The Menges Group

Strategic Health Policy & Care Coordination Consulting

Executive Summary: Assessment of the Pharmacy Carve-In Model for Virginia's Medicaid Program

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I. Introduction

Virginia's Medicaid Managed Care Organizations (MCOs) coordinate and pay for the pharmacy benefit for nearly all of the medications utilized by the Commonwealth's Medicaid enrollees. This is commonly referred to as a "pharmacy carve-in" approach. Five MCOs – Aetna Better Health, Anthem HealthKeepers Plus, Molina Healthcare of Virginia, Sentara Health, and UnitedHealthcare Community Plan of Virginia – collectively paid for 99.2% of Virginia's Medicaid prescriptions during CY2023.

Over the last few years, some Virginia stakeholders have indicated an interest in moving to a pharmacy "carve-out", whereby the Commonwealth would instead manage the pharmacy benefit for MCO enrollees, including directly paying for drugs made available to Medicaid members. A full Medicaid carve-out model would create a government, single-payer system (within Medicaid) for retail pharmacies, using Medicaid's fee-for-service payment methodology. Virginia's Association of Health Plans has engaged The Menges Group to assess the fiscal and programmatic impacts of switching to a carve-out model.

II. Current Pharmacy Rebate Dynamics

DMAS implemented a Common Core Formulary in 2018, optimizing the usage of drugs with the lowest net (post-rebate) cost through Medicaid managed care contracts that hold MCOs responsible for timely encounter submissions. However, evolving brand drug prices and rebates are disrupting the traditional MCO model of steering prescriptions toward drugs with the lowest net cost to MCOs, as the lowest-cost drug from an MCO's perspective is often different from the lowest net cost for Medicaid, as federal statutory rebates are paid to the government and do not flow to or through MCOs. Through the American Rescue Plan Act (ARPA) of 2021, from January 2024 forward, the 100% rebate cap is no longer in effect, meaning that a rebate could be greater than the drug's initial cost. While other states may need to implement a preferred drug list, DMAS is already well-positioned to steer prescription volume to the lowest net-cost drugs while minimizing financial risk from high-cost drugs. In conjunction with the integrated care and integrated data advantages a carve-in affords the MCOs, this represents a "win-win scenario."

III. Cost Impact of a Carve-Out

The estimated net cost impact of a pharmacy carve-out is an annual state fund cost increase of $44 million. Our cost impact was determined through an assessment of the following components:

- **Drug mix and drug rebates:** Virginia's Common Core Formulary, implemented by DMAS in 2018, ensures that the MCOs steer volume to the drugs that are most cost-effective to Virginia taxpayers. Because of the mature existence of the Common Core Formulary, we expect that the drug mix, and therefore the associated rebates, would not be meaningfully different under a carve-in or carve-out model going forward.

- **Initial (pre-rebate) payments to pharmacies:** Each MCO pays pharmacies based on negotiated contracts. However, under a carve-out, the Actual Acquisition Cost (AAC) payment model would be required of DMAS, which creates favorable pricing on ingredient costs but involves a far higher dispensing fee (more than $10 versus MCO payments which are typically below $2). The PBM of one of the Virginia MCOs modeled that a carve-out would increase annual pharmacy payments for their enrollees by over $10 million, which extrapolates to $152 million if applied across all MCO Medallion 4 enrollees. **The Commonwealth's share of this is anticipated to be 25% of the overall Medicaid cost increase, or $38 million**.

- **Risk margin payments:** MCOs are compensated for bearing the full risk of health care costs. A pharmacy carve-out would reduce the financial risk that health plans face, thereby reducing the amount of risk margin compensation that would need to be included in the MCO capitation rates. **We estimate that the Commonwealth would save an estimated $11.3 million annually from the loss of pharmacy risk margins in a carve-out but would lose budget reliability by taking on the risk of price increases.**

- **Administrative cost impacts:** Under a carve-out, many administrative functions will transition to DMAS and/or its contractor(s). However, the administrative functions that currently occur, such as pharmacy claims processing, prior authorizations, and member and provider calls, will not diminish, so there is no reason to expect administrative savings to occur. What would change administratively under the carve-out is the lower federal match rate for the new administrative duties that DMAS takes on, **resulting in an estimated $17 million loss of federal matching funds for Virginia.**

- **340B program impacts:** Under a carve-out, DMAS could potentially "take for itself" the savings that Virginia's FQHCs currently derive through their participation in the 340B program, which provides discounted drugs to FQHCs. These savings would, however, come directly at the cost of impairing the ability of the FQHCs to fulfill their mission. Because a State Plan Amendment process is available to "keep the FQHCs whole" even if a carve-out were implemented, we have not envisioned that DMAS will seek to secure 340B savings off the back of its own safety net system.

IV. Capitation Rate-Setting Issues

Virginia's MCOs have had a successful partnership with DMAS and its actuarial contractor, Mercer. Notwithstanding the favorable overall history, the MCOs have viewed the pharmacy component of the capitation rate as underfunded for multiple years and are concerned that the cost dynamics of this component may warrant some methodological revisions due to:

- **Eligibility changes:** Medicaid eligibility unwinding has led to a disproportionate loss of coverage for individuals with low/no prescription drug use. The remaining beneficiaries have higher pharmacy costs, which should be accounted for in the capitation rate.

- **Rising drug costs:** In 2014, drugs costing over $1,000 per prescription accounted for 32% of Medicaid pharmacy pre-rebate spending. In 2024, this figure had increased to 63%. Additionally, the rising popularity and demand for specific drugs, such as GLP-1 weight loss drugs, could lead to substantial new costs.

- **"Better-than-free" drugs:** Brand-name drug manufacturers' reactions to some of their drugs now being "better than free" when used in Medicaid are difficult to predict.

While the pharmacy arena poses particular capitation rate-setting challenges, carving in the drug benefit is valuable to DMAS in creating budget predictability.

V. Implementation Risks of Moving to a New Model

The shift from an integrated carve-in model to a carve-out model for Medicaid pharmacy benefits introduces significant implementation risks, as seen in states that recently transitioned. These challenges include disruptions in access to medications, increased costs, and administrative complications. In California, the transition to a carve-out led to disturbing access issues, such as long wait times and delayed prior authorizations, causing a dramatic drop in prescription fulfillment **(8+ million less than had been occurring under the carve-in setting)**. Although California later relaxed prior authorization and other cost containment measures to restore access, this resulted in a substantial increase in prescription costs **(over $2 billion more than occurred during the prior year under the carve-in).** Kentucky and Mississippi also faced operational disruptions in the first few months, including billing issues and turning off prescriber edits. New York encountered some fragmentation in care coordination as providers struggled with unclear distinctions between pharmacy and medical benefits, leading to delays in medication access and poor health outcomes for some.

VI. Quality Comparison of Carve-In and Carve-Out Approaches

National and regional analyses indicate that the carve-in model leads to superior quality scores in Medicaid compared to the carve-out model. A 2023 Elevance Public Policy Institute report, "Medicaid Prescription Drug Management: Quality Scores Compared Across Different Approaches," found that the fully MCO-managed model outperformed the FFS model in 97% of HEDIS score comparisons. Regional comparisons of Virginia's Medicaid MCOs in 2022 and 2023 also showed that Virginia outperformed the collective group of its neighboring states with regard to HEDIS scores across 28 pharmacy-related quality measures.

VII. Data Integration in Carve-In and Carve-Out Settings

One must consider the degree to which the MCOs' data-driven care coordination capabilities will be compromised relative to the current carve-in model.

- **Real-time data access:** In a carve-in, prescription drug data is immediately available and integrated with MCO systems for efficient care coordination. A carve-out delays data access and decreases data compatibility, reducing an MCOs' ability to respond to pharmacy-related issues in real-time.

- **Communication efficiency:** The carve-out model can lead to communication breakdowns between members, providers, and MCOs, leading to fragmented care, delays in medication access, and confusion over responsibility for care.

- **Swift intervention:** Real-time pharmacy data is crucial for care managers to effectively address medication issues, monitor adherence, and coordinate care, specifically for those with complex conditions, ensuring timely interventions and adhering to personalized treatment plans.

VIII. Access and Adherence Advantages of Carve-In Model

Virginia's Medicaid MCOs use a range of strategies to support medication access and adherence for members, including proactive adherence calls, IT systems to monitor and address barriers to medication fills, longer days-supply of medication, and collaborative efforts between care managers and pharmacists to assist with post-discharge transitions and complex treatments. These efforts help prevent gaps in medication access, ensure continuity of care during transitions and emergencies, and address one-off needs, improving both health outcomes and member satisfaction. A few specific examples of the MCOs' efforts can be found in the Appendix.

IX. Recommendations

1) Preserve the current carve-in pharmacy model for the Medicaid program

We estimate that a switch to a carve-out would have an adverse annual state fund impact of roughly $44 million. The carve-in approach also provides better budget predictability by keeping pharmacy costs with the MCOs, that assume the financial risks. Programmatically, the carve-in model supports integrated, whole-person care, as MCOs have established systems for care coordination, using comprehensive data and staff to optimize medication access and adherence. In contrast, a carve-out model would disrupt these systems, introduce implementation risks, and potentially lead to medication access issues and increased costs.

2) Preserve the Common Core Formulary

Preserving the Common Core Formulary is crucial for identifying and steering Medicaid enrollees to the lowest-cost drugs, helping reduce overall program costs and benefiting Virginia taxpayers, especially as many brand drugs are now "better than free" to Medicaid.

3) Enhance Reimbursements to Critical Access Pharmacies

There are many situations – particularly in Virginia's rural areas – where a specific pharmacy creates far superior medication access to Medicaid enrollees than would be available without it. To support the existence of critical access pharmacies, we suggest that Virginia MCOs be required by DMAS to pay these pharmacies at relatively robust payment rates.

4) Increase MCO Policymaking Representation

Currently, the Virginia MCOs have one representative on the Drug Utilization Review Board Committee and one representative on the Pharmacy and Therapeutics Committee. Because the MCOs account for 99% of the total Medicaid spend, we recommend additional MCO representation on both committees to ensure the input received reflects the program makeup.

5) Consider capitation rate-setting revisions for the pharmacy component

Virginia's MCOs have concerns over the underfunding of the pharmacy piece of the capitation rate, citing rising drug prices, the unpredictable impact of new "better than free" brand drugs, and the financial uncertainty around high-cost medications like GLP-1 weight loss drugs. We encourage the MCOs, DMAS, and Mercer to collaboratively address these challenges, including potentially committing to revisit rates at mid-year and to consider retroactive rate adjustments when there are new drugs or gene therapies that enter the market, or new indications for drugs.

X. Appendix: Case Examples of Virginia MCOs' Management of the Drug Benefit

Case Example 1: Supporting An Enrollee Through an Out-Of-State Emergency

In early 2024, a Virginia member was flown to the Cleveland Clinic for a cardiac procedure and was scheduled to fly back late on Friday. Unfortunately, inclement weather canceled the flight, so this patient was suddenly and unexpectedly stranded in Cleveland until another flight could be scheduled. As a result, the care management team was pulled in to find a hotel for at least one night as well as transportation.

Early on Saturday, the pharmacy team received a call from care coordinators indicating that the member was high acuity and out of multiple medications. The pharmacy director immediately contacted the PBM to (1) locate pharmacies near the hotel, (2) engage with pharmacies about the targeted medications to ensure they had adequate supplies, and (3) grant early-refill overrides for these medications. The care management team then supplied transportation to get the patient to the pharmacy as well as meal coordination and arranged an alternate flight back to Virginia.

This level of care coordination, and the speed at which services were available to the member would be compromised in a carve-out scenario.

Case Example 2: Addressing Member Needs When Drug is Discontinued

Earlier this year, Relyvrio, a medication used to treat amyotrophic lateral sclerosis (ALS), was discontinued following reports from Amylyx that the drug failed to provide clinical benefits. For members who were currently on Relyvrio, ensuring continuity of care was crucial due to the debilitating nature of ALS.

Our MCO took a proactive approach by reviewing the utilization of Relyvrio among our members. We reached out to the prescribing physicians to assess their plans for transitioning to alternative treatments based on this new information. Our pharmacy team worked closely with both the prescribing physicians and pharmacies to expedite the authorization process for new medications. This ensured that there were no delays in getting the necessary approvals and that members received their new treatments promptly.

By proactively coordinating care and expediting necessary approvals, we ensured continuity of treatment and minimized disruptions. Such comprehensive support and coordination may be challenging to achieve in a carve-out setting, where fragmented care management can hinder timely and effective responses to significant changes in medication availability.

Case Example 3: Same-Day Replacement Medications Due to House Fire

A 24-year-old member with a history of major depressive disorder, anxiety, and obstructive sleep apnea receives case management and medication management services at Mount Rogers Community Services Board. Her family experienced a house fire early one morning and most of the inside of the house was lost including the member's medications. Her medications included two antipsychotics, antidepressant, oral contraceptive, and vitamin D.

The member contacted her Care Manager on the day of the fire at 3:00PM for assistance. Since she recently had them filled, the member's pharmacy told her the replacement medications would not be covered. Our Care Manager immediately accessed the member's pharmacy history in the MCO's PBM's portal and identified the specific medications processed by the pharmacy on the same day that rejected for early refill. Our Care Manager then reached out to our pharmacy team for assistance and early refill overrides were entered into the pharmacy claims system. The Pharmacy team contacted the pharmacy to reprocess the claims and the member ultimately received her medications ***on the same day*** *avoiding any medication discontinuation issues.*