

Setting the Record Straight: Medicaid Pharmacy Carve-Outs Raise Costs for Taxpayers

In February 2019, the West Virginia Department of Health and Human Resources' Bureau for Medical Services (BMS) released the [Pharmacy Savings Report, West Virginia Medicaid](#). The report asserts that the state saved more than \$54 million in 2018 by removing—or “carving out”—prescription drug coverage from the state’s Medicaid managed care program, and instead covering drugs through an unmanaged fee-for-service (FFS) program.

The report’s findings run completely contrary to analyses of Medicaid prescription drug programs in other states—as well as conclusions reached by other researchers. How can we understand the disconnect?

Separate analyses refute West Virginia’s Medicaid drug cost savings claim

To understand the findings, an independent analysis¹ tested the *Pharmacy Savings Report’s* conclusions. Using comprehensive data from State Drug Utilization files sent by states to CMS (the federal agency that oversees Medicaid), the analysis found that drug costs and savings were significantly different from those claimed in the report:

- West Virginia’s costs per Medicaid prescription rose sharply after the carve-out was implemented in 2017. In the 15-month period from July 2017 to September 2018, **West Virginia’s Medicaid costs per prescription increased by 12.6%, compared to the U.S. average increase of 4.1%**. West Virginia’s increase in prescription costs was three times that of the rest of the nation, representing an estimated increase of \$18 million in annual spending.
- The proportion of lower-cost generic drugs covered by West Virginia’s Medicaid program *decreased* during the same period, which means there was an increase in the use of comparable higher-cost brand drugs. In the rest of the nation during this same time period, the rate of generic drug utilization *increased* in both Medicaid fee-for-service and managed care drug programs. Why is this important? **Because the average net cost of a generic drug in Medicaid is roughly *nine times* lower than the average cost of brand-name drugs.**

Administrative cost savings are grossly inflated

The *Pharmacy Savings Report’s* estimates of program savings are driven largely by a conclusion that the move to a fee-for-service program yielded administrative savings of \$56 million. But this figure is equivalent to **40% of the combined total administrative costs of West Virginia’s four Medicaid managed care plans**. That means these estimated savings are grossly inflated. An independent analysis¹ estimated that the administrative costs attributable to the managed care prescription drug program were about \$7 million, a much more realistic figure.

¹ America’s Health Insurance Plans (AHIP) retained the Menges Group to review the BMS report’s methodology and the impacts of moving Medicaid drug coverage back to a fee-for-service setting. That analysis can be found at <http://www.ahip.org/wp-content/uploads/Assessment-of-Study-of-WV-Rx-Carve-Out-Impacts-0419.pdf>

States with managed care drug programs save taxpayer dollars

An analysis² that compares Medicaid prescription drug costs in states with managed care drug programs and states with fee-for-service programs from 2011 to 2017 shows:

- States that moved to **managed care models saw only a 0.9% increase** in their collective Medicaid pharmacy costs per prescription, including savings from rebates.
- States that maintained their **fee-for-service pharmacy programs saw a 16.1% increase** in their collective Medicaid pharmacy costs per prescription, including savings from rebates.

Several problems led to wrong conclusions in the Pharmacy Savings Report

The analysis shows that the *Pharmacy Savings Report* reached inaccurate conclusions for several reasons:

1. **The report relied on estimated changes in drug prices, not actual changes in Medicaid drug expenditures.** The report estimated the change in pharmacy costs using a “re-pricing” methodology instead of using available “before and after” data. The comprehensive “before and after” assessment¹ of moving prescription drugs out of Medicaid managed care indicates that **the carve-out created an additional \$18 million in annual Medicaid payments by the state to pharmacies—roughly \$15 million more than the report estimated.** This data also shows that the switch to a carve-out reduced the percentage of generic drugs used in West Virginia’s Medicaid program.
2. **Administrative cost savings were overestimated.** In their audited financial statements, the combined administrative costs of West Virginia Medicaid managed care plans for their Medicaid operations in calendar year 2017 totaled \$139 million, about 8.4% of their total combined Medicaid premium revenues. Based on prior analysis of Medicaid managed care plans, estimates show that less than 5% of those administrative costs could be attributed to Medicaid pharmacy benefits management—approximately \$7 million. The majority of Medicaid plan administrative costs are spent on administering physical and behavioral health services. Activities such as enrollment processing, member education and outreach, member services, quality improvement, case management, data reporting and analysis, and fraud control are not tied to specific benefits. Carving out prescription drugs (or any other covered service) does not lower these cross-cutting administrative costs.
3. **The analysis does not consider the value of drug utilization information to improved care coordination.** The advantages of integrating coverage of prescription drugs with coverage of physical and behavioral health services are compelling, as health care providers and clinical teams gain greater visibility into all the major components of their members’ care. Carving out drug coverage from the medical and behavioral health services runs directly counter to the integrated, whole-person-focused coordinated care model the Mountain Health Trust Medicaid managed care program is designed to deliver. When care and services are not coordinated, the result will be higher overall costs to the Medicaid program and worse health outcomes for enrollees.

Conclusion

West Virginia’s transition to the pharmacy program carve-out approach has increased the state’s Medicaid costs. Health plans know that Medicaid needs to work for people who rely on it, and state and federal taxpayers who pay for it. Working with state leaders and community partners, health plans ensure that Medicaid is effective, affordable, and accountable. Integrated prescription drug management ensures that taxpayer dollars are used wisely and that care is integrated and coordinated for Medicaid enrollees.

² *Medicaid Prescription Drug Utilization and Expenditure Dynamics*, published by the Association for Community Affiliated Plans, November 2018.