

Study on the Financial Implications of a Pharmacy Carve-Out on the Maryland HealthChoice Program

INTRODUCTION

Fiscal year 2007 budget language requires the Department of Health and Mental Hygiene (the Department) to study the potential savings from carving-out prescriptions drugs from HealthChoice, Maryland’s statewide Medicaid managed care program. The Department gathered information from both its fee-for-service (FFS) program and HealthChoice program. Our evaluation methodology and findings are described below.

EVALUATION AND FINDINGS

This review only looked at the financial cost of providing pharmacy services. As such, the cost of providing pharmacy services was slightly less in the FFS program. However, this review did not consider other factors – including the direct and indirect costs on other services provided by the MCO or the affect on quality of care by carving-out pharmacy services from the MCO.

While the HealthChoice and FFS program provide services to disabled individuals with similar diagnoses, children and families remain the majority of the HealthChoice population. This factor makes it difficult to directly compare HealthChoice and FFS. Moreover, the indirect costs of a carve-out are difficult to quantify but have the potential to negatively impact costs and quality. We address direct and indirect costs and their implications in greater detail below.

Direct Costs

A) Comparison of *unit cost* of prescription drugs under fee-for-service vs. managed care

Description of Methodology

The Department collects total pharmacy costs from the MCOs on an annual basis. In order to better understand the MCOs’ unit costs, however, the Department needed to look at the following components: ingredient costs, dispensing fees, and all rebates. To obtain this information, a survey of all the MCOs regarding the National Drug Codes (NDC) most utilized (in terms of dollars spent) by HealthChoice enrollees was performed in the spring of 2006. DHMH completed the survey based on its FFS costs as well. The survey was divided into two sections: one for adults and one for children. The data provided by the MCOs (and the State) were prepared in the following format:

Section I: Prices of Top 50 NDCs (Dollars Spent) for HealthChoice Adults*

NDC	Ingredient Cost/Script	Dispensing Fee/Script	Gross Price	Total Rebate	Net Price
Code # 1					
Code # 50					

*Average price of scripts for services provided 1/1/05 – 6/30/05. Section II was provided in the same format for children under the age of 21.

For adults in HealthChoice, the top 50 NDCs reflected approximately 43 percent of the total pharmacy dollars. For children under 21, the top 50 NDCs reflected about 53 percent of the overall pharmacy dollars. To calculate the MCO aggregate price of each NDC, the price information provided by each MCO was calculated by each MCO's pharmacy encounters for service months January through June 2005. To calculate overall MCO aggregate prices of each component category, the aggregate calculated pharmacy dollars were divided by the overall number of scripts. To calculate the adult aggregate prices, approximately 132,000 encounters were used. For children, approximately 82,000 encounter records were used. For comparative purposes the exact same encounters used to calculate the aggregate MCO NDC-level drug prices, and overall prices were also used to calculate the overall FFS prices.

Results

The following two tables summarize the overall results of the pricing study:

Table 1: Overall Aggregate Prices of Top 50 NDCs (Dollars Spent) for HealthChoice Adults*

NDC	Ingredient Cost/Script	Dispensing Fee/Script	Gross Price	Total Rebate	Net Price
MCO Price	\$174.50	\$1.78	\$176.28	\$7.56	\$168.72
DHMH Price	\$158.46	\$2.91	\$161.37	\$45.12	\$116.26
Var.(\$s)	+\$16.04	-\$1.13	+\$14.91	-\$37.54	+\$52.46**

*Average price of scripts for services provided 1/1/05 – 6/30/05. **OOB due to rounding.

Table 2: Overall Aggregate Prices of Top 50 NDCs (Dollars Spent) for HealthChoice Children*

NDC	Ingredient Cost/Script	Dispensing Fee/Script	Gross Price	Total Rebate	Net Price
MCO Price	\$71.20	\$1.78	\$72.98	\$3.85	\$69.14
DHMH Price	\$71.45	\$3.04	\$74.49	\$20.97	\$53.53
Var.(\$s)	-\$0.25	-\$1.26	-\$1.49	-\$17.12	+\$15.61**

*Average price of scripts for services provided 1/1/05 – 6/30/05. **OOB due to rounding.

Clearly, the most significant findings of the pricing survey are the differences in the size of the rebates obtained by the State compared to those achieved by the MCOs. While the MCOs are averaging rebates in the 4 to 5 percent range, State rebates for both adults and children based upon the mix of encounters for these specific NDCs are estimated to be about 28 percent. If the MCOs received rebate levels similar to those in the FFS program, an additional \$50 million would have been generated in savings.

B) Comparison of *utilization* of prescription drugs under FFS vs. managed care

Description of Methodology

In order to determine whether or not the HealthChoice program is better able to manage enrollees' utilization of prescription drugs, DHMH compared enrollees with similar ages (21 to 64 years old) and disability status under both programs over a three-year period (2003-

2005).¹ For this analysis, mental health scripts that are carved-out of HealthChoice were excluded.

Results

There appears to be no material difference between the two programs (see below).

**Table 3: Average Number of Scripts Per Member Month: 2003 – 2005
(HealthChoice Encounters Adjusted for Completeness)**

FFS vs. MC (adjusted)	CY 2003	CY 2004	CY 2005
Dual Eligibles (FFS)	2.75	2.79	2.84
HealthChoice (MC)	2.75	2.75	2.78

Again, Maryland was unable to compare the utilization of children and parents in its FFS and managed care programs. In 2003, The Lewin Group, however, conducted a study that compared five state FFS programs and thirteen Medicaid-focused health plans in ten states. Lewin found that for children and parents the utilization level was 15 and 20 percent lower in the managed care setting.² This means, a pharmacy carve-out could result in additional annual expenditures of approximately \$12 million to \$16 million from increased utilization.

C) Comparison of the *mix* of prescription drugs under FFS vs. managed care

Description of Methodology

The Department used the same enrollee groups described in Section B to evaluate whether or not the HealthChoice program has been more successful at promoting the use of lower-cost drugs (generics). The following table illustrates the percentage makeup of generic and brand-name drugs for the population of adults with disabilities:

Table 4: Mix of Drugs Utilized under FFS and Managed Care: CY 2003 - 2005

FFS vs. MC	Brand/Generic	CY 2003	CY 2004	CY 2005
Dual Eligibles (FFS)	Generic	64.8%	64.3%	63.2%
Dual Eligibles (FFS)	Brand	35.2%	35.7%	36.8%
HealthChoice (MC)	Generic	71.4%	72.0%	72.0%
HealthChoice (MC)	Brand	28.6%	28.0%	28.0%

Results

¹ Specifically, the only eligibility coverage categories that were used for this analysis were S01 (PAA), S02 (SSI), S04 (Pickle Amendment), S05 (Sec. 5103), and S98 (ABD-Medically Needy). These same coverage categories that are part of the HealthChoice-eligible population are also part of the dually-eligible population under FFS. In HealthChoice, there are about 44,000 adults with disabilities. In FFS, there are about 17,500 with these same coverage categories.

² The Lewin Group and Association for Health Center Affiliated Health Plans, *Comparison of Medicaid Pharmacy Costs and Usage between the Fee-For-Service and Capitated Setting* (Center for Health Care Strategies, Inc., January 2003).

The differences in the mix of drugs under managed care and FFS appears to be significant. In 2005, the average FFS cost (before rebates) for generic drugs was about \$27.74; for brand-name drugs it was \$137.06. In applying these unit costs to approximately 1.4 million encounters for adults with disabilities, the MCOs have been able to generate approximately \$13.3 million in savings by using lower-cost drugs. In applying these findings to the entire population, the MCOs saved \$30 million during 2005.

- D) Quantifying the implication of reducing premium tax dollars and federal matching funds due to the lowering of the capitation payments by removing the pharmacy component (taking into consideration the federal matching rates for both the Maryland Children’s Health Program (MCHP) and the non-MCHP populations)

Description of Methodology

The Legislature passed HB 2 during the 2004 Special Session, which required all payers to be subject to a 2 percent tax on their premium revenue starting in 2005. The monies are directed to assist with malpractice reform and to raise Medicaid provider rates. The Department projected members and capitation rates to evaluate the loss in premium revenue to the State.³

Results

Current premium taxes in the 2006 projections are a little over \$36 million. If pharmacy services were carved out of HealthChoice, projected premium taxes would be reduced to about \$32 million, translating to a \$2 million loss in federal matching dollars if pharmacy services were carved out.

- E) Comparison of the impact on administrative costs

A carve-out would also impact (reduction) the non-medical (i.e., administrative) expense components of the MCOs’ capitation as well. The following assumptions were used to illustrate the estimated impact of a pharmacy carve-out on the non-medical components (excluding premium taxes discussed above) of the HealthChoice rates:

<u>Component</u>	<u>Assumptions Used</u>
Medical Management	75% Fixed, 25% Variable
Re-Insurance Administrative	No adjustment
Other Administrative Expense	75% Fixed, 25% Variable
Risk Margin	Non-Hospital % of Total
Profits	HealthChoice Formula
Premium Tax	Discussed in Section “D” above

The 1 percent budget cut was also taken into consideration and reflected as an adjustment to profits (as the MCOs interpret the cut).

³ Those projected member months were applied at the rate cell level.

Results

Using the above assumptions, the following tables reflect the reduction in 2006 payments for the non-medical expense components as well as the increase in the Department's administrative costs to oversee pharmacy services in the FFS program.⁴

Table 5: Estimated Impact on 2006 HealthChoice Non-Medical Expense Rate Components

Admin. Loadings	Rates w/ Rx PMPM	Rates w/o Rx PMPM	Reduction (\$'s in Millions)
Medical Management	\$6.27	\$6.06	\$1.3
Other Admin. Exp.	\$21.32	\$20.61	\$4.3
Risk Margin	\$0.94	\$0.68	\$1.6
Profits (Reduced Budget)	\$0.92	\$0.77	\$0.9
Total			\$8.1

Table 7: Estimated Impact on DHMH's Administrative Costs (Fee-For-Service)

Admin. Loadings			Increase (\$'s in Millions)
Total			\$5.6

The total savings from these components would be approximately \$2.5 million if pharmacy services were carved out of HealthChoice.

Examining just the direct cost component of pharmacy services, our analysis indicates that approximately \$20 million (or approximately 1.1 percent of the total HealthChoice costs) could be saved by carving out pharmacy services from HealthChoice.

Indirect Costs

F) Other Issues to Consider

In 2003, Arizona hired The Lewin Group to evaluate whether or not it was more cost effective to carve out pharmacy services from their managed care program.⁵ The Lewin Group recommended that Arizona not carve-out pharmacy services. Since the analyses, States have been able to negotiate higher rebates. Lewin, however, also identified other quality considerations, including:

⁴ In July 2006, Mercer presented to the MCOs that the overall non-medical expense loadings were 14.9 percent of medical expense. Using the above assumptions and implementing a pharmacy carve-out would increase the overall non-medical expense loadings to 16.1 percent of medical expense (13.9 percent of the overall rate). This would still fall below the CMS 15 percent "rule of thumb."

⁵ The Lewin Group, *Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System* (Center for Health Care Strategies, Inc., November 2003).

- **Disrupting the ability to manage other aspects of health care.** Pharmacy data is used to manage and coordinate enrollees' care. A carve-out could potentially negatively impact the timing and quality of the pharmacy data received by the managed care organizations, causing the State to incur additional costs and enrollees to receive a lower quality of care.
- **Creating additional complexities for enrollees.** Enrollees would now have to contact the State and its contractor on pharmacy issues, while continuing to deal with their managed care organizations for other health care issues.
- **Generating potential cost-shifting incentives.** Under a carve-out, the health plans' incentives could change in a manner that encourages/creates cost-shifting behaviors that would add to the State's costs.

The Department is concerned about the impact of a carve-out on the overall stability of the HealthChoice program. The rates allow for a profit margin of 1.9 percent. Any change that would further reduce these margins could destabilize the program, resulting in access and quality issues.

Additional Comments from the Managed Care Organizations

The Department provided the MCOs with an opportunity to review the data and analyses and to provide comments. Those comments are attached (see Attachments 1-5). In summary, the MCOs that responded expressed significant concerns about carving-out pharmacy services.

Recommendation

In examining the direct-cost component of pharmacy services, our analysis indicates that approximately \$20 million (or approximately 1.1 percent of the total HealthChoice costs) could be saved by carving-out pharmacy services from HealthChoice. However, our position is that pharmacy services should not be carved out from HealthChoice.

We believe that the negative aspects associated with carving-out pharmacy services outweigh the benefits. Pharmacy is only one component of the services managed by the MCOs. Many of the issues identified by Lewin and the MCOs could result in a financial loss to the State, particularly if Maryland experiences a shift in pharmacy utilization for parents and children - which alone could result in additional FFS expenditures of approximately \$12 million to \$16 million. These issues must be taken into consideration before deciding to carve-out pharmacy services. Alternatively, the Department recommends that it continue to explore other options for improving the efficiency of the entire HealthChoice program.