exhibit 8. Cost Per Prescription Increases in Selected Therapeutic Classes Under CCF

Medallion Cost and Usage	Jan-Jun 2018 (Pre-CCF)	Jan-Jun 2019 (Post-CCF)	% Change or Percentage Point Differential
<b>1. CNS Stimulants</b>			
\$/Rx - Overall	\$144.74	\$202.99	40.3%
Generic % of Rx	81.4%	51.2%	-30.2%
<b>2. Antirheumatics</b>			
\$/Rx - Overall	\$1,912.59	\$2,864.51	49.8%
Generic % of Rx	66.3%	54.8%	-11.5%
<b>3. Atypical Antipsychotics</b>			
\$/Rx - Overall	\$132.32	\$180.41	36.3%
Generic % of Rx	92.3%	88.0%	-4.4%

Exhibit 9 examines each of these three therapeutic classes focusing on the five drugs with the highest market share (based on prescriptions during the first two quarters of 2018). These tabulations demonstrate shifts in the drug mix under CCF toward more expensive brands and away from generics. Market share increases of greater than 3% in brand drugs are highlighted in

red in Exhibit 9, with market share decreases of 3% or more in generic drugs highlighted in orange.

In addition to these indications of worsening management of the front end drug mix in the first two quarters of 2019, within all three of these therapeutic classes the highest-cost drug (within the top 5 market share drugs) experienced an increase of greater than 3% in prescription market share and/or that the lowest-cost drug experienced a decrease of greater than 3% from the pre-CCF timeframe to the post-CCF timeframe. These instances are shown in bolded blue text in Exhibit 9.

### Exhibit 9. Specific Drug Mix and Cost Impacts Within Selected Therapeutic Classes

	Drug Name, In Order of Descending Market Share for Jan-Jun 2018	Brand/ Generic Indicator	Market Share Differential	% Change in \$/Rx	Rank Among Top 5 Subset, M3 2018 \$/Rx
CNS Stimulants	(1)AMPHETAMINE/DEXTROAM PHETAMINE	G	-12.98%	-4.4%	5
	(2)METHYLPHENIDATE	G & Uncat	-13.87%	-9.8%	2
	(3)Vyvanse	B	3.72%	0.4%	1
	(4)DEXMETHYLPHENIDATE	G	-3.61%	7.3%	3
	(5)ATOMOXETINE	G	0.45%	2.0%	4
	<i>All Other Drugs in Class (29)</i>	B, G, & Uncat	26.29%	27.5%	NA
Antirheumatics	(1)HYDROXYCHLOROQUINE	G	-6.50%	-17.1%	3
	(2)Humira	B	9.16%	14.4%	1
	(3)AZATHIOPRINE	G	-5.22%	-14.7%	5
	(4)METHOTREXATE	G	-0.10%	-20.4%	4
	(5)LEFLUNOMIDE	G	0.34%	-25.9%	2
	<i>All Other Drugs in Class (6)</i>	B & G	2.34%	8.9%	NA
Atypical Antipsychotics	(1)QUETIAPINE	G	2.78%	-13.4%	4
	(2)RISPERIDONE	G	0.40%	14.7%	5
	(3)ARIPIRAZOLE	B & G	-6.01%	-1.3%	2
	(4)OLANZAPINE	G	-0.18%	2.2%	3
	(5)LATUDA	B	3.33%	-2.1%	1
	<i>All Other Drugs in Class (18)</i>	B, G, & Uncat	-0.33%	48.9%	NA

### *Financial Losses Incurred due to Weakened Management of Front-End Drug Mix*

Another way to examine comparative cost-effectiveness of the management of front-end prescription drug costs under the Common Core Formulary compared to a full PDL latitude model is to compute a single therapeutic classes' expenditures using the market share (mix) of individual drugs that existed during pre-CCF (first half of 2018) timeframe and comparing this to actual 2019 costs. We have applied this calculation to the top seven classes experiencing the highest raw dollar increases due to cost per prescription changes, as shown in Exhibit 10.

Collectively across these seven classes, increased initial (pre-rebate) pharmacy expenditures of \$16.3 million were attributable to the drug mix changes comparing the first six months of 2018 and the first six months of 2019 for Medallion enrollees.

## Exhibit 10. Impact of CCF Drug Mix on Expenditures Within Selected Drug Classes

Therapeutic Class	Medallion 4 Jan-Jun 2019 Expenditures	Computed 2019 Spending at 2019 \$/Rx and 2018 Mix of Rx	Expenditure Differential based on Prescription Mix
1. CNS Stimulants	\$33,877,180	\$25,404,763	(\$8,472,417)
2. Antirheumatics	\$8,994,547	\$6,237,659	(\$2,756,889)
3. Atypical Antipsychotics	\$6,759,062	\$4,911,005	(\$1,848,056)
4. Narcotic Analgesic Combinations	\$5,035,083	\$3,990,534	(\$1,044,550)
5. Miscellaneous Metabolic Agents	\$2,337,294	\$1,531,777	(\$805,517)
6. Inhaled Corticosteroids	\$10,563,099	\$9,436,889	(\$1,126,210)
7. Insulin	\$10,953,008	\$10,744,682	(\$208,326)
<b>Total</b>	<b>\$78,519,274</b>	<b>\$62,257,308</b>	<b>(\$16,261,966)</b>

## V. Programmatic Impacts

The use of a uniform, state-mandated formulary is promoted by some constituents and policymakers both for fiscal savings reasons and for programmatic advantages. Our analyses conveyed in prior sections of the report indicates that Virginia has not experienced fiscal benefits from the switch to Common Care Formulary’s (CCF’s) uniform PDL, but rather is experiencing additional Medicaid costs of approximately \$13 million during CY2019. This section assesses several programmatic arguments made in favor of and against the uniform PDL – administrative simplification, PDL updating, and supplemental rebate negotiation dynamics.

### A. Administrative Simplification

*The key programmatic argument made in favor of a uniform PDL is administrative simplification for prescribers, as there is just one Medicaid PDL for all Virginia managed care plans in lieu of up to six separate Medicaid PDLs.*

The administrative simplification argument looks at PDLs only through a Medicaid lens, whereas the provider community faces a much broader set of dynamics. As of 2018, Medicaid paid for only approximately 9% of population-wide prescriptions in Virginia, based on Kaiser Family Foundation data. Creating “uniformity” for the Medicaid PDL does not change the number of PDLs that are in use for other managed care plans (such as commercial or Medicare Part D) which pay for 91% of all Virginia’s prescriptions<sup>3</sup>. *Private insurance (62% of Virginia’s prescription volume) and Medicare Part D (24% of Virginia’s prescription volume) do not have PDL uniformity.*

<sup>3</sup> Kaiser Family Foundation - Number of Retail Prescription Drugs Filled at Pharmacies by Payer, Timeframe 2018

An assessment of Medicare health plan options on the Medicare.gov website indicates that 20 different Medicare Advantage plan options exist in Richmond City and 31 plan options exist in Arlington County, for example.<sup>4</sup> The commercial health insurance is even more dispersed. Given these dynamics, the prescriber and pharmacy community need to work with dozens of PDLs regardless of the institution of Virginia’s Common Core Formulary. It is both accurate and misleading to emphasize that prescribers will move from six Medicaid PDLs to one in “selling” the uniform PDL to policymakers. The broader picture is that a prescriber’s business is moving from perhaps 45 PDLs to 40 and their administrative situation is not changing nearly as much as is being implied.

While the administrative advantages of employing a singular uniform PDL tend to be overstated, such administrative simplification might not materialize at all. Creating Medicaid PDL “one-ness” comes at the expense of maintaining consistent PDL content for any given health plan. All Virginia Medicaid MCOs serve other populations in addition to Medicaid. A Medallion 4.0 enrollee is more likely to be viewed by a prescriber practice as an “Aetna patient” or an “Anthem patient” than as a Medicaid patient, for example. Forcing providers to look up different formularies within the same payer entity arguably adds to their administrative burden. Virginia’s Medicaid program has been privatized across the various Medallion 4.0 MCOs, with the express objective of creating a more mainstream system of coverage for impoverished Virginians than Medicaid can achieve in its own silo. Efforts such as the CCF that create Medicaid uniformity across these health plans risk creating more provider confusion and burden than it will alleviate.

The Common Core Formulary (CCF) creates other administrative challenges, as described in the following quote from a Virginia MCO pharmacy director. “Retail Pharmacies react to new to market generics by immediately stocking and trying to fill new prescriptions with the generic. The CCF PDL antagonizes this process by delaying (bi-annual P&T) and mandating brands. This has residual effects with medical providers as pharmacies implement the generic dispensing with other lines of business. The CCF PDL antagonizes this natural market effect.”

## **B. PDL Updating**

*One key cost management advantage of the PDL latitude model is the speed at which MCOs can make appropriate modifications to their PDL to accommodate the introduction of new drugs, pricing changes, etc.*

Pharmacy benefits management is a dynamic activity, as there is an ongoing flow of product price changes, new brand drugs being introduced, patent expirations, and generic options. An important programmatic need is for the organizations and individuals managing the drug benefit to nimbly address these evolving circumstances. Our analyses indicate that MCOs are typically far more adept at meeting this need and making prompt, appropriate PDL adjustments than is the

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<sup>4</sup> [https://www.medicare.gov/plan-compare/#/search-results?plan\\_type=PLAN\\_TYPE\\_MAPD&fips=51013&zip=22201&year=2020&lang=en](https://www.medicare.gov/plan-compare/#/search-results?plan_type=PLAN_TYPE_MAPD&fips=51013&zip=22201&year=2020&lang=en)

Medicaid FFS setting. One example involves the introduction of new, curative Hepatitis C drugs during the past several years. Nationally during 2017, Zepatier was introduced as the lowest-cost curative Hepatitis C product and received 36% market share in that year among Medicaid MCO-paid prescriptions, versus 17% market share among FFS-paid prescriptions. In 2018, a lower-priced product (Mavyret) was introduced, which received 63% market share in that year for MCO-paid prescriptions, versus 46% market share in the Medicaid FFS setting. We estimate that Medicaid MCOs' use of lower-cost Hepatitis C medications during the 2014-2018 timeframe created Medicaid cost reductions of \$435 million relative to the Medicaid FFS setting. The MCOs' and their PBMs' proven ability to adjust their PDLs promptly to move market share advantageously is forfeited by Virginia's Common Core Formulary.

### **C. Supplemental Rebates**

*The uniform PDL will lead to enhanced supplemental rebate revenues, as DMAS will be able to negotiate with manufactures with the leverage of all Virginia Medicaid prescription volume in each therapeutic drug class.*

Of significant concern is the attractive psychological impact rebates seem to create among many state purchasers and policymakers. Our Medicaid analyses throughout the past several years have been consistent and compelling in demonstrating that managing the front-end mix of drugs effectively yields lower net costs than a strategy that focuses on rebate maximization. The three states with the largest Medicaid rebates per prescription in FFY2018 ranked 48<sup>th</sup>, 49<sup>th</sup>, and 50<sup>th</sup> in net costs per prescription, for example. Nonetheless, the rebate revenues that arrive have a “bonus money” aura and create a perception of savings that can be highly misleading. Securing rebates is also professionally attractive to many staff within the Medicaid agency.

A further policymaking challenge is that “doing deals” with manufacturers puts the Medicaid agency and its pharmacy team at the center of prescription drug cost management. It is critical that Virginia not get caught up in playing the wrong game in its effort to manage Medicaid prescription drug costs. Back-end price-focused strategies are yielding higher net costs than approaches focused on front-end drug-mix management. Vast evidence exists that Medicaid MCOs excel at managing the mix of drugs.

Another issue related to the supplemental rebates is that policymakers often feel they are acquiring better purchasing power through a uniform PDL. With all Medicaid volume behind them, states sometimes assert that they are uniquely positioned to negotiate more favorable rebates with manufacturers. What is typically missed in this calculation, however (beyond taking an ill-advised rebate-focused approach in the first place), is that the MCOs are typically contracting with pharmaceutical benefits management (PBM) entities that have far more covered lives of purchasing power than the Virginia Medicaid population – or even Virginia's total population – represents. CVS, Express Scripts, Optum Rx, and other PBM entities have vastly superior purchasing power relative to DHS. In this context, the uniform PDL can only diminish the baseline level of prescription drug purchasing power Virginia's Medicaid program is currently accessing through its MCO partners.

## **VI. Concluding Observations**

While the use of a uniform, state-mandated formulary has gained increased adoption within Medicaid MCO programs, evidence of its fiscal efficacy is lacking. The two states using the uniform PDL approach on the largest scale and for the longest time, Florida and Texas, have relied heavily on Medicaid MCOs and should be national leaders in managing pharmacy costs. However, these states, on average, rank 32<sup>nd</sup> in net (post-rebate) costs per prescription.

Our analyses of Virginia's Common Core Formulary (CCF) impacts indicate that the uniform PDL cost the Commonwealth's Medicaid program over \$13 million in net (post-rebate) costs during CY2019, \$5.5 million of which were increased state fund outlays. Annual costs from 2020 forward will likely be much higher.

We encourage Virginia policymakers to restore the Medicaid MCOs' latitude to operate their own PDLs and utilize their full set of cost management tools. Maintaining the Common Core Formulary is not in the best interests of DMAS nor the Commonwealth's taxpayers. An alternative option is to maintain a common PDL among the Medicaid MCOs, but have the Medicaid MCOs play the lead role in determining the PDL content. This approach is used in Michigan, where favorable net cost per prescription outcomes have been achieved.

As long as the CCF remains in operation, we encourage that objective analyses of its fiscal impacts be conducted no less frequently than annually. The initial amounts paid for all Medicaid prescriptions, as well as the statutory and supplemental rebates garnered, are publicly available information. It is important to continue tracking Virginia's Medicaid pharmacy expenditure progression.