The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Pennsylvania Medicaid's Preferred Drug List Policy Options

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I. Executive Summary and Introduction

A. Overview

Pennsylvania's Medicaid Managed Care Organizations (MCOs) currently pay for approximately 95% of the state's Medicaid prescriptions. Pennsylvania currently allows each Medicaid MCO to utilize its own preferred drug list (PDL). Pennsyvania's Department of Human Services (DHS) has indicated that Medicaid MCOs will be required to utilize a single PDL to be established by DHS.

We have been engaged to estimate the fiscal impacts of switching to a uniform PDL in Pennsylvania, and to assess the programmatic advantages and disadvantages of this policy change.

B. Key Findings

The most significant findings from our analyses are summarized below.

1. **A change to a uniform, state-administered PDL would result in a 13% increase in pharmacy expenditures, increasing state fund costs by $81 million in SFY2020 and $437 million over 5 years.**

    - Based on our analysis, transitioning the PDL responsibility back to the state would represent a significant and costly step backwards for the Pennsylvania HealthChoices program. We estimate that by transitioning to a state-determined, uniform PDL, Pennsylvania would experience an overall net Medicaid cost increase of approximately $211 million during SFY2020, representing an added cost of $81 million in state funds. The uniform PDL would increase Pennsylvania's pharmacy expenditures by 13.3% in SFY2020.

    - Across the five-year timeframe SFY2020 – SFY2024, the added cost of a uniform PDL approach is estimated at $1.1 billion for Pennsylvania's Medicaid program, with $437 million of these additional costs being financed through state funds.

2. **National tabulations of each state's Medicaid prescriptions demonstrate the importance of focusing on drug mix rather than rebates.**

    - States that control the Medicaid PDL entirely are not performing as well as Pennsylvania in terms of net cost per prescription and generic dispensing rates. Our analyses focus on Florida and Texas, the two large states with longstanding uniform PDL approaches and who rely on the capitated Medicaid model in a similarly extensive manner as does Pennsylvania. These states pay more for prescriptions

upfront (e.g., with greater use of brand drugs), and then seek to recoup that unfavorable cost differential through accessing relatively large rebates.

- Our analyses demonstrate that the states that are faring the best on net (post-rebate) cost per prescription are predominantly those that have the highest generic dispensing rates and lowest initial (pre-rebate) costs.

- The states most successful in garnering rebates are least successful at controlling net costs. During FFY2017, the three states with the highest rebates per Medicaid prescription – Connecticut, South Dakota, and Vermont – are the three states with the nation's *highest* net costs per Medicaid prescription in that year.

3. **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 given. Such efficiencies are offset by the loss of administrative simplicity across enrollees of the same MCO, given that all the Health Choices plans serve other populations in addition to Medicaid.

   - Also, the aura of enhanced purchasing power by combining all Medicaid supplemental rebate negotiations in one entity (DHS) ignores the reality that the PBMs currently negotiating supplemental rebates on behalf of the Health Choices MCOs typically have vastly larger purchasing power than DHS will ever be able to obtain.

Taking all of our analyses into account, we encourage Pennsylvania policymakers to preserve the PDL latitude model within Health Choices. A switch to a uniform PDL is not in the best interests of DHS nor the Commonwealth's taxpayers.

II. Data Analyses Findings

A. Pennsylvania's Baseline Costs

Pennsylvania's net (post-rebate) Medicaid prescription drug spending totaled $1.5 billion during FFY2017, ranking fourth-highest among the 50 states. Pennsylvania partners extensively with Medicaid managed care organizations -- 98% of Pennsylvania's Medicaid prescription drug expenditures were paid by MCOs during FFY2017. Policies related to the Medicaid managed care program's prescription drug benefit therefore have a determinative impact on Pennsylvania's overall Medicaid spending on prescription drugs as well as the degree to which pharmacy benefits are optimally integrated with other covered services.

Exhibit 1 summarizes Pennsylvania's statistics and ranking among all states on various key Medicaid prescription drug metrics.

Exhibit 1. Overview of Pennsylvania Medicaid Prescription Drug Costs – FFY2017

Statistical Measure	FFY2017 Pennsylvania Baseline	Pennsylvania's Ranking (across 50 states plus DC)	Ranking Criteria
Pre-Rebate Cost Per Prescription	$85.36	30	State with lowest cost/Rx is #1
Rebates per Prescription	$47.03	22	State with largest rebates/Rx is #1
Net (post-rebate) Cost Per Prescription	$38.33	28	State with lowest cost/Rx is #1
Generics as Percentage of All Prescriptions	87.8%	17	State with largest percentage is #1
Share of Pre-Rebate Pharmacy Expenditures for Medications with an Average Cost Per Prescription above $1,000	46.8%	6	State with largest percentage is #1

Pennsylvania ranked near the middle of all states (28th) in FFY2017 regarding net cost per Medicaid prescription. Some dynamics are inherenty working against Pennsylvania with this particular statistic. First, states adopting Medicaid expansion experience higher costs per prescription due to the demographics of the expansion population and their associated medication needs. To estimate the impacts Medicaid expansion are having on net cost per prescription, we assessed FFY2011 and FFY2016 net cost per prescription in 13 states that have always had 100% of prescriptions paid in the FFS setting (in order to control for impacts of MCO management on pharmacy benefit management). Among these 13 states, 8 states did not adopt Medicaid expansion and these states collectively experienced a 17% increase in net cost per Medicaid prescription from FFY2011-FFY2016. Among the 5 states (within the 13 continuous FFS states) that did adopt Medicaid expansion, net cost per prescription increased by 22% from FFY2011-FFY2016. This suggests that Medicaid expansion has a 5-percentage point upward impact on Medicaid net cost per prescription.

We have also quantified the degree to which certain drug classes have relatively high Medicaid usage in expansion states. Expansion states accounted for 76.8% of nationwide Medicaid spending for drugs treating Hepatitis C and HIV infection from October 2017 through June 2018, for example, versus 69.8% of all other Medicaid medications. These dynamics unavoidably push Pennsylvania's Medicaid costs per prescription upward.[1]

B. Key Drivers of Effective Medicaid Pharmacy Cost Management

Exhibit 2 presents key pharmacy cost and usage indicators for the six states with the largest Medicaid programs. All six of these states predominantly use MCOs to pay for Medicaid prescription drugs. Across these large states, Pennsylvania had the second-lowest net cost per prescription during FFY2018.

Exhibit 2. Medicaid Prescription Drug Rankings Among the Six Largest States

Medicaid Expenditure Size Rank, FY2017	State	Adopted Medicaid Expansion?	Rank, FY2017 Net Cost Per Prescription (#1 ranked state has lowest cost)	Rank, FY2017 Net Rebates Per Prescription (#1 ranked state has largest rebates)	Rank, Generic Percentage of Prescriptions, FY2017	Percentage of FY2017 Medicaid Prescriptions Paid by MCOs	MCO Latitude Over PDL
1	California	Yes	31	31	16	74.1%	Strong
2	New York	Yes	36	30	14	86.4%	Strong
3	Texas	No	30	7	46	94.9%	None
4	**Pennsylvania**	**Yes**	**28**	**22**	**17**	**95.4%**	**Strong**
5	Florida	No	41	10	34	92.2%	None
6	Ohio	Yes	17	44	21	90.8%	Limited

Exhibit 2 also provides points of comparison between states using a uniform PDL model within their Medicaid MCO programs (e.g., Florida and Texas), and those allowing MCOs strong latitude over the PDL (e.g., California, New York, and Florida). Ohio uses a hybrid model combining some aspects of a uniform PDL with MCO latitude.

The rebate and generic usage rankings in Exhibit 2 demonstrate that states are not able to achieve both large rebates per prescription and a high generic percentage. Each of these strategies – a price-focused approach driven by "back end" rebate maximization, and a mix-focused approach driven primarily by steering use towards more inexpensive drugs at the "front end" -- must largely be pursued at the expense of the other. Florida and Texas have used a uniform PDL for several years and have been highly successful at capturing relatively large rebates per

[1] We also notice a correlation between net costs per Medicaid prescription and northeastern states with a strong teaching hospital presence. Massachusetts (35th), New York (36th), Maryland (37th), and Connecticut (49th) all rank among the highest-cost third of states in terms of net costs per Medicaid prescription.

prescription (both ranking among the top 10 states on this metric). However, these states rank in the bottom third in their generic usage rates.

Our data analyses strongly indicate that managing drug mix effectively is most likely to yield the most favorable net costs. During FFY2017, the average net cost per prescription among the 10 states with the largest rebates per Medicaid prescription, $43.73, was 34***% above*** the corresponding net cost per prescription across the 10 states that had the most favorable generic dispensing rate ($32.63). The 10 states with the highest generic usage rank an average of 10th across all states in net costs per prescription, but rank an average of 44th on rebates per prescription.

Conversely, the states most successful in garnering rebates have been least successful at controlling net costs. The 10 states with the highest rebates per prescription rank an average of 41st across all states in net costs per prescription and an average of 45th across all states in their generic usage rates. During FFY2017, the three states with the highest rebates per Medicaid prescription – Connecticut, South Dakota, and Vermont – are the three states with the nation's *highest* net costs per Medicaid prescription in that year.

III. Estimated Cost Impacts of a Uniform PDL in Pennsylvania

Our estimated cost impacts of Pennsylvania moving to a uniform PDL were derived using the methodology described below.

1) We quantified FFY2017 costs per prescription in Pennsylvania, Florida, and Texas. Florida and Texas are the two large states that have used the uniform PDL model in their Medicaid managed care programs throughout the past several years. Exhibit 3 presents these cost per prescription figures.

   Our key data source for these tabulations is the State Drug Utilization Files published by CMS, which contain quarterly data by national drug code (NDC) for each state and for every Medicaid prescription. This source conveys the volume of prescriptions and the corresponding Medicaid amount paid, separately indicating drugs paid in the fee-for-service setting and those paid by MCOs. A separate CMS data source, the CMS Financial Management Reports (FMR), captures the Medicaid prescription drug rebates each state receives in each federal fiscal year. The reported rebates include both the ACA's statutory rebates as well supplemental rebates the state negotiates with manufacturers. Together, these data sources permit tabulation of each state's Medicaid initial (pre-rebate) cost per prescription, rebates per prescription, and the net (post-rebate) cost per prescription.[2]

2) Given that Pennsylvania has adopted Medicaid expansion and Florida and Texas have not, we applied a 5% factor to Florida's and Texas' base year costs to create eligibility parity between Pennslvania and these two states. These figures are shown in the right hand column of Exhibit 3. The derivation of the 5% factor was described in Section II.

Exhibit 3. Projected Cost Per Prescription Differential of Uniform PDL, FFY2017

State	FFY2017 Net Cost Per Prescription	5% Parity Adjustment for Medicaid Expansion in FL and TX
Pennsylvania	$38.33	$38.33
Florida	$43.44	$45.61
Texas	$39.27	$41.23
Florida/Texas Average	$41.36	$43.42
Pennsylvania Difference vs. FL/TX Average	**$3.03**	**$5.09**

[2] Medicaid MCO supplemental rebates are published in the FMR reports for several states, and these percentage rebates are used to estimate the Medicaid MCOs' supplemental rebate levels in all other states with Medicaid MCO programs.

3) Florida's and Texas' costs per prescription figures were averaged together, creating a differential of $5.09 per prescription in FFY2017 (after adjusting for Medicaid expansion). This per prescription figure represents a 13.2% estimated cost increase in Pennsylvania's net Medicaid pharmacy expenditures should a uniform PDL be implemented. This $5.09 figure was trended upwards annually by 4% to account for typical cost per prescription escalation. Additional per prescription costs of the uniform PDL for each state fiscal year in Pennsylvania are shown in Exhibit 4 for the five-year timeframe SFY2020 – SFY2024.

Exhibit 4. Projected Additional Cost of Pennsylvania's Uniform PDL, SFY2020 – SFY2024

Year	Pennsylvania Per Prescription Difference vs. FL/TX Average (4% Annual Increase Assumed)	Medicaid MCO Prescription Volume (FFY2017 Level Used Throughout)	Estimated Additional Cost of Uniform PDL in Pennsylvania	Additional Federal Cost of Uniform PDL	Additional State Fund Cost of Uniform PDL
SFY2020	$5.67	37,162,038	$210,811,142	$130,044,124	$80,767,019
SFY2021	$5.90	37,162,038	$219,243,588	$135,245,888	$83,997,700
SFY2022	$6.14	37,162,038	$228,013,332	$140,655,724	$87,357,608
SFY2023	$6.38	37,162,038	$237,133,865	$146,281,953	$90,851,912
SFY2024	$6.64	37,162,038	$246,619,220	$152,133,231	$94,485,988
5 Year Total			**$1,141,821,147**	**$704,360,920**	**$437,460,227**

Note: Federal share assumes 90% match on Medicaid expansion prescriptions, which are assumed to represent 25% of all Pennsylvania Medicaid prescriptions, and 52.25% of all other Medicaid prescription drug costs.

4) These cost per prescription differentials are multiplied by the annual volume of prescriptions paid by Pennsylvania's Medicaid MCOs. The actual FFY2017 prescription volume (37.2 million) was used throughout the five-year projection period. The resulting figures, shown in the middle column of Exhibit 4, represent our annual estimate of the overall Medicaid cost increases the uniform PDL model will create in Pennsylvania. These annual adverse impacts are estimated at more than $200 million, totaling over $1.1 billion across the five-year timeframe SFY2020 – SFY2024.

5) The cost impacts were broken out between the Federal and State share of Medicaid costs. We assumed that 25% of Pennsylvania's Medicaid prescription drug costs are for the expansion population's medications (at a 90% Federal match rate), with the remaining costs paid by the Federal Government at Pennsylvania's "regular" Federal match rate of 52.25%. Adverse annual State Fund impacts are estimated at more than $80 million.

IV. Programmatic Impacts

The use of a uniform PDL is promoted by some constituents and policymakers both for fiscal savings reasons and for programmatic advantages. The prior section of the report indicates that the fiscal advantages of a uniform PDL do not exist, and that a change to a uniform PDL approach will create large-scale increases in Pennsylvania's Medicaid expenditures. This section assesses the programmatic arguments made in favor of and against a uniform PDL.

Administrative Simplification: The key argument made for a uniform PDL is administrative simplification for prescribers, as there will be just one Medicaid PDL in lieu of nine current PDLs (one for each Health Choices MCO and one for the remaining Medicaid fee-for-service prescription volume).

The administrative simplification argument looks at PDLs only through a Medicaid lens, whereas the provider community faces a much broader set of dynamics. Medicaid pays for only approximately 18% of population-wide prescriptions in Pennsylvania, based on Kaiser Family Foundation website 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 82% of all Pennsylvania's prescriptions. Medicare Part D and private insurance do not have PDL uniformity. Thus, the prescriber and pharmacy community will need to work with dozens of PDLs regardless of Pennsylvania's Medicaid PDL policies.

> "Medicare.gov identifies 32 plans in zip code 19107 alone."
>
> -- HealthChoices MCO Pharmacy Director

While the administrative advantages of moving Medicaid to one PDL tend to be substantially overstated, such administrative efficiencies 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 Health Choices plans serve other populations in addition to Medicaid. A uniform PDL seeks to force-fit prescribing activity into a "Medicaid silo" that does not exist in Pennsylvania.

Pennsylvania providers currently have minimal Medicaid FFS prescription volume, but routinely serve patients of the same plan across the health plan's multiple products. A HealthChoices enrollee is more likely to be viewed as an "Aetna patient" or a "Geisinger patient" than as a Medicaid patient, for example. Forcing providers to look up different formularies within the same payer entity adds to their administrative burden. Pennsylvania's Medicaid program has been privatized across the various Health Choices MCOs, with the express objective of creating a more mainstream system of coverage for impoverished Pennsylvanians than Medicaid can achieve on its own. Any effort to create Medicaid uniformity across these health plans risks creating more provider confusion and burden than it will alleviate.

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.

Many of the HealthChoices MCOs serve Medicaid populations in states where they have PDL latitude and states (such as Florida and Texas) where the uniform PDL approach is used, and the DHS PDL for Pennsylvania's fee-for-service prescriptions provides some insight into how the Commonwealth's PDL will be structured. The Health Choices plans provided numerous examples to us regarding how they are more nimbly able to modify their PDLs than is a state Medicaid PDL, a few of which are conveyed below.

- Converted all insulin glargine (Lantus) members to the new biosimilar Basaglar, which is available at a lower net cost.

- Excluded all branded Proton Pump Inhibitors from the formulary (with branded products being available through the prior authorization process). The state's PDL would include omeprazole, pantoprazole, and Dexilant – two generics and one branded product.

- Within the SGLT2 class of medications, Steglatro was preferred immediately as it had a 40% discount from other medications in the class.

- Immediate substitution of the generic medication Ventolin as it came to market.

- Biosimilairs such as Retacrit, Zarxio, Nivestym, and Ranflexis were made preferred immediately upon release to market to ensure cost savings.

Supplemental Rebates: The uniform PDL will lead to enhanced supplemental rebate revenues, as DHS will be able to negotiate with manufactures with the leverage of all Pennsylvania Medicaid prescription volume in each therapeutic drug class.

The cost impact estimates in Section III factor in the additional supplemental rebates states using the uniform PDL approach (such as Florida and Texas) are obtaining. These additional rebates are helpful in and of themselves. However, the comprehensive data analyses we are able to conduct demonstrate that these additional rebates do not come close to offsetting the increased costs that occur at the "front end" when the drug mix moves to costlier drugs (e.g., fewer generics).

Of perhaps greater concern is the attractive psychological impact rebates seem to create among many state purchasors and policymakers. The rebate revenues that arrive have a "bonus money" aura. As shown in Section II, the preponderance of the states' Medicaid experience with rebate-focused approaches has been that overall net costs are much higher than when a front-end drug-mix management strategy is deployed. It is critical that Pennsylvania not get caught up in "playing the wrong game" in its effort to manage Medicaid prescription drug costs. Rebate

maximization can be akin to conveying to one's spouse how wonderful the family's extensive credit card spending has been because a cash back check just arrived in the mail.

Purchasing Power:

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 feel 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 Pennsylvania Medicaid population -- or even Pennsylvania'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 Pennsylvania's Medicaid program is currently accessing through its MCO partners.

Capitation Rate Fairness: The uniform PDL approach puts health plans in the awkward position of being placed at risk for a benefit over which they cannot deploy their set of care coordination and cost management tools.

If a uniform PDL is implemented, it will be important for the State to fairly compensate the MCOs accurately for the increased pharmacy costs that occur as well as for each MCO's lost supplemental rebate revenue. Capitation rates will need to increase by a relatively large percentage because the plans' up-front costs will be pushed northward by the brand drugs that are placed on the formulary in the interest of securing supplemental rebates. These drugs' higher "front-end" costs will directly be borne by the MCOs, whereas the "back-end" rebates will accrue to the state outside of the MCOs' revenue stream.

Diminishment of Utilization Management:

Alignment of preferred drug lists is typically accompanied by alignment of prior authorization criteria, and in some cases, point-of-sale utilization management programs (UM). While this creates consistency in benefit designs among Medicaid payers, it can potentially force MCOs who have historically employed highly robust criteria and UM programs to use less stringent criteria under the statewide program. This can lead to a net increase in overall utilization, particularly among high cost specialty medications, and those with potential for misuse and diversion.

V. Conclusions

Our analyses indicate that the Commonwealth of Pennsylvania and its taxpayers would incur significant costs if DHS adopts a uniform, state-determined Medicaid PDL. The state fund cost of this policy change is estimated at $81 million in the first year (SFY2020) and $437 million across the five-year timeframe SFY2020 – SFY2024.

The programmatic dynamics of switching to a uniform PDL are also unfavorable, as discussed throughout Section IV.

We encourage Pennsylvania policymakers to preserve the PDL latitude model within Health Choices. A switch to a uniform PDL is not in the best interests of DHS nor the Commonwealth's taxpayers.