The Menges Group

Strategic Health Policy & Care Coordination Consulting

Assessment of Report on Impacts of West Virginia Medicaid Prescription Drug Carve-Out

Prepared for America's Health Insurance Plans

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I. Introduction

America's Health Insurance Plans (AHIP) engaged The Menges Group to review a report titled "Pharmacy Savings Report, West Virginia Medicaid," produced by Navigant Consulting for the West Virginia Department of Health and Human Resources, Bureau for Medical Services in February 2019. This report found that considerable savings occurred by virtue of West Virginia carving prescription drugs out of their Medicaid managed care program. These findings were counter to the body of work The Menges Group has produced analyzing Medicaid prescription drug costs throughout the past several years. We were asked to review the report's methodology and assess the impacts of carving out Medicaid prescription drugs using our own analyses.

II. Executive Summary

The above-mentioned Pharmacy Savings Report inaccurately estimated cost savings from West Virginia carving prescription drugs out of its Medicaid managed care program for several reasons. First, it estimated the change in pharmacy costs using a re-pricing methodology instead of looking at available data regarding the actual change in West Virginia's Medicaid pharmacy costs before and after the carve-out was implemented. The data, reported directly by the state, show that carving prescription drugs out of the Medicaid managed care arena has created an additional $18 million in annual Medicaid payments to pharmacies — roughly $15 million more than the report estimated. Tabulations using these data also show that the switch to a carve-out reduced the percentage of generic drugs used in West Virginia's Medicaid program.

Second, the report over-estimated the administrative cost savings that would arise by carving prescription drugs out of Medicaid managed care based on faulty tabulations and/or a misunderstanding of MCO administrative expenses. The report's tabulations suggest that West Virginia will somehow trade down $50 million in annual pharmacy-related administrative costs under the carve-in for just $9 million under the carve-out. Per the MCOs' audited financial statements, the West Virginia Medicaid MCOs' collective administrative costs for their Medicaid line of business during calendar year 2017 totaled $139 million, or 8.4% of their overall Medicaid premium revenues. Based on our knowledge of Medicaid MCO operations, less than five percent of these administrative costs can be attributed to pharmacy benefits management activities. Unfortunately, the report's figures allocated more than 35% of the MCOs' Medicaid administrative costs to the prescription drug benefit.

Third, the Pharmacy Savings Report estimated savings from carving out prescription drugs due to reduced Health Insurance Fund (HIF) allocations. We anticipate that the Health Insurance Fund is a mechanism fundamentally designed to draw down additional federal Medicaid

matching funds to lower net state fund Medicaid costs, and that reductions in the HIF amounts will have a detrimental state fund impact.

Finally, the report does not consider the programmatic impacts of the carve-out policy. The programmatic advantages of a carve-in are compelling relative to the carve-out approach. Most important, the pharmacy carve-out runs directly counter to the integrated, whole-person-focused coordinated care model the Mountain Health Trust Medicaid managed care program is designed to deliver.

Our calculations strongly suggest the carve-out approach has increased, rather than reduced, West Virginia's Medicaid costs. Restoring the integrated, carve-in model would best serve the State's fiscal interests and optimally support the effective integration and coordination of care.

III. Assessment of Pharmacy Costs

The report estimated pharmacy cost impacts using a re-pricing methodology to establish a baseline cost comparison using a single price source (National Average Drug Acquisition Cost / NADAC rates). It found that West Virginia's Medicaid pharmacy costs increased slightly (by $2.5 million in SFY2018) by switching to a carve-out policy.

Relying on this re-pricing approach – and only this approach – fails to assess actual "before vs. after" costs in an accurate and comprehensive manner. Under the carve-in approach, the Medicaid managed care organizations (MCOs) were at dollar-for-dollar risk for pharmacy costs, and thus had a strong incentive to do whatever they could to cost-effectively manage the mix and the price of prescription drugs.

The federal Centers for Medicare and Medicaid Services (CMS) publishes a comprehensive data file at the National Drug Code (NDC) level for each state and calendar quarter that contains 100% of prescriptions and pre-rebate pharmacy expenditures for each drug. The State Drug Utilization data files sent to CMS by states now contain five calendar quarters of West Virginia data since carve-out (July 2017 through September 2018). We calculated average Medicaid costs per prescription in this timeframe 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 USA, for MCO-paid drugs, and for drugs paid in the fee-for-service setting. We also tabulated the percentage of all prescriptions filled with a generic drug. The results of these tabulations are presented in Exhibit 1.

West Virginia's costs per Medicaid prescription rose sharply after the carve-out was implemented, increasing 12.6% between the pre-post comparison timeframes presented above. During this same timeframe, nationwide Medicaid costs per prescription increased by 4.1%.

These tabulations indicate that West Virginia's Medicaid prescription drug spending increased by roughly 8.5 percentage points due to the policy change to a carve-out model.

Exhibit 1. Comparison of West Virginia Medicaid Prescription Drug Costs and Usage Under Carve-In and Carve-Out Model

Statistical Measure	West Virginia	USA Total	USA MCO	USA FFS
Average Pre-Rebate Cost Per Prescription, April 2016 – June 2017 (last 15 months of WV Carve-In Model)	$62.70	$81.74	$71.85	$105.92
Average Pre-Rebate Cost Per Prescription, July 2017 – September 2018 (first 15 months of WV Carve-Out Model)*	$70.61	$85.11	$75.18	$110.04
Percent Increase	12.6%	4.1%	4.6%	3.9%
Generic Percentage of All Prescriptions during last 15 months of WV Carve-In Model	86.5%	86.8%	88.1%	83.6%
Generic Percentage of All Prescriptions during first 15 months of WV Carve-Out Model	85.9%	87.0%	88.2%	83.9%
Percentage Point Change	-0.6	+0.2	+0.1	+0.3

** Rebate data are not yet publicly available for FFY2018, preventing post-rebate cost comparisons. Reported cost figures are adjusted upwards slightly to estimate the volume of prescription drug costs that were suppressed (CMS does not publish information on NDCs with fewer than 11 prescriptions in a given state and quarter). For several states we made additional larger adjustments to address under-reporting of data in the most recent quarter(s), which increased the 2018 USA total by several percentage points.*

During the carve-in timeframe, 67.9% of West Virginia's Medicaid prescription drug expenditures occurred through MCO-paid prescriptions. The overall 8.5% cost increase is therefore attributable to "only" 67.9% of West Virginia's Medicaid spending. Prorating this impact to the MCO-paid prescriptions (8.5 / 0.679) yields an estimate that West Virginia's pharmacy costs for the drugs paid by MCOs increased by 12.5% due to the change to a carve-out model.

The two right-hand columns of Exhibit 1 also demonstrate the significant differences in average costs per Medicaid prescription between the MCO-paid environment and the FFS environment. These figures strongly demonstrate the financial value of the carve-in approach nationwide.

This 12.5% additional cost represents approximately $36 million annually (pre-rebate) when applied to the CY2017 volume of Medicaid MCO-paid expenditures prior to the carve-out. These annual additional costs on a net, post-rebate basis would be roughly half this amount, or $18 million.

Exhibit 1 also demonstrates that West Virginia's Medicaid drug mix has changed in an adverse manner since the carve-out, with the generic percentage dropping in the post-carve-out timeframe relative to the pre-carve-out period. Nationally, the generic percentage increased in Medicaid during this same timeframe. The average net cost of a generic drug in Medicaid is roughly *nine times lower* than the average brand cost. Thus, modest movement in the generic percentage has significant cost implications. This finding demonstrates the need to take drug mix into account in assessing carve-out impacts (which the Pharmacy Savings Report's methodology did not do).

West Virginia's overall Medicaid cost per prescription trajectory post carve-out is well-aligned in direction and magnitude with another comparison we conducted looking at a 100% sample of Medicaid prescription drug claims from 2011 through 2017.[1] During 2011, 13 states used a prescription drug carve-out model within their Medicaid MCO program. Nine of these states subsequently switched to a carve-in approach as of FFY2017. The remaining four states with a carve-out model in FFY2011 retained their carve-out approach through FFY2017 (Missouri, Nebraska, Tennessee and Wisconsin). The four states that maintained their carve-out model represent a "control group," and their drug cost and utilization progression from FFY2011-FFY2017 was compared with the group of 9 states that used a carve-out model during 2011 but then switched to a carve-in model. These comparisons are shown in Exhibit 2.

Exhibit 2. Performance Progression Among States Switching to Carve-In as Compared with States Retaining Carve-Out Model

	9 States with 2011 Carve-Out Switching to Carve-In			4 States with 2011 Carve-Out Retaining Carve-Out Through 2017		
Performance Measure	FY2011	FY2017	Percent or Percentage Point Change, 2011-2017	FY2011	FY2017	Percent or Percentage Point Change, 2011-2017
Generic Dispensing Rate	70.96%	86.63%	15.66%	76.92%	84.59%	7.67%
Initial (pre-rebate) Cost Per Prescription	$76.40	$81.38	6.5%	$68.77	$92.37	34.3%
Net (post-rebate) Cost Per Prescription	$38.59	$38.93	0.9%	$38.11	$44.25	16.12%

[1] "Assessment of Louisiana Medicaid's Prescription Drug Carve-Out Option," https://www.themengesgroup.com/upload_file/louisiana_carve_out_report__may_2018.pdf

While the two groups of states had similar net costs per prescription during FFY2011, the states that switched to a drug benefit carve-in achieved a much lower net cost per prescription trend from 2011-2017 (0.9%) than states that retained the carve-out model (16.1%).

The figures in Exhibit 2 also demonstrate the success states have had with drug mix using the carve-in model. The generic dispensing rate rose 15.7 percentage points from 2011-2017 in the states that switched to a carve-in, whereas the generic dispensing rate increased by 7.7 percentage points among the four states that maintained their carve-out approach.

IV. MCO Administrative Costs

The Pharmacy Savings Report found a $56 million savings in SFY18 administrative spending due to the prescription drug carve-out. This estimate was driven primarily by an assumption that the capitation rates paid to the MCOs include approximately a 10% allocation for administration, and that roughly a 10% administrative savings will apply to all the pharmacy costs that are removed. We have concerns with this approach and with the specific figures used in the report.

The Menges Group maintains a database of Medicaid MCO financial statements, and we have aggregated the Medicaid line of business financial information across West Virginia's four Medicaid MCOs for CY2017 as shown in Exhibit 3 below:

Exhibit 3: Aggregate CY2017 Medicaid Line of Business Financial Performance of West Virginia's Four Medicaid MCOs

Financial Statistic	CY2017 Amount	Percentage of Revenue
Total Revenue	$1,649,464,762	
Prescription Drug Expenses	$289,771,120	17.6%
Total Medical Expenses (including Rx)	$1,483,378,095	89.9%
Administrative Expenses (including claims adjustment expenses)	$139,107,139	8.4%
Operating Margin	$26,979,528	1.6%

The Pharmacy Savings Report indicates that $50 million in "Rx Admin" costs occurred under the carve-in model during SFY2017 related to the Medicaid managed care program. Administrative costs across the entire Medicaid line of business for the four MCOs in CY2017 totaled $139 million (combining all reported administrative costs with claims adjustment expenses). We cannot discern a credible path to the $50 million figure found in the report. The highest figure we could reach, trying to apply the report's methodology (which would grossly over-estimate actual prescription drug administrative costs), would be 17.6% of $139 million, taking the

prescription drug expenses' share of the total administrative expenses. This totals just $24 million.

While we cannot track the administrative expenses estimated in the report, we also have significant concerns with the approach, which seemed to assume that if 18% of premiums (or medical costs) was for prescription drug expenditures, then the health plan's overall administrative spending will be reduced by that same percentage through the pharmacy carve-out. The argument made is that West Virginia will somehow trade down $50 million in annual pharmacy-related administrative costs under the carve-in for just $9 million under the carve-out.

Looking at the administrative detail in the health plans' financial statements, and taking into account our knowledge of Medicaid MCO operations, nearly all administrative costs that the health plan incurred under the carve-in continue to occur under the pharmacy carve-out model.

All transactional aspects of pharmacy benefits management should be closely similar under the carve-in and carve-out models. MCOs are also at full risk for their administrative costs and have a strong incentive to manage these costs effectively.

Some MCO administrative costs will no longer occur under a pharmacy carve-out. Each West Virginia Medicaid health plan may no longer need a Medicaid pharmacy director under the carve-out, and the MCOs will receive and process fewer member services and provider calls (those related specifically to the drug benefit). However, at most we envision these costs would amount to 2-3 percent of the Medicaid health plans' overall administrative costs. There will also be some elements of increased costs for the MCOs under the carve-out. The health plan will still need to obtain and work with the prescription drug data for its members, for example, as these data are central to effective care coordination. Unfortunately, under the carve-out model this information will not come to MCOs on their terms, but rather according to the state's desired transmission file.

A crude but reasonable annual net Medicaid administrative savings from the carve-out would be 2% of all MCO administrative costs, which is approximately $3 million annually in West Virginia. We would also assume that roughly a 2% profit margin is built into the capitation rates. This percentage, applied to the MCOs' annual prescription drug expenditures, is approximately $6 million.

Taken together, we can envision the administration and operating margin components to create an annual carve-out savings of approximately $9 million. Based on the earlier estimate of an $18 million annual **net cost increase** in prescription drug spending under the carve-out, these savings components would still leave the Medicaid program spending $9 million more per year under the carve-out model.

V. Other Financial Impacts

The Pharmacy Savings Report identified that the Health Insurance Fund (HIF) allocations paid to (and by) West Virginia's Medicaid MCOs would be approximately $11 million lower under the carve-out model. We have not researched the specifics of this program but have two general observations.

First, if this money does disappear altogether, this presumably has significant damaging consequences in terms of West Virginians having diminished access to health insurance and health care. Simply reducing coverage, if that is what is presumed here, will of course yield savings. Extending that logic, enormous fiscal savings would occur by eliminating the Medicaid and Medicare programs altogether – but these "savings" would result in devastating health impacts.

Second, typically these kinds of special taxation programs are put in place to draw in additional federal matching funds and are highly effective at increasing the overall federal share of Medicaid costs and reducing the net state fund costs. A typical construct would be for a $100 monthly capitation payment to Medicaid MCOs to be increased to say, $103, with the federal government paying match on the full $103 amount. The state would then collect the $3 back via the premium taxes. All of the premium taxes would go to the state, essentially "gaming" the federal match to the state's advantage.

Again, we have not researched the details of the HIF, but it is important to ensure that West Virginia is not reducing its access to increased federal match by lowering HIF contributions and claiming this as a "savings." These dynamics could easily result in the carve-out creating a further detrimental overall state fund impact rather than the HIF mitigating some of the carve-out's adverse fiscal impacts.

VI. Programmatic Impacts

The report was limited to estimating financial impacts of the policy change to a pharmacy carve-out model. Programmatic impacts were not addressed. However, it is critical to consider the programmatic dynamics of the carve-in/carve-out policy decisions, which overwhelmingly support the carve-in model. At the most fundamental level, Mountain Health Trust is seeking to create a whole-person focused, highly coordinated system of care and coverage. Pulling something as central to Medicaid beneficiaries' health care as pharmacy out of this system is antithetical to the goals of integration and coordination.

Medicaid 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 (a pregnancy vitamin, an opioid medication, etc.) that trigger prompt and valuable care coordination actions. Importantly, the *absence* of these transactions (e.g., a missed refill) are also immediately apparent which can also trigger adherence supports. MCOs' ability to coordinate care optimally is supported by a pharmacy carve-in model and is compromised by a carve-out approach.

VII. Concluding Observations

The Pharmacy Savings Report significantly understated the increased pharmacy costs that have occurred by virtue of moving to a carve-out policy and significantly overstated the administrative savings that the carve-out model is likely yielding.

Our calculations strongly suggest that the carve-out approach has increased, rather than reduced, West Virginia's Medicaid costs.

It is also important to consider the programmatic advantages/disadvantages of these policy options. Carve-outs of all types – and certainly pharmacy carve-outs – work directly against the objectives of achieving optimal integration and coordination of care.