



THE HSC HEALTH CARE SYSTEM

Savings Generated by New York's Medicaid Pharmacy Reform

Sponsored by: Pharmaceutical Care Management Association

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October 2012

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I. Executive Summary

Medicaid is one of the nation's few remaining programs in which public agencies still use a fee-for-service (FFS) model to deliver pharmacy benefits. In this FFS model, care coordination and benefits management are typically limited and pharmacy reimbursement rates are established by government officials in the regulatory and/or legislative arena. Medicare Part D and commercial payers on the other hand, rely upon competitive negotiations between pharmacy benefits managers (PBMs) and drug retailers to reduce costs.

In 2011, the FFS model accounted for more than two-thirds of Medicaid prescriptions nationwide, even for Medicaid enrollees who receive their other health benefits through managed care organizations (MCOs).

The passage of the Affordable Care Act (ACA) in 2010 allowed states to collect statutory manufacturer rebates on prescriptions reimbursed by capitated Medicaid MCOs. Before this, many state Medicaid programs continued to use a FFS pharmacy benefit approach for fear of losing access to those rebates. Since 2010, many states have revisited the idea of modernizing pharmacy benefits.

New York is among a growing number of states shifting away from a FFS pharmacy benefit to reduce costs without reducing the number of enrollees or the quality of pharmacy benefits they receive. In January 2011, Governor Andrew Cuomo created a Medicaid Redesign Team (MRT) with a goal of **“ending the state’s Medicaid fee-for-service system and replacing it with a comprehensive, high-quality and integrated care management system that will lower costs and improve health outcomes.”**

The Pharmaceutical Care Management Association (PCMA) engaged Special Needs Consulting Services (SNCS) to analyze the initial financial impacts of New York’s change to a PBM approach.

Major Findings:

- **New York Medicaid saves \$425 million in 2012, four times greater than expected.** SNCS projects that New York’s Medicaid program and taxpayers will save an estimated \$425 million in 2012 by transitioning to a more efficient PBM approach. This is four times the \$100 million in savings originally estimated by the New York Department of Health.
- **The federal government saves more than \$212 million.** The federal government splits the savings with New York since it is responsible for roughly 50 percent of Medicaid costs.

- **The vast majority of savings is from greater use of generics and lower-cost brands.** New York Medicaid MCOs expect to achieve generic drug dispensing rates of up to 84%, compared to a 79% rate that would be expected under Medicaid FFS.
- **Dispensing fees are no longer higher than those paid by Medicare and private insurers.** Consistent with the commercial sector and Medicare Part D, pharmacy dispensing fees have been reduced from \$3.50 under the FFS carve-out approach to an average of approximately \$1.75 under the PBM approach.
- **There is even greater savings potential since New York has yet to tap into the savings available through affordable pharmacy networks and targeted use of mail-service pharmacy.**

This report resoundingly validates New York's decision to move to integrated, more comprehensive pharmacy benefits management in its Medicaid program. The size and immediacy of the savings are compelling outcomes. This data may be useful to other states seeking to reduce Medicaid costs, while simultaneously ensuring patient access.

II. Why New York Is Reforming Its Medicaid Pharmacy Program

State Budget Crisis Drives Need for Greater Efficiency in Medicaid

At the start of 2011, New York faced an unprecedented budget crisis and policymakers looked toward the State’s Medicaid program—the most expensive in the nation—for savings. New York spends more per Medicaid enrollee than any other state.

State Seeks Greater Care Coordination by Integrating Pharmacy Benefits

State policy leaders embarked on a program to reform New York’s Medicaid program using a “care management for all” approach. This commitment was consistently reinforced by recommendations of the Medicaid Redesign Team (MRT), which was formed through an Executive Order by Governor Andrew Cuomo. One of the MRT’s key goals was “ending the state’s Medicaid fee-for-service system and replacing it with a comprehensive, high-quality and integrated care management system that will lower costs and improve health outcomes.”¹

Effective October 2011, this “care management for all” approach involved a departure from FFS in Medicaid pharmacy. Tens of millions of annual Medicaid prescriptions have migrated to MCOs which now manage prescription drugs as part of the overall budget.

Manufacturer Rebates Equalized for Fee-for-Service and MCOs

The passage of the Affordable Care Act (ACA) in 2010 allowed states to collect statutory manufacturer rebates on prescriptions reimbursed by capitated Medicaid MCOs. Before this, many state Medicaid programs continued to use a FFS pharmacy benefit approach out of fear of losing access to those rebates. Since 2010, many states have revisited the idea of modernizing pharmacy benefits in the direction of more comprehensive management and stronger integration with other Medicaid covered services.

¹ “A Plan to Transform the Empire State’s Medicaid Program: Better Care, Better Health, Lower Costs – Multi-Year Action Plan,” New York State Department of Health, 2011.

III. Large, Immediate, and Higher-than-Expected Savings Have Occurred

Initial-Year Savings of \$425 Million

The October 2011 switch to an integrated pharmacy benefit management carve-in approach has yielded immediate financial savings to New York's Medicaid program and to taxpayers:

- SNCS estimates \$425 million in CY2012 savings from integrated pharmacy benefit management for New York's managed Medicaid enrollees.
- SNCS estimates that the federal government will save more than \$212 million in 2012 from switching to a PBM approach.
- The integrated, carve-in approach to pharmacy benefits has reduced baseline prescription costs for New York's Medicaid MCO enrollees by 15.4%.
- First-year savings from carving in pharmacy benefits are approximately four times the amount New York's DOH originally estimated.

These savings are equally shared by New York and the federal government due to the state's 50% Federal matching rate for Medicaid. DOH previously estimated savings of \$50 million in state funds from the carve-in. These savings occur in four main areas:

Savings Area #1: Greater use of Generics and Lower Cost Brand Medications

Medicaid MCOs and PBMs substantially increase the use of more affordable generics. For every percentage point increase in the generic dispensing rate (GDR), prescription drug expenditures typically fall by 1-2 percentage points. SNCS projects that Medicaid MCOs will increase the GDR from 79% under the FFS carve-out model to 84% under the integrated carve-in model.

MCOs also encourage the use of more affordable brands when generics are not available to address the significant price variation among different brand medications that treat the same condition. Likewise, competing generic medications also have considerable price variation. PBM and MCO management of the mix of drugs accounts for the vast majority of the total \$425 million in projected Year 1 savings for the carve-in program.

Savings Area #2: Stop Paying Drugstores Higher Dispensing Fees than Medicare and Private Insurers Do

While New York Medicaid's fee-for-service pharmacy dispensing fee had been administratively set by the State at \$3.50 per prescription, Medicaid MCOs typically pay dispensing fees of approximately \$1.75 as occurs with employer-sponsored plans and Medicare Part D plans.

Savings Area #3: Reduce Fraud, Waste, and Abuse

Medicaid serves population subgroups that are particularly vulnerable to fraud, waste, and abuse in a FFS delivery model.

Medicaid MCOs identify enrollees who obtain pain medications from multiple prescribers or repeatedly claim that medications have been "lost or stolen." MCOs monitor these situations and limit days supply and/or impose other benefits management techniques in such situations.

SNCS estimates that New York's transition to an integrated pharmacy benefit will produce a 0.5% reduction in prescriptions that involve inappropriate utilization, fraud, waste, or abuse.

Savings Area #4: Potential Savings with Preferred Pharmacy Networks and Mail-Service Pharmacy

New York Medicaid MCOs/PBMs have generally contracted with the vast majority of Medicaid participating pharmacies in their service areas. They have not yet moved toward pharmacy networks in order to reduce costs, as MCOs typically do with hospitals, physicians, and other provider networks.

With competition among pharmacies intensifying in recent years, many payers—including large employers, Medicare, and Tricare—are now using pharmacy networks in a variety of forms that reduce pharmacy costs.²

In Medicare, seven Medicare Part D prescription drug plans (PDP) include lower-cost pharmacy network options. Enrollment in these plans is growing twice as fast as overall Part D enrollment.³ In Tricare, the Department of Defense has also recently implemented a preferred pharmacy network. Medicare's pharmacy access standards are based on those used by Tricare.

² "As Pharmacy Networks Slim Down, Payers Have a Lot to Chew On," *Drug Benefit News*, June 2012.

³ "Humana-Wal-Mart Preferred Network Plan Wins Big in Part D," *Drug Channels*, August, 2012.

In Florida, the state Medicaid program requires managed health plans to establish networks that include one licensed pharmacy per every 2,500 beneficiaries.⁴ With more than 4,000 pharmacies⁵ serving less than 4 million⁶ enrollees in Florida, such a standard allows for the implementation of high performance networks, although the Florida Pharmacist's Association has sued the state in an attempt to block such networks.⁷

Mail-service pharmacies save an average 15% relative to the same-sized prescriptions filled at drugstores by reducing ingredient costs and eliminating dispensing fees.⁸

Many assume that mail-service pharmacies cannot be effective in Medicaid because of the short-term eligibility of many beneficiaries, the risks that impoverished beneficiaries have unstable housing and unreliable mailboxes, and state-imposed limits on days' supply. However, many Medicaid prescriptions can be provided steadily to those with stable eligibility and addresses. Despite this fact, mail-service pharmacy has been used sparingly in New York Medicaid.

⁴Florida Agency for Health Care Administration, "2012 - 2015 Health Plan Model Contract Attachment II-Core Contract Provisions," page 137 of 258, posted 8-30-2012 effective 0-01-2012.

⁵"2011-2012 Chain Pharmacy Industry Profile," National Association of Chain Drug Stores, 2011.

⁶"Medicaid Enrollment: June 2011 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured, June 2012.

⁷"Pharmacies Sue State over Medicaid HMO Plan," *The Palm Beach Post*, July 26, 2012.

⁸ "Pharmacies Will Save \$46.6 Billion Over the Next Decade and the Cost of Proposed Restrictions," Visante, February, 2012.

IV. New York Medicaid Reform Implementation

Detailed Planning Facilitated Transition to Integrated Pharmacy Benefits

New York's Department of Health (DOH) was responsible for implementing the transition of the Medicaid pharmacy benefit from a carve-out approach to the carve-in model. The carve-in became effective in New York in October 2011 and the planning/implementation effort was compressed into roughly a six month timeframe.

Initially, DOH commissioned a Medicaid Redesign Team to evaluate and propose recommendations for comprehensive fee-for-service pharmacy reform. DOH accepted and enacted a series of recommendations related to preferred drug lists, pharmacy reimbursements, and manufacturer rebates.

Each Medicaid MCO was required to prepare a comprehensive transition plan to ensure a smooth transition of benefits for enrollees to the managed care plan. The transition plans were to be designed to minimize the potential impacts on beneficiaries, providers, and prescribers during the implementation phase. Within each plan, an analysis of formulary coverage, pharmacy access, beneficiary and provider notifications, and strategies for special needs populations was included.

Following DOH approval of the plans, the MCOs notified enrollees and providers of the impact of the pharmacy carve-in reform. Notification occurred one month prior to the implementation phase. Additionally, the MCOs were required to establish a call center to receive questions from enrollees and providers, as well as to conduct outreach to providers.

Better Data Promises to Improve Care Coordination

Prior to the carve-in, there was a three to six month delay between the pharmacy point of service for the enrollee and the point at which DOH reported the pharmacy data to the health plan. The significant time lag inhibited MCOs' efforts to deliver comprehensive care coordination to their enrollees. Since the carve-in implementation, health plans receive more detailed and timely pharmacy data that allows them to provide highly integrated care in 'real-time'.

Ensuring Access to Specialty Medications

To ensure that specialty medications provided via the mail are reaching members consistently, MCOs have worked closely with DOH and other stakeholders. Prior to the carve-in, health plans offered prescription mail order or retail pickup at the discretion of the enrollee; however, health plans could not restrict enrollees to mail-order only. During the initial transition period of the carve-in, health plans developed their own specialty formularies and could designate drugs on the formulary as mail-order only. Because the specialty formularies were not in statute and differed among plans, DOH

compiled a list of 454 specialty drugs from all the health plans and established criteria for a statewide formulary, which was reduced to approximately 400 designated specialty drugs. While not all health plans utilize mail order for specialty pharmacy, nor are they required to, all drugs on the uniform list are available for mail order if the plan offers the option. The implementation of this policy took effect on October 7, 2012.

Addressing Patient Transition Concerns

The carve-in approach has been closely watched by various stakeholders including patient advocate organizations striving to ensure that Medicaid beneficiaries receive access to the benefits/coverage to which they are entitled. While some consumer advocates expressed concern about the overall transition period and disruptions in access to drugs, the data collected has not mirrored their complaints. Plans were surveyed during the transition period on their experience with prior authorization of drugs. Overall, health plans reported that only 1% of drugs required prior authorization. Of the 1%, two-thirds of these drugs were being filled with prior authorization, and only one-third of these drugs were being denied. In response to complaints from the mental health advocate community, the New York Office of Mental Health engaged health plans and mental health consumer advocates in a work group to identify barriers to prescription benefits.

Physicians Adjusting to New Formularies

The carve-in model forces New York's physician community to work with an array of Medicaid MCOs who have different formularies and pharmacy benefits management programs, whereas under the carve-out model the physician community worked only with one payer for all Medicaid prescriptions. While this creates more complex administrative dynamics for some providers, most physicians are accustomed to working with a wide range of health plans, PBMs, and pharmacies across their full panel of Medicaid and non-Medicaid patients. Additionally, many physicians were already working with the Medicaid MCOs on pharmacy-related issues for their non-Medicaid patients (Child Health Plus, Medicare, and/or commercial) enrolled in those health plans.

V. Methodology

The Pharmaceutical Care Management Association (PCMA) engaged Special Needs Consulting Services (SNCS) to analyze the initial financial and programmatic impacts of New York's change to a carve-in PBM approach. To conduct this assessment, SNCS conducted the following tasks:

- **Quantitative Data Collection:** SNCS downloaded and worked with CMS data on Medicaid pharmacy usage and costs from two data sources, MSIS data files and State Drug Utilization Data files. This information was used to establish a baseline volume of Medicaid prescriptions, costs per prescription, and the brand/generic mix of these prescriptions. Finally, data reported by the New York Department of Health comparing the first three months of the carve-in to the last three months of the carve-out was used to validate the model.
- **Qualitative Data Collection:** SNCS conducted a series of interviews with Medicaid MCO executives and DOH staff to obtain information on the transition of the pharmacy benefit to MCOs/PBMs

SNCS downloaded and worked with CMS data on Medicaid pharmacy usage and costs from two data sources, MSIS data files and State Drug Utilization Data files. The latter source was used to establish a quarterly baseline volume of Medicaid prescriptions, costs per prescription, and the brand/generic mix of these prescriptions. MSIS data were tabulated as a secondary source to confirm the validity of the overall annual costs and number of prescriptions. The known quarterly costs from the State Drug Utilization Data were trended to 2012 based on the observed changes from 2010 to 2011. Average ingredient rebates are estimated to be 50% on brand drugs and 15% on generic prescriptions.

SNCS estimated savings for 2012 are \$425 million, representing all funds (\$212.5 million in state funds). The SNCS carve-in estimate constitutes a 15.4% reduction in net costs for MCO enrollees' prescriptions relative to the carve-out setting. SNCS derived these savings by estimating impacts for each of the following factors:

- **Drug Mix:** DOH has provided the MCOs with historical FFS pharmacy claims files on their currently enrolled members. MCOs have therefore been able to conduct comparisons with the FFS experience of their own members. Based on data reported by DOH and interviews with MCOs, SNCS projected an average generic dispensing rate of 83.6% for 2012 for the MCOs under the integrated carve-in model, five percentage points above the baseline figure of 78.6% under the FFS carve-out model. SNCS also estimates that the average unit cost of medications with brands – as well as within generics – is being reduced by ten percentage points due to drug mix impacts.

- **Prescription Volume:** In comparing their per member per month (PMPM) prescription volume with PMPM data for Medicaid FFS during the carve-out years, New York MCOs interviewed for this study have not yet discerned a substantial volume differential during the first months of the integrated model. Based on the experience in other states, however, SNCS has assumed a 0.5% prescription volume will likely occur in the carve-in setting.
- **Dispensing Fees:** New York's Medicaid dispensing fee is \$3.50 for both brand and generic medications. New York Medicaid MCOs indicated that their dispensing fees were negotiated by their PBMs and that these amounts were often consistent across all MCO lines of business (commercial, Medicare, and Medicaid) in a range of \$1.50 - \$2.00. SNCS is estimating an average Medicaid MCO dispensing fee of \$1.75 in modeling the cost impacts of New York's carve-in.
- **Ingredient Costs:** New York's Medicaid ingredient cost for brand drugs is Average Wholesale Price (AWP) minus 17%, a favorable legislatively-determined rate. The MCOs and their PBMs were generally viewed as negotiating a slightly smaller discount. The MCOs did not expect that any meaningful price difference exists for generic drugs (between Medicaid FFS and what their PBMs negotiate). Most payers (including DOH) base their payments for generics off the Maximum Allowable Cost (MAC) schedule. SNCS incorporated these unit pricing assumptions in our model.
- **Administrative Costs:** The costs of administering the pharmacy benefit have been largely transferred from DOH under the carve-out model to MCOs under the carve-in. While some added administrative costs are needed to implement the more comprehensive pharmacy benefits management programs the PBMs/MCOs deliver, SNCS views these added administrative costs to be minor. SNCS has assumed that added state payments to MCOs for their services related to the pharmacy carve-in will total 2% of the net amounts paid for pharmacy services under the carve-in model, largely offset by the reduced administrative costs DOH experiences. Other MCO direct costs, such as hiring new care coordination staff to oversee the PBM and to better integrate the pharmacy benefits with the medical benefits, are not likely to be significant. Most Medicaid MCOs were already using the pharmacy data provided by DOH to support their care coordination efforts, and most had a pharmacy director in place because they operate other lines of business (e.g., Child Health Plus, Medicare, and commercial) that use a pharmacy carve-in model.

After factoring in an allocation for MCO administrative costs related to the increased pharmacy benefits management efforts that occur under the carve-in and a risk margin payment to MCOs (to acknowledge that they are now being placed at financial risk for the pharmacy benefit), SNCS estimates a net savings from the carve-in of 15.4% in CY2012 due to the carve-in approach. This estimate is consistent with the early experience reported by the Medicaid MCOs to date.

Based on data released by New York DOH, there has been an overall 19.3% reduction in the reported per member per month (PMPM) cost during the first three months of the integrated, carve-in pharmacy benefit. The total Medicaid paid amount decreased from \$846 million to \$696 million. The savings were driven by changes in the drug mix; average cost per prescription dropped 21.7% from \$76.53 in the final carve-out months to \$59.93 in the initial carve-in months. There was also a slight increase in the utilization from 1.09 to 1.13 prescriptions per member per month.