The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Virginia Medicaid Pharmacy Benefits Carve-Out Impacts

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I. Executive Summary and Introduction

A. Overview

Virginia's Medicaid Managed Care Organizations (MCOs) coordinate and pay for the pharmacy benefit for the vast majority of the Commonwealth's Medicaid enrollees. These six MCOs -- Aetna, Anthem, MCCVA (Magellan), Optima (Sentara), United, and Virginia Premier -- collectively paid for most (89.9%) of Virginia's Medicaid prescriptions during FFY2018, well above the national percentage of 71.7%. This benefit administration model is commonly known as a pharmacy "carve-in". Recently, some Virginia policymakers have indicated an interest in moving to a pharmacy "carve-out", whereby the state would instead manage the pharmacy benefit for MCO enrollees, including paying directly for drugs made available in the program.

We have been engaged by Virginia's Association of Health Plans to estimate the fiscal impacts of Virginia switching to a carve-out model as well as the programmatic advantages and disadvantages of this potential change.

This report details our findings on the impacts of a pharmacy carve-out and potential next steps for policymakers.

B. Recommendations

Based on the analysis detailed in this report, we offer the following recommendations:

1) Programmatically, a pharmacy carve-out diminishes the Medicaid programs ability to deliver whole-person integrated care. Other states' carve-out experiences also demonstrate that a carve-out will result in a substantial increase in net pharmacy expenditures relative to a carve-in. Access and adherence to needed medications are best supported under the carve-in model, taking advantage of the MCOs' comprehensive set of programs in these areas. The pharmacy benefit should remain carved in unless and until there is compelling, objective fiscal evidence that a carve-out will produce large-scale savings without eroding access, care management resources, and enrollees' clinical outcomes.

2) While the carve-out option is being more thoroughly assessed, we encourage Virginia to take steps to achieve near-term fiscal savings under the existing carve-in model. These steps include full disclosure of all pharmacy-related costs (e.g., including the amounts PBMs are being paid and what *their* operating margins and administrative costs have been), supplemental rebate levels, etc. This information will allow policymakers to identify specific problems and opportunities and devise tailored solutions. These solutions, for example, could involve mandatory pass-through pricing by PBMs (such that the cost paid to the PBMs by the MCO for any given prescription is identical to the amount paid by the PBM to the pharmacy). Other possible solutions could involve creating a Medicaid administrative cost and operating margin ceiling on PBMs, requiring

that certain MCO/PBM contract terms be renegotiated, and establishing a minimum supplemental rebate percentage to be built into each Medicaid MCO's capitation rate.[1]

All of our analyses indicate that Virginia's best pharmacy benefits policy option involves retaining the integrated pharmacy carve-in approach and establishing cost savings enhancements within this model.

C. Key Findings

The most significant findings from our analyses are summarized below.

1. **A change to a pharmacy carve-out would result in a 20.2% increase in net (post-rebate) Medicaid pharmacy expenditures across the five year timeframe SFY2020 - 2024, increasing state fund costs by $12 million in SFY2020 and $157 million over five years.** These cost impact estimates take into account initial payments to pharmacies (dispensing fee and ingredient cost) under both program design options, drug mix differences, federally mandated (statutory) rebates on brand and generic drugs, and supplemental rebates garnered on brand drugs through negotiations by MCOs, the state, and/or PBMs. The estimates also take into consideration administrative cost dynamics and the risk margin included in the MCOs' capitation payments for the prescription drug benefit.

    - Based on our analyses, transitioning pharmacy benefits management responsibility from Medicaid MCOs to fee-for-service (FFS) would represent a significant and costly step backwards for Virginia's Medicaid program. This study has tabulated the experience of nine states moving from a carve-out to a carve-in during the past several years, and compares these results with findings from the three carve-out states that retained their carve-out approach through the same time period. These comparisons take into account all Medicaid precriptions in all twelve states, the initial payments to pharmacies for these prescriptions (including dispensing fees and ingredient costs), the mix of drugs delivered to Medicaid beneficiaries, and all statutory and supplemental rebates.

    - Based on this experience, we estimate that by adopting a pharmacy carve-out Virginia would experience an overall net cost increase of approximately $35 million during SFY2020, representing an added cost of $11.9 million in state funds. This policy change would increase Medicaid pharmacy expenditures by 8.3% in SFY2020.

    - In Year 3 and beyond, the estimated annual net cost increase of the carve-out model is 24.9%, which captures the long-term differential experienced across the 12 states we were able to fully compare. Our phase-in estimates are driven by an expectation that

[1] In the effort to identify and address excess PBM retention, we caution that simply eliminating certain approaches (e.g., abolishing "spread pricing" PBM practices) may not yield savings, depending on the extent to which these modifications are conjoined with increased Medicaid payments to Virginia's pharmacies.

continuity of care requirements will preserve, albeit only in the short term, much of the drug mix accomplishments the MCOs have achieved.

- Across the five-year timeframe (SFY2020 – SFY2024), the added cost of a pharmacy carve-out is estimated at $463 million for the overall Medicaid program, with $157 million of these additional costs being state funds.

The net cost increase of a pharmacy carve-out is attributable to the state's increased reliance on brand-name and other costlier drugs in order to secure more rebates, higher dispensing fees, and decreased ability to promptly make needed modifications to the preferred drug list to address emerging dynamics such as price changes, patent expirations, and new drug introductions.

2. National tabulations of each state's Medicaid prescriptions demonstrate the importance of focusing on optimizing front-end drug mix rather than securing back-end rebates.

- Increased drug rebates occur in the carve-out setting, but these rebates do not offset the higher costs that occur by forfeiting optimal "front-end" drug mix management.

- States that have adopted a pharmacy carve-out and/or control the Medicaid preferred drug list entirely are not performing well in terms of net cost per prescription and generic dispensing rates.

- 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 lowering 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.

- National aggregate figures for FFY2018, shown in Exhibit 1, demonstrate that Medicaid MCOs are managing the mix of drugs between generics and brands far more effectively than what is occurring in the FFS setting. Given that the average net cost of a brand drug is roughly ***9 times higher*** than the average generic, the 4.1 percentage point difference in generic usage between the MCO and FFS settings has an enormous financial impact. Exhibit 1 also shows that MCOs are achieving lower net costs *within* generics and *within* brands. Taking all of these impacts together ***the national average net cost per prescription was 27.1% lower in the Medicaid MCO setting than the Medicaid FFS setting.*** These net figures take into account all statutory and supplemental rebates paid by manufacterers in both settings.

Exhibit 1. Net (Post-Rebate) Costs Per Prescription Across All USA Medicaid Prescriptions, MCO vs FFS Settings, FFY2018

	MCO	FFS	MCO as a Percentage of FFS
Pre-Rebate Brand $/Rx	$492.29	$566.49	86.9%
Pre-Rebate Generic $/Rx	$20.44	$24.90	82.1%
Total $/Rx	$75.90	$110.73	68.5%
Post-Rebate Brand $/Rx	$166.44	$190.15	87.5%
Post-Rebate Generic $/Rx	$17.78	$21.66	82.1%
Post-Rebate Total $/Rx	$35.32	$48.46	**72.9%**
Generic % of all Scripts	88.0%	83.9%	

3. **Programatically, the carve-out approach would be detrimental to the whole-person care coordination model that Virginia's Medicaid program has embraced.**

- Removing the pharmacy benefit out of the capitated Medicaid program – and placing it into a fiscal silo – is antithetical to the goals of care integration and coordination. Prescription drug treatments are central to the health services Medicaid beneficiaries receive, and prescription drug data are essential to discerning individuals' health needs and comorbidities, new diagnoses, and treatment adherence patterns.

- MCOs conduct significant efforts to facilitate access and adherence – initiatives that occur on both a systematic and individual case basis. These valuable programs will be forfeited (or at best, diminished) under the carve-out model. Virginia's six MCOs were invited to provide both process examples and case examples regarding how their direct management of the drug benefit is supporting their efforts to identify and address their enrollees' overall health needs, as well as information as to how their health plan facilitates access and adherence to appropriate medication regimens. Several of these examples are conveyed in text boxes in Section IV of this report.

Taking all of our analyses into account, we encourage Virginia's policymakers to maintain the carve-in model under which the Medicaid MCOs currently operate. This does not – and should not – preclude the state and the MCOs from developing initiatives (and new program requirements) that will yield further savings on net prescription drug expenditures. For example, if excess and hidden costs are occurring in the supply chain through some PBM business practices, it is appropriate and important that these excess costs need to be identified and removed. Prohibiting "spread pricing" practices by PBMs and instead requiring "pass-through" pricing is one important option to consider. However, our findings indicate that such savings will be maximized *within* the full-risk, highly coordinated and integrated system of care that the MCO capitation contracting environment delivers.

II. States' Experiences with a Medicaid Pharmacy Carve-Out

A. Analysis of Progression of States Previously Using Pharmacy Carve-Out

During 2011, 13 states used a pharmacy carve-out model in their Medicaid MCO programs. With the passage of the Affordable Care Act (ACA), the large statutory rebates— which had previously been payable only for Medicaid prescriptions paid in the fee-for-service (FFS) setting— were extended to all Medicaid prescriptions, including those paid by MCOs. As a result, 10 of these 13 states moved to a pharmacy carve-in approach (Delaware, Illinois, Indiana, Iowa, Nebraska, New York, Ohio, Texas, and Utah) during the ensuing years. Three of the 2011 carve-out states – Missouri, Tennessee, and Wisconsin – retained their carve-out approach throughout the 2011-2018 timeframe. West Virginia switched from a carve-out to a carve-in, but then back to a carve-out during this seven year timeframe. West Virginia data is therefore excluded from the Exhibit 2 but addressed separately later in this report.

These dynamics permit a comparison of the progression of key Medicaid prescription drug costs and metrics between these two groups of states. Our tabulations include all Medicaid prescriptions between FFY2011-FFY2018, including all Medicaid prescriptions in each of these states, as well as all associated rebates. Even the smaller group of three states provides a large statistical volume of data – approximately 38 million prescriptions during FFY2018, for example. A summary of these tabulations is presented in Exhibit 2.

Exhibit 2. Comparison of Costs and Usage Between States that Retained Carve-Out Model and States that Switched to Carve-in Model

	Net Cost Per Prescription			Generics as Percentage of all Prescriptions			Rebates Per Prescription		
State Grouping	FFY2011	FFY2018	% Change	FFY2011	FFY2018	Percentage Point Change	FFY2011	FFY2018	% Change
Rx Carve-Out State Throughout 2011-2018 Timeframe (3 States)	$37.98	$44.90	**18.2%**	76.8%	84.6%	7.8%	$31.19	$54.64	75.2%
Rx Carve-Out in 2011, Carve-In During 2018 (9 States)	$39.04	$39.21	**0.4%**	71.0%	86.6%	15.6%	$37.62	$46.55	23.7%

The states that switched to a carve-in model have collectively outperformed those that retained their carve-out approach. A key metric demonstrating this performance is that the states that carved-in the drug benefit as a group experienced a 0.4% increase in net cost per prescription across the entire FFY2011-FFY2018 timeframe (after factoring in rebates). States that continued to carve-out the pharmacy benefit experienced an 18.2% cost increase.

This 17.8 percentage point difference in net cost per prescription between these two state groupings provides strong evidence of the MCOs' favorable impact on drug spending under the carve-in model. This differential is derived from a massive volume of prescriptions (the 12 states assessed represented 36% of all MCO-paid Medicaid prescriptions during 2018 and 26% of all Medicaid prescriptions), and capture this volume across an eight-year timeframe. The net cost figures include all up-front payments to pharmacies (dispensing fees and ingredient costs) in these states' Medicaid programs as well as all rebates obtained (statutory and supplemental negotiated amounts).

Three factors need to be taken into consideration to more appropriately estimate the cost difference between the carve-in and carve-out settings. The first is Medicaid expansion. States adopting Medicaid expansion experience higher costs per prescription due to the demographics of the expansion population and their associated medication needs (e.g., a higher incidence of cancer, hepatitis C, and HIV infection than the underlying Medicaid population experiences).

1. To estimate the impact Medicaid expansion is having on net cost per prescription, we assessed FFY2011 and FFY2016 net cost per prescription data 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, eight 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 five 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 net cost per prescription, which requires adjustment to the figures in Exhibit 1. All three states that retained the carve-out model are non-expansion states, whereas seven of the ten states that switched to a carve-in have adopted Medicaid expansion and can be expected to have higher per prescription costs as a result.

2. A second adjustment is needed because the comparisons in Exhibit 1 include all prescriptions, whereas the states switching to a carve-in model continued to have some FFS Medicaid prescription volume (which the MCOs can not impact). During FFY2017, Medicaid MCOs paid for 85.6% of all Medicaid prescriptions across the 10 states that switched to a carve-in.

3. The third adjustment reflects that operating margins need to be factored into the pharmacy component of the MCO capitation rates in the carve-in model (to fairly compensate health plans for the risk they are taking), but not in the carve-out model.

Exhibit 3 presents the adjustments to the net cost per prescription figures to account for these three dynamics and create a more accurate estimate of the relative costs between the carve-in and carve-out models that occurred between these two groups of states. The adjustments for the Medicaid expansion and the fact that states switching to a carve-in model still have some

FFS prescriptions increase the carve-out model's estimated percentage savings from carve-in from 17.8% to 24.9%.

Exhibit 3. Derivation of Overall Savings Differential Attributable to Carve-In Model

Item #	Description	3 States that Maintained Carve-Out Model Throughout 2011-2018	9 States with Carve-Out Model in 2011 that Switched to the Carve-In Model as of 2018	Derivation Comments
1	Percentage of Group's 2017 Prescriptions Impact of Medicaid Expansion	100.0%	18.0%	Tabulated using CMS State Drug Utilization Data Files
2	Cost Per Prescription Impact of Medicaid Expansion	5.0%	5.0%	Menges Group Analysis of Net Cost/Rx Progression in States that Expanded Versus States that Did Not Adopt Expansion
3	Cost Per Prescription Adjustment	5.00%	0.90%	Multiply above two rows
4	Initial 2018 Net Cost/Rx	$44.90	$39.21	Tabulated using CMS State Drug Utilization Data Files and CMS FMR Reports
5	Expansion Parity-Adjusted 2018 Net Cost/Rx	$47.15	$39.56	Add Row 3 Percentage to Row 4 Cost
6	2011 Net Cost/Rx	$37.98	$39.04	Tabulated using CMS State Drug Utilization Data Files and CMS FMR Reports
7	Percentage Change from 2011-2018	24.1%	1.3%	Percentage by which Row 5 Exceeds Row 6
8	Percentage Differential considering Medicaid Expansion		22.8%	Subtraction using Figures in Row 7
9	Percentage of 2018 Prescriptions Paid by MCOs in 9 States that Switched to Carve-In Model		78.9%	Tabulated using CMS State Drug Utilization Data Files
10	Percentage Differential also Considering % of Prescriptions Paid by MCOs Across the Group of 9 States		28.9%	Divides Row 8 Figure by Row 9 Figure
11	Percentage Offset for Operating Margin Avoidance Under Carve-Out (on pharmacy portion of capitation)		-4.0%	2% Operating Margin Estimated, Doubled Since Applied to Pre-Rebate Pharmacy Costs
12	Final Differential (Carve-In Savings Percentage)		**24.9%**	Difference Between Rows 10 and 11

Note that the additional statistics presented in Exhibit 2 are also important in conveying the different cost management approaches that occur in the MCO and FFS settings. Under the carve-in, the MCOs have been highly effective at managing the "front-end" mix of drugs, whereas the carve-out states have been highly effective at obtaining large "back-end" rebates. The states switching to a carve-in approach have achieved greater use of generics than has occurred in the carve-out states, with the states retaining the carve-out approach obtaining much larger rebates per prescription.

Our data analyses across all states strongly indicate that managing drug mix effectively – as is done in carve-in states – 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 in net costs per prescription, but average 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 ranked an average of 41st across all states in net cost 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 – were the three states with the nation's *highest* net costs per Medicaid prescription in that year.

B. West Virginia's Initial Experience Since Adopting a Medicaid Pharmacy Carve-Out Model

The above analyses focus on states moving from a carve-out to a carve-in approach. Only one state in recent years – West Virginia – has implemented a pharmacy carve-out. This section of the report briefly analyzes West Virginia's early experience with its Medicaid pharmacy carve-out approach.

Using CMS State Drug Utilization data files, we calculated average Medicaid costs per prescription during the first seven post carve-out quarters (July 2017 through March 2019) as well as the same statistic for the last five calendar quarters of the carve-in model (April 2016 through June 2017). We calculated the same information for the overall USA Medicaid program. West Virginia's pre-rebate costs per Medicaid prescription rose sharply after the carve-out was implemented, increasing 12.5% between the pre-post comparison timeframes described above. During this same timeframe, nationwide Medicaid costs per prescription increased by 5.1%. This trend differential of 7.4 percentage points is likely attributable to the change to a carve-out that occurred during FFY2017.

The net cost per prescription trend comparison is available through the end of FFY2018 and is shown in Exhibit 4. West Virginia's net cost per Medicaid prescription grew by 13.2% between the last full carve-in fiscal year (FFY2016) and the first full carve-out year (FFY2018). During this same timeframe, nationwide net costs per Medicaid prescription grew by a much smaller degree – 3.8%. This trend differential of 9.4 percentage points could also be attributable to the change to a carve-out that occurred in West Virginia during FFY2017.

Exhibit 4. Net Cost Per Prescription Trends, 2016 to 2018

	Net Cost Per Medicaid Prescription		Overall Percentage Change 2016 to
Jusrisdiction	FFY2016	FFY2018	2018
West Virginia	$25.94	$29.36	13.2%
United States	$37.60	$39.04	3.8%

These cost outcomes – one performed on a pre-rebate basis, the other on a net (post-rebate) basis, and representing slightly different but similar pre-versus-post carve-out implementation timeframes– are directionally similar to the multi-state experience described previously. Notwithstanding savings estimates prepared by a consulting firm engaged by West Virginia's Medicaid agency,[2] the accumulation of costs since the carve-out model was implemented strongly indicates that the West Virginia carve-out is resulting in increased net pharmacy expenditures.

The magnitude of this difference is smaller in West Virginia, where the two estimates suggest "only" a 7.4% to 9.4% cost increase occurred due to the carve-out (whereas the large multi-state group comparisons derive a 24.9% differential). A potential explanation for this reduced impact in West Virginia, given the vast evidence of the importance of front-end drug mix, is that MCO enrollees have continued their existing drug therapies during the first year of the carve-out. Over time, the larger shift away from generics and other lower-cost drugs that have occurred in other states may well occur in West Virginia as the carve-out's initial continuity of treatment regimens (those initiated under the carve-in) becomes a smaller proportion of overall Medicaid prescriptions.

In summary, each state's Medicaid initial pharmacy costs and rebates are publicly available and countable. It is important to continually take advantage of this body of information to inform optimal policymaking.

The accumulated evidence across states switching from a carve-out model to a carve-in approach indicates enormous improvements in net pharmacy cost trends have occurred across the past several years, relative to the states that have maintained their carve-out approach. The experience of the one state that has moved from a carve-in to a carve-out approach during the past several years, West Virginia, further demonstrates the cost effectiveness of the carve-in model.

Moving to a carve-out approach in Virginia would run counter to all of this accumulated experience and evidence and would invite tremendous risk that the Commonwealth's net costs would increase.

III. Cost Impact Modeling

A. Virginia's Baseline Pharmacy Costs

During FFY2018, Virginia's net (post-rebate) Medicaid drug spending totaled more than $343 million. Virginia contracts and partners extensively with Medicaid MCOs, which paid for 89.9% of Medicaid's prescriptions and 91.6% of Medicaid's net prescription drug expenditures during FFY2018. Policies related to the Medicaid managed care program's prescription drug benefit therefore have a determinative impact on overall Medicaid spending on prescription drugs as well as the degree to which pharmacy benefits are optimally integrated with other covered

[2] http://www.ncpa.co/pdf/state-advoc/west-virginia-report.pdf

services. Exhibit 5 summarizes Virginia's statistics and rankings among all states on various key Medicaid prescription drug metrics.

Exhibit 5. Overview of Virginia Medicaid Prescription Drug Costs – FFY2018

State	Net Cost/Rx, 2018	Rank, Net Cost/Rx, 2018	Generic Percentage of all Prescriptions, 2018	Rank, Generic % of Scripts, 2018	MCO Percentage of all Prescriptions, 2018
Virginia	$38.57	23	86.1%	28	88.6%
USA	**$39.04**		**86.9%**		**71.7%**

Virginia is currently a mid-level performer in terms of net Medicaid costs per prescription and generic usage. As described in a separate document assessing the Common Core Formulary's (CCF) impacts, we estimate that Virginia's pharmacy cost and usage management have slipped backwards somewhat under the uniform formulary approach required of the MCOs.

B. Cost Impact Modeling of a Carve-Out Approach

Our approach to estimating the carve-out model's cost impacts included the following steps.

First, we used Virginia's MCOs' net FFY2018 pharmacy costs, $394 million, as a base. These costs were trended forward by an annual trend factor of 4.0% to estimate net MCO pharmacy costs in each state fiscal year from 2020-2024. These figures are shown in the second column of Exhibit 6.

Second, we applied the 24.9% cost factor derived earlier in this report, reflecting the average savings the nine carve-out states experienced when they moved to the carve-in model. This savings factor takes into account all initial ingredient costs, dispensing fees, the mix of drugs prescribed, statutory rebates, and supplemental negotiated rebates in both the carve-in and carve-out settings.

We have phased this impact in evenly across the first three years of the carve-out, taking into account West Virginia's initial experience with the carve-out but relying primarily on the larger volume and longer-term evidence across the ten states moving to the carve-in approach. The phase-in also assumes that the detrimental effects of weaker front-end management of drug mix will be softened initially by continuity of care (and continuity of medication regimens) that preserves, for many Medicaid beneficiaries, the more cost-effective drug regimens the MCOs have used.

The phase-in assumptions estimate an 8.3% net pharmacy cost increase in the first year of the carve-out, a 16.6% increase in Year 2, and a 24.9% increase from Year 3 forward. As shown in Exhibit 6, this factor yields an estimated increase in Medicaid's net pharmacy expenditures (attributable to the switch to a carve-out model) of $35 million in SFY2020, accumulating to $463 million across the five-year timeframe SFY2020 – SFY2024.

The two right-hand columns of Exhibit 6 convey the distribution of these increased Medicaid costs between federal and state funds, respectively. The proposed carve-out is projected to create increased pharmacy expenditures of $12 million in state funds during SFY2020 and a total additional state fund cost of approximately $157 million across SFY2020 – SFY2024.

Exhibit 6. Pharmacy Carve-out Impacts on Total Pharmacy Expenditures

Year	Net Medicaid Costs Under Current Program Structure, MCO-Paid Prescriptions (4% Annual increase assumed)	Estimated Percentage Net Cost Increase of Carve-Out	Estimated Net Costs Under Carve-Out Approach, MCO-Paid Prescriptions	Additional Pharmacy Expenditures Due to Carve-Out	Additional Federal Cost of Carve-Out	Additional State Cost of Carve-Out
FFY2018 Actual	$394,134,239					
SFY2020	$422,136,114	8.30%	$457,173,412	$35,037,298	$23,124,616	$11,912,681
SFY2021	$439,021,559	16.60%	$511,899,138	$72,877,579	$48,099,202	$24,778,377
SFY2022	$456,582,421	24.90%	$570,271,444	$113,689,023	$75,034,755	$38,654,268
SFY2023	$474,845,718	24.90%	$593,082,302	$118,236,584	$78,036,145	$40,200,439
SFY2024	$493,839,547	24.90%	$616,805,594	$122,966,047	$81,157,591	$41,808,456
5 Year Total	**$2,286,425,360**	**20.24%**	**$2,749,231,890**	**$462,806,530**	**$305,452,310**	**$157,354,220**

Estimating Administrative Cost Impacts

Administrative cost impacts for the carve-out require estimating two dynamics:

1) the degree to which Medicaid MCO administrative costs would be eliminated in a pharmacy carve-out environment; and

2) the extent that the reduction in Medicaid MCO administrative costs would need to be offset by increased state costs in managing the Medicaid managed care pharmacy benefit.

<u>Administrative Cost Dynamics:</u>

Most pharmacy-related administrative costs will move from the MCOs to the state under the carve-out, with the volume of these costs not likely to be significantly reduced nor increased. Examples of these functions include:

- *Pharmacy claims processing:* The volume of Medicaid prescriptions – and the corresponding claims processing costs – are not expected to materially change under the carve-out model (although this administrative work would shift from the MCOs to the state).

- *Prior authorizations:* The volume of prior authorization requests – and the corresponding costs of handling these requests – are not expected to materially change under the carve-out model.

- *Member and provider calls regarding prescription drug benefit:* The volume of pharmacy-related issues the members will experience is not expected to significantly change under the carve-out model. However, many of these calls will continue to be

directed to the MCOs as beneficiaries will often not know whom to contact. Members may also experience frustration in no longer having a "one stop shop" for questions related to their Medicaid benefit.

The administrative activities and costs that will be reduced overall under the carve-out include the following areas:

- MCO pharmacy staff primarily managing others' work will be reduced as all pharmacy management is housed at DMAS. Many of these positions, however, would need to be shifted to FFS setting to provide these functions at a similar level of quality. It is important to note that many of the MCOs are multi-state entities that serve a larger Medicaid population than does the entire Commonwealth of Virginia. These organizations may be more efficient in the management of the pharmacy benefit (and have scale economies) relative to the Virginia fee-for-service environment. Therefore, the shift in staff positions could net out unfavorably under the carve-out.

- Pharmacy work regarding compliance with regulatory requirements will largely be eliminated.

The MCO administrative costs that will *not* be reduced under the carve-out model are described below:

- *Rebate Negotiation Costs:* Most Medicaid MCOs operate lines of business beyond serving Medicaid enrollees, and thus will continue to manage pharmacy benefits for these other populations under a Medicaid carve-out model. The health plans will continue to contract with PBMs, for example, and these PBMs will continue to negotiate supplemental rebates with manufacturers as currently occurs.

- *Pharmacy Data Integration:* These MCO costs will likely increase under the carve-out due to needing to work with the data in the state's standardized format. Currently, data integration at each MCO is tailored to each MCO through its relationship with its PBM. The timing and level of detail available will also be diminished, which is discussed in the report's programmatic section.

Analysis of Audited Medicaid MCO Financial Statements

We have sought to quantify the impacts of the pharmacy carve-in/carve-out by analyzing Medicaid MCOs' financial statement data during time periods of a carve-out approach as compared to these health plans' administrative costs under the carve-in approach. Several states moved from a carve-out to a carve-in model during the past decade, and we analyzed financial statement data for ten Medicaid MCOs operating in these states. These plans were Medicaid-focused entities – more than 90% of their collective revenues were derived from their Medicaid line of business. While each MCO has its own administrative cost trajectory, a common theme was that the health plans' Medicaid administrative costs as a percentage of their Medicaid revenue tended to be lower under the carve-in model than under the carve-out. This finding

indicates that the health plans' administrative costs are not proportional to the pharmacy benefit. For example, if the health plan's revenues grew by 15% under the carve-in, the health plans' administrative costs typically increased by much less than 15%. These results are shown in Exhibit 7.

Exhibit 7. Administrative Costs as a Percentage of Revenue During Carve-Out and Carve-In Timeframes

Health Plan	State	Administrative Costs as % of Medicaid Revenue	
		During Last Full Year of Carve Out	During First Full Year of Carve-In
Harmony Health Plan	Illinois	15.1%	10.3%
Meridian	Illinois	15.8%	7.9%
Buckeye Health Plan	Ohio	18.3%	16.6%
WellCare	Ohio	17.5%	15.4%
CareSource	Ohio	11.4%	10.8%
Cook Childrens	Texas	7.0%	6.1%
Parkland Community Health Plan	Texas	10.3%	10.5%
Superior Health Plan	Texas	10.7%	10.0%
Molina	Utah	7.9%	10.3%
HealthChoice	Utah	7.6%	8.6%
10 Plan Straight Average		**12.2%**	**10.7%**
10 Plan Combined Total		**12.0%**	**11.1%**

Taking the Exhibit 7 data in the opposite direction, it would clearly be inappropriate to assume that if a pharmacy carve-out were to reduce an MCO's revenues by 15%, the MCOs' administrative costs would decrease by anything near 15%. Much of the Medicaid MCOs' administrative costs are tied to general care coordination activities, and these costs do not swing up or down significantly based on whether the pharmacy benefit is carved in our carved out.

Per Member Per Month (PMPM) costs provide another lens into the analysis. Collectively, the ten health plans' PMPM Medicaid revenues increased by 31% between the last full pharmacy carve-out year and the first full carve-in year. However, these plans' PMPM administrative costs collectively increased by 18% during this timeframe, more closely in line with the degree to which other MCO PMPM costs increased (e.g., PMPM Hospital/Medical costs increased by 13%). Based on these figures, we would attribute roughly 5% of MCOs' administrative costs to managing the pharmacy benefit under the carve-in model. In the same context, any administrative capitation rate reduction to the MCOs under a carve-out that is larger than this 5% amount as likely to be unsound and inappropriately jeopardize the health plans' viability.

Distinguishing Administrative Savings from Relocation of Existing Costs

The above analyses suggest that if Virginia moved to a pharmacy carve-out, the MCOs' administrative costs would drop by roughly 5% as a result. However, the fact that MCOs are no longer paying these costs does not mean the expenditures disappear altogether. Rather, the vast majority of these expenditures would reappear as Virginia Medicaid administrative costs paid directly the the Department of Medical Assistance Services (DMAS) or paid indirectly by a pharmacy benefits management organization contracting with DMAS. We see no reason to assume the core transactional work related to the pharmacy benefit (e.g., processing and paying claims, conducting prior authorizations) will change in volume nor cost when moving from the MCO to the FFS setting.

In addition, DMAS will need to transmit daily pharmacy files to each MCO in order for the health plans to maintain "real time" prescription data for medical management, and this will impose some new costs on MCOs and on DMAS.

As noted earlier, we envision that some MCO pharmacy administrative positions would be eliminated by the carve-out. However, most of these positions would need to be shifted to the FFS setting to provide these functions at a similar level of quality.

We do not see a path to significant administrative savings occurring by virtue of carving out the pharmacy benefit. The vast majority of MCOs existing administrative work will continue to occur, and the vast majority of the MCO administrative cost reductions that do occur will simply reappear as DMAS/PBM costs.

The area where we do believe significant savings will occur under the carve-out is that the health plans will no longer need to be paid a risk margin for the pharmacy benefits portion of the capitation rate. For example, if a 2% risk margin is built into the capitation rates, and the pharmacy benefit comprises 15% of the health plans' expected medical costs, then a 0.3% capitation rate reduction would be warranted under the carve-out. We have factored this savings component into our cost impact analyses in Item #11 of Exhibit 3. This had the effect of lowering the fiscal advantage of the carve-in approach by a few percentage points (from 28.9% to 24.9%).[3]

[3] While the two percent risk margin is reasonable and in line with nationwide Medicaid MCO performance, our understanding is that the risk margin currently used in Virginia is approximately one percent. If the one percent figure is more depective of the capitation rate-setting risk margins going forward, the added costs of the carve-out model would be approximately $5 million higher (more adverse) each year than what we have estimated.

IV. Programmatic Impacts of Medicaid Pharmacy Benefits Management Approaches

In addition to the financial impacts the carve-out will have, it is critical to consider the programmatic dynamics of the carve-in versus carve-out policy decisions. These programmatic impacts overwhelmingly favor the carve-in model. At a fundamental level, the integrated carve-in creates a whole-person focused, well-coordinated system of care and coverage. Pulling the pharmacy benefit out of this system – and into a fiscal silo – is antithetical to the goals of care integration and coordination. Prescription drug treatments are central to the health services Virginia's Medicaid beneficiaries receive, and prescription drug data are essential to discerning individuals' health needs and comorbidities, new diagnoses, and treatment adherence patterns.

Virginia's MCOs have two significant care coordination advantages in the carve-in environment. First, the prescription drug data are available on their own terms, integrated with their staff and information systems in the manner they deem to be most effective. Second, the prescription drug claims information is available to the MCO immediately. Unlike other health services, prescription drugs have no claims submission/payment lag time. These transactions are visible immediately and can flag issues that trigger prompt and valuable care coordination actions. MCOs' ability to coordinate care is supported by a pharmacy carve-in and is compromised by a carve-out.

Some specific programmatic advantages of a pharmacy carve-in and disasadvantages of a pharmacy carve-out are conveyed below, capturing the "lived experience" input we received from Virginia's Medicaid MCOs.

Collaborating to Provide Education Surrounding Hepatitis C Therapy
This plan collaborates with a specialty pharmacy to operate a clinical program for members on Hepatitis C therapy, taking advantage of the "real time" availability of the pharmacy claims data. The goal of the program is to improve adherence, provide care coordination, and measure health outcomes for members through patient monitoring and engagement. This program provides coordination between the member's PCP and specialists, and the plan's case management services. Patient management includes education, monitoring treatment side effects, and coordinating the delivery of prescribed medications. The specialty pharmacists and case managers, in coordination with the plan, review lab results, measure patient compliance, and monitor possible side effects and drug-drug interactions. Using these measures, pharmacists and case managers determine how the patient is responding to the treatment and may recommend appropriate adjustments to the patient's physician. Additionally, educational resources and wellness kits are provided to help the member manage their conditions and medication(s).

Streamlining Utilization Management
Health plans who offer integrated medical/pharmacy platforms are able to connect data from both benefits in order to streamline clinical utilization management. For example, this plan uses medical claims information in real time for the adjudication of pharmacy claims that require diagnosis verification for medical necessity. When a pharmacist submits a claim for a plan member, their integrated platform reviews that member's medical claims history, and if the desired diagnosis is identified, the claim is paid without delay. Absent this integration, these medical necessity reviews typically require prior authorizations, which are both costly and time-consuming.

Collaborating to Provide Education and Reduce Waste of Oncolytic Medication: The same plan also partners with the specialty pharmacy for members taking oral oncolytic medication. A dedicated oncology healthcare team provides support for the clinical, physical, educational, and emotional needs of members and their caregivers. Prior to initiation of therapy, the specialty pharmacy outreaches to the member to ensure understanding and to confirm shipment and delivery. Due to the complex nature of oral oncolytic medication, the plan instituted a partial fill program for the first fill. The specialty pharmacy dispenses a partial fill of therapy to ensure the member is able to tolerate the medication before dispensing a full fill of therapy, helping to prevent medication waste. Care coordination is also created prior to first fill between the specialty pharmacy and the plan's care management team.

Leveraging Pharmacy Claims Data to Identify Emerging Health Conditions
GIven that pharmacy data is processed in real time and claims records are shared by PBMs with their health plans on a daily (at least) basis, it is often the earliest indicator for health plans to identify emerging health conditions for their members. Plans use this information to connect members with care management solutions, specialist provider referrals and other clinical resources. For example, when a member fills (or attempts to fill) a high-risk opioid prescription, the health plan is alerted in real time, agility that can reduce costs and improve health outcomes. In Medicaid programs where pharmacy is carved out, the sharing of pharmacy claims data can be significantly delayed, unreliable in quality and in a format that does not allow for the same degree of seamless integration with real time clinical programs.

Collaborating with Specialty Pharmacy: One plan partners with select specialty pharmacies that have demonstrated value and follow best practices in managing complicated disease states. Because specialty drugs typically require ongoing clinical assessment, they are associated with higher costs, enhanced educational needs, and care coordination between member and physicians. The plan's specialty pharmacy collaborations help to address appropriate utilization, enhance access, improve care coordination, and measure outcomes.

Medication Access and Adherence Support

Virginia's Medicaid MCOs deliver a compelling level and mix of support to their members regarding accessing needed medications and adhering to prescribed regimens. Five specific access and adherence examples of efforts the health plans are making are conveyed below. A pharmacy carve-out model compromises the MCOs technical ability to deliver these supports, as well as the financial viability of doing so.

Five Access Examples from Virginia Medicaid MCOs

1. **Providing Override Support to Access Suboxone** – A relatively new member was unable to get her Suboxone filled. She had been using an out of network provider for the past 90 days under the continuity of care process. In this specific area, there was geographical scarcity related to ARTS/SUD providers. A Care Coordinator and the member were able to work towards an in-network appointment, but it was after the 90-day continuity of care period. The Care Coordinator reached out to a pharmacist to support an override to maintain member's adherence and followed up to ensure the member's appointment and transfer of care was completed. The Pharmacy staff provided an approval so the member could obtain her Suboxone.

2. **Nebulizer Access and Readmission Prevention:** Upon receiving a call from a member care specialist about a recent emergency department visit, a member's caregiver brought up concerns regarding their medication. Through the discussion, it was discovered the member had been to the hospital due to issues breathing from chronic bronchitis. The member had been prescribed Albuterol Nebulizing Solution and Nebulizer, but was having trouble getting their Nebulizer due to an issue with the way the prescription was written. The member's caregiver was concerned because they had been using more of his emergency Albuterol Inhaler to supplement until the physician corrected the prescription. Their concern was that they were out of that medication now and would be without anything for the weekend. While the care coordinator was assisted the member in getting the corrected prescription, and the health plan, with assistance from a pharmacist decided it was in the best interest of the member to give them an override for the Albuterol Inhaler.

3. **Ensuring Continued Access to Medications During Emergencies and Disasters** This plan and its PBM collaborate during emergencies and disasters to ensure that their members have ready and continued access to their medications. In August 2018, officials feared that a dam in Lynchburg, Virginia was going to overflow. The plan alerted its PBM that many of its members were being evacuated to higher ground and would need access to their medications. Per the shared protocol, the PBM relieved the requirements for authorizations and reporting; members obtained their medications seamlessly for the period of their evacuation. Afterward, the plan received an accurate and complete follow-up report from the PBM to ensure that the business plan was on track with monitoring medication utilization. After a disaster is over, the PBM provides the plan with a follow-up report so the plan can monitor the medications that were dispensed during the period of disruption.
4. **Finding Vitamins for Vegans:** The plan had a member that would only take Vegan Vitamins, so a staff member worked with Virginia Commonwealth University students to find vitamins in a vegan form, provided the member with this information so she could order them. The member mailed her invoice to the plan. The plan added the vitamins to their system and the member was able to receive reimbursement.
5. **Troubleshooting a Drug Utilization Review (DUR) Issue** – A member and her therapist reported a denial issue with filling the member's Zyprexa 20mg through her pharmacy. A Care Coordinator spoke to the pharmacy and determined the pharmacy needed additional support from the plan, then reached out to a plan pharmacist for support and guidance. This medication was denied due to having already filled Zyprexa 15 mg and Latuda. In this case they had duplicate therapy with another antipsychotic medication and a high dose due to a dose change but the previous dose was filled recently. The health plan pharmacy tech was able to verify with the prescriber's office that the member was stopping the 15 mg and only taking the 20 mg. The Pharmacy Director allowed the pharmacy tech to enter an override for this medication on a one-time basis and the pharmacy was confirmed to have a paid claim.

Five Adherence Examples from Virginia Medicaid MCOs

1. **Adherence Calls**: The health plan's technicians drive adherence by calling each patient approximately a week before he/she would run out of the current stock of medication (based on day's supply) to set up the next medication refill. In addition, the technicians ask a set of questions to assess patient adherence as well. For example, the technician asks the patient how many doses the patient has remaining and evaluates if this number makes sense with what the patient should have remaining. If the technician determines an issue may exist, he/she will warm transfer the call to a pharmacist who works with the patient to determine a reason for the apparent non-adherence and provides tips to overcome these barriers.

2. **Ensuring Continued Adherence to Prescribed Therapies:** This plan uses an adherence program that identifies members that may not be following a prescriber's instructions regarding medications. There are several components to this program:

    - System identifies members beginning therapy with a long-term medication, such as a blood pressure lowering medication. Pharmacists counsel the member regarding the importance of adherence with their medication.
    - System targets members who are 14 or more days late on filling their medication. The plan identifies adherence barriers that may be contributing to non-adherence. The plan focuses on educating members about the benefits of taking their medication as prescribed and supporting members to improve adherence.
    - System targets members who are late on refills; members are contacted by IVR and can opt to immediately call the pharmacy for a refill. Refill rates for members reached by IVR are approximately 1.5 times higher than for other members.

3. **Medication Assisted Treatment (MAT) Education:** This plan's pharmacy team supplies a sizable number of reports that are used for various care management activities and adherence programs. One example includes a first fill/drop off report that informs the care manager when a member begins or stops MAT. The care manager can engage the member to discuss whether MAT is still needed or educate the member on the importance of continuing the medication for those on therapy.

4. **Assessing Needs Post-Discharge:** This plan's pharmacy team assists care management team with transition post discharge. A clinical pharmacist reviews discharge summary to ensure medications are being filled. A full medical review is carried out to determine baseline adherence to existing medications, drug to drug interactions, poly-pharmacy, and potential gaps in care. In one particular case, the pharmacist and care management collaborated on outreaching to a member where current demographic information was not accurate. After contacting the prescriber and pharmacy a more current phone number was obtained. It was learned the member had moved and was having trouble getting his/her medication. The clinical pharmacist and the care manager determined what pharmacy would be near the member and assisted the member with transferring the needed medications to a pharmacy closer to where he/she was living. Additional education was carried out around the importance of taking the prescribed medications to avoid hospitalizations in the future.

5. **Explaining Complex Treatments for Asthma:** One of this plan's pharmacists outreached to a member and her caretaker as part of the asthma adherence programs. The pharmacist spoke with the member's mother, who was very concerned about her daughter's medication and wondered if something might be wrong. The pharmacist informed her that the call was to provide tips and helpful information so that she can get the most benefit out of her daughter's medication. The member's mother was confused about the inhalers the doctor had provided for her daughter to use. She had never heard of

asthma before. The member seemed overwhelmed with all the medication the doctor had provided her. The pharmacist carefully reviewed her long-acting inhaler, described its use, priming the inhaler, side effects as well as what she could expect from the use of the medication. The pharmacist also laid her fears to ease by stating that the medication can be used for long term care of her daughter's lungs. She was very grateful for the information stating that she now understood the difference between not only rescue and long-acting prevention inhalers, but also thanked the pharmacist for discussing other medications.

V. Concluding Observations

Moving to a pharmacy carve-out model for Virginia's managed care programs inherently diminishes the integrated system of health coverage that is being delivered to Virginia's impoverished residents. Medications are a central component of health treatment. Access and adherence to an optimal medication regimen are essential to this population's health.

Effective administration of the pharmacy benefit involves four major components:

(1) Sound management of the mix of drugs prescribed.
(2) Sound management of the net price of each drug.
(3) Integration of prescription drugs and data with medical care and data.
(4) Extensive efforts to assist beneficiaries in accessing and adhering to an optimal medication regimen.

The carve-out model is focused almost entirely on the second of these components – securing the lowest possible net price for the medications prescribed. While the extent to which these unit price advantages will materialize for the Virginia's Medicaid program is debatable, overwhelming evidence exists that the carve-out will diminish the program's ability to achieve the other three critical components – effective drug mix management, optimal integration and coordination across pharmacy and medical services, and robust access and adherence support mechanisms.

The traditional FFS Medicaid setting has always been effective at minimizing unit prices to providers. However, controlling *only* this lever led Medicaid to become an increasingly substandard payer, with providers unwilling to accept Medicaid thwarting the very access to care the Medicaid program is seeking to deliver.

Our financial impact analyses indicate that the state would incur significant costs if it adopts a carve-out. Virginia's state fund costs of the carve-out approach are estimated at $12 million in the first year (SFY2020) and $157 million across the five-year timeframe SFY2020 – SFY2024. Even more concerning are the carve-out's adverse programmatic impacts on care coordination, as conveyed throughout Section IV.

We encourage Virginia's policymakers to preserve the carve-in and focus instead on available options for cost savings and administrative improvements within this integrated structure.