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PHARMACY SAVINGS REPORT

Original February 25, 2019

Amended April 2, 2019

WEST VIRGINIA MEDICAID

Actuarial Assessment of the SFY18 Impact of Carving out Prescription Drugs from Managed Care for West Virginia's Medicaid Program

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Overview & Intended Use

This version of the report is amended as of April 2, 2019. This update corrects the level of Federal financial participation that is applied to the total Medicaid savings for the program. Additional statements of clarification were also provided. No calculation in this report has changed since the original version dated February 25, 2019, aside from the amount of savings to the State of West Virginia due to Federal financial participation.

The West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS) requested that Navigant Consulting, as a subcontractor to The Lewin Group, assess the potential savings that have been achieved during SFY18 (July 1, 2017 – June 30, 2018) due to the carve-out of prescription drug services from West Virginia's Medicaid managed care program.

The information contained in this document was prepared to estimate the cost savings to the State of West Virginia and may not be appropriate for any other purpose. Any user of the information should possess a familiarity with West Virginia's Medicaid program, and a certain level of expertise in pharmacy claim costs, actuarial science, and healthcare modeling is required to avoid misinterpretation of the data presented.

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Caveats

The figures presented rely heavily on data received from DXC and are only appropriate insofar as the base data is credible. Additionally, note that about 10% of claims in either the SFY17 or the SFY18 periods were unable to be priced under the NADAC repricing step. For those claims, the unit cost was assumed to be the same under both a FFS/MCO scenario and NADAC. These figures represent Navigant's best estimate of cost savings to the State at the time of this report.

Furthermore, additional considerations could be made such as risk adjusting different periods to ensure the same level of acuity. This would be a practical method to ensure equivalence between populations of different time periods, with respect to the underlying risk that is changing between those time periods. At the time of this analysis, a risk adjustment model was not able to be run on the data due to the time needed to consider such an adjustment, so this was excluded from the modeling of savings.

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Executive Summary

BMS requested that Navigant Consulting, as a subcontractor to The Lewin Group, assess the potential savings that have been achieved during SFY18 (July 1, 2017 – June 30, 2018) due to the carve-out of prescription drug services from West Virginia's Medicaid managed care program.

Navigant took a prescribed approach by repricing both SFY18 and SFY17 pharmacy claims to the unit cost rates from the National Average Drug Acquisition Cost (NADAC) fee schedule to appropriately compare the two years of data. Navigant also adjusted the SFY18 fee-for-service (FFS) experience to reflect how claims would be reimbursed under managed care. A comprehensive review of pricing in SFY18 along with managed care experience prior to SFY17 suggests that the current FFS arrangement is more cost effective than the prior managed care arrangement, even though actual FFS costs in SFY18 were significantly higher than managed care experience in SFY17 even after accounting for trend and membership differences. Additionally, it is our understanding that the drastically higher dispensing fees present in SFY2018 are a result of mandated CMS rule and not necessarily a byproduct of carving pharmacy benefits out of managed care. More detail on this conclusion is provided in this report.

Additionally, administrative expenses must be factored into savings estimates. Due to significant MCO administrative burden and taxes and fees, such as the Health Insurance Provider Fee (HIF), the State ended up saving money on pharmacy due to the carve-out. In total, our actuarial estimate suggests savings of $54,450,000 in SFY18 to the West Virginia Medicaid program. We estimate that 89.27%[1] of West Virginia's Medicaid prescription drug costs for this analysis are paid by Federal funds due to Federal Medical Assistance Percentage (FMAP) based on the blend of different match rates across populations, as well as State administered costs. This produces a savings to the State's budget of approximately $5,840,000. We consider these savings estimates conservative and note that this estimate is a baseline and that different assumptions and scenarios result in different figures. Alternative scenarios resulted in higher levels of savings and could be outlined further in an expanded analysis that breaks this down by population. Additionally, we note that additional analysis could be performed to explain what caused this counterintuitive result, as managed care typically can be expected to result in lower costs than FFS arrangements.

Additional details on how these savings are determined can be found below. Note that these savings were also determined by examining the claims and administrative expenses and repricing the claims. Actual pharmacy claim costs increased significantly from SFY17 to SFY18, with much of this being attributable to significantly higher dispensing fees as well as greater volume of claims. However, it is important to note that year-to-year pharmacy costs under managed care varied significantly in the years leading up to the carve out in SFY18. For instance, the use of SFY15 base data to project manage care expenses that would have occurred in SFY18 results in higher projected managed care claim costs than FFS in SFY18. Therefore, it is important for the State to recognize that experience will vary year-to-year and that proper utilization controls, especially for new pipeline drugs, will be necessary to manage and maintain savings.

[1] FMAP percentage revised as of April 2, 2019

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Overview of Methodology

As of July 1, 2017, pharmacy services were shifted from managed care to a FFS reimbursement structure. This memo describes how Navigant determined the SFY18 fiscal impact of implementing the carve-out pharmacy services to West Virginia's Medicaid program and summarizes the savings and important considerations for the State.

Navigant took the following steps to calculate these savings:

1. Reprice both SFY17 managed care and SFY18 FFS experience to NADAC rates to establish baseline comparison of costs, adjust for dispensing fees, and calculate difference in expected claim costs as of SFY18.
2. Analyze differences in administrative costs covered by the State under both managed care and FFS reimbursement arrangements.
3. Forecast SFY18 managed care claim costs, as if managed care was still in place, using actual SFY17 experience as the base data.
4. Ensure all base expenses and projections have appropriate exclusions for drugs that were not covered by MCOs in SFY17 or FFS in SFY18.

Step 1

Navigant reviewed the State's drug costs in SFY18 and compared the effective rates to NADAC rates for individual drugs to determine the percentage of NADAC the State was paying for prescription drugs. A similar exercise was done for the MCOs' SFY17 experience, even though they were not originally indexed to NADAC. Then, total claim costs in SFY18 were repriced to model SFY18 experience under managed care. To do this, Navigant removed the dispensing fees and repriced the FFS claims to the average MCO reimbursement using NADAC as the index. The MCO dispensing fee pricing was then added back to show the SFY18 amount under MCO pricing. This total repricing difference is shown below in Table 1.

Step 2

Navigant examined administrative expense fees under managed care (capitation admin amount and HIF) compared to FFS (DXC, State, and additional vendor fees). This can be found at the bottom of both Tables 1 and 2. This administrative cost difference combined with the repricing difference results in a total likely savings shown in Table 3.

Step 3

Separately from the calculations made above, managed care claim costs from SFY17 were projected forward using trends by therapeutic class, as sourced from Express Scripts. These claim costs, projected into SFY18, were used for comparison to the implied savings from the repricing exercise.

Step 4

Drugs not covered by MCOs in SFY17 or FFS in SFY18 were excluded from this analysis. This includes Hepatitis-C and hemophiliac drugs, as well as Spinraza.

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Summary Analysis

As described in the methodology, managed care costs for SFY17 were compared to SFY18 both for claims and administrative expenses.

Analyzing Claims

The steps described in the methodology for repricing FFS SFY18 experience to what it would have been under managed care comprises the claims component of our comparison, shown below in Table 1. From this, it can be observed that repricing to managed care shows that FFS costs are slightly higher (about $2.5m) than managed care for just the claims component. Note that the figures, such as the percentages, are rounded for presentation purposes.

Table 1

CLAIM COST DIFFERENCES		
SFY18 FFS Rx Claim Cost for MCO members	(a)	$569,774,383
Dispensing fees	(b)	$122,511,975
SFY18 Claim Cost w/o dispensing fees	(c) = (a) - (b)	$447,262,407
MCO as % of FFS compared to NADAC	(d)	125.14%
SFY18 FFS Rx Claim Cost for MCO members adj. for NADAC	(e) = (c) * (d)	$559,722,448
MCO Dispensing Fees % of Base Claims	(f)	1.4%
SFY18 Rx Claim Cost (w/MCO pricing)	(g) = (e) * [1 + (f)]	$567,288,359
Claim cost difference due to repricing	**(h) = (a) - (g)**	**$2,486,024**

In Table 1, line item (a) represents the total FFS pharmacy experience for MCO members during SFY18. It should be noted that differences in member mix among populations, notably SSI and West Virginia Health Bridge (ACA Expansion), will occur year-to-year, especially between SFY17 and SFY18 as some populations were still relatively new to managed care. Line item (d) is a ratio of NADAC-based pricing for both the respective time periods (MCO experience for SFY17 and FFS experience for SFY18) while also accounting for differences in population mix.

For NADAC pricing, Navigant applied the NADAC price based on the date of service on the claim and matched that with the applicable effective date range from the NADAC schedules.

Analyzing Administrative Expenses

Administrative expenses differ significantly between managed care and FFS. Under managed care, the administrative expenses paid to the MCOs exceeded 10% of the pharmacy costs in aggregate. In addition, we note that taxes and fees (such as the HIF) do not need to be paid under the FFS arrangement. The figures from SFY17 were grossed up to SFY18 to account for both change in membership as well as pharmacy utilization and unit cost changes. This results in $66.8m paid in MCO admin expenses compared to $9.9m paid in State admin expenses under FFS. This can be shown below in Table 2.

Table 2

ADMINISTRATIVE COST DIFFERENCES		
SFY17 MCO Rx Admin	(i)	$49,995,426
Annual HIF Amount	(j)	$11,362,597
Annual Rx Trend Factor	(k)	1.089
Grosses up for SFY18 (Total Trend)	(l) = [(i) + (j)] * (k)	$66,829,253
SFY18 DXC Rx admin expense for MCO members	(m)	$8,943,624
BMS extra staffing and vendor costs	(n)	$950,739
SFY18 FFS Rx admin for MCO members	(o) = (m) + (n)	$9,894,363
Administrative cost difference	**(p) = (o) - (l)**	**($56,934,890)**

The administrative expense used in line item (i) is based on the SFY17 MCO capitation rates and the effective administrative load applied to the rates and therefore the pharmacy portion of those rates. Navigant recognizes this amount could vary based on a more isolated analysis of expected administrative spend for standalone pharmacy managed care rates and the impact of spread pricing. The annual HIF amount may also vary year-to-year due to moratorium statuses. This analysis assumes the HIF is in place moving forward and that the HIF amount allocated to West Virginia MCOs would be adjusted to reflect the lower base premiums, net of the pharmacy carve-out. Additionally, line item (k) represents an annual pharmacy trend of 8.9%. This is designed to also include member mix change between SFY17 and SFY18.

Total Difference

The difference between the FFS experience, repriced as if it were managed care pricing, leads to the following table. This includes cost differentials both for claim cost repricing as well as administrative expenses for the State.

Table 3

Carve-out Net Cost/(Savings) Impact		
Claim cost difference due to repricing	(h)	$2,486,024
Admin cost difference	(p)	($56,934,890)
Total	(q) = (h) + (p)	**($54,448,866)**

Observations & Considerations

This analysis indicates that the bulk of the savings are due to administrative costs. Appropriate control of utilization will continue to be required over time to maintain achieved savings.

Merely projecting SFY17 MCO experience to SFY18 shows a potential claim cost differential of $54.4m, which would remove much of the potential savings as shown above in Table 3. However, when Navigant examined past data periods, it appears that MCO experience in SFY17 may have been suppressed and therefore lower than expected. With that said, the change in population mix could be further examined on how these aggregate experience amounts should be projected forward, rather than using a simple trend amount. Navigant compared the SFY17 and SFY18 data SFY15 data summaries from the State, which showed a similar level of experience, after adjusting for excluded drugs and despite being two years older. As shown in Table 4, forecasting with older data in SFY15 shows that projected SFY18 managed care spend is closer to actual SFY18 FFS spend. In this case, it is in the best interest of the actuary to look at multiple base periods to have a more reasonable projection of future experience. Note that SFY16 experience is not referenced only because a validated data set, either from an actuarial rate certification or MCO attestation, was not readily available at the time of the analysis.

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Table 4

Pharmacy Claim Expenses for Populations Impacted by Carve-out	
SFY15 Experience (used in base data for SFY17 rates)	$474,124,543
SFY17 Experience (from overall MCO financials collected for SFY20 rate development)	$475,724,437
Projected SFY18 (from SFY17)	$518,144,282
Projected SFY18 (from SFY15)	$560,616,509
Projected SFY18 (average SFY15/17)	$539,360,489
Actual SFY18 (FFS)	$569,774,383

As seen in Table 4, differences in claim expenses vary from $9.2m (Projection from SFY15 data) to $51.6m (Projection from SFY17), independent of NADAC-based repricing. In both cases, the State of West Virginia appears to be saving money in large part due to the differences in administrative expenses. It is critical that multiple years of data be considered for a projection rather than just relying on the most recent year of managed care experience (SFY17). This brings greater credibility to the projection rather and smooths out year-to-year volatility in experience.

Additional factors that could be considered in this analysis but are not subject to the savings estimate include rebates, changes in the State's preferred drug list (PDL), and pharmacy benefit changes:

Rebates

Rebates do not play a factor in the savings. These are received by the State directly from manufacturers. Excluding physician-administered drugs (which are still part of the managed care claims), total rebates invoiced for all members increased from $417.6m in SFY17 to $423.2m in SFY18.

Preferred Drug List (PDL)

While numerous changes have been made to the State's PDL, Navigant recognizes that these would be savings the State has achieved independent of the shift from managed care to FFS. These changed have not been fully calculated but the drugs covered by these PDL changes are likely a small fraction of overall expenses.

Exclusions from Analysis

BMS has overseen several other benefit changes. These have included carve-outs of hemophiliac and Hepatitis-C drugs. These drugs have been appropriately excluded from this analysis.

Point-of-Sale vs. Outpatient Setting

Over the past couple years, there has been a nationwide trend with greater utilization of

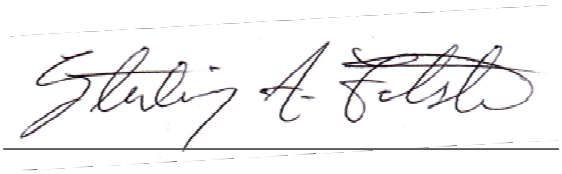
high cost outpatient drugs. This analysis only examines drugs covered by the prescription drug benefit (point-of-sale drugs) and does not include outpatient administered drugs that would still be covered by the MCOs through a hospital setting.

State Economic Impact

This analysis is not intended to address the economic advantage to the State resulting from the carve-out, notably that State-based pharmacies are receiving more revenue rather than being spread out across national networks.

Additional statistical observations of the data can be found in Appendix A. Note that breakouts by category of aid do not show material differences in impacts on utilization and savings.

Sincerely,



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Appendix A – Statistical Observations

Navigant made the following observations regarding the data received from the State for both managed care experience in SFY17 and FFS experience in SFY18.

The average dispensing fee in SFY17 under managed care (through the PMCs the MCOs used) was $0.59 per script. In SFY18 under FFS this was increased to $10.49 per script, resulting in total dispensing fees of $122.5m in SFY18. In the FFS model, dispensing fees are based on the actual costs of a pharmacy to dispense a prescription. Dispensing fees increased for one primary reason. In February 2016, CMS required states to submit state plan amendments for reimbursement changes to outpatient pharmacies in the Covered Outpatient Drug final rule. CMS required reimbursement to pharmacies at aggregate actual acquisition cost with a cost-based dispensing fee. West Virginia was able to utilize the cost-to dispense study conducted by the state of Ohio, and the resulting $10.49 dispensing fee and other reimbursement was approved by CMS and implemented before the July 1, 2017 carve-out. The National Average Drug Acquisition Cost (NADAC) survey was chosen as the actual drug cost used to reimburse pharmacies.

A table for the top five therapeutic classes, in terms of dispensing fee percentage of drug cost, is shown as follows.

Table 5

Rank	Therapeutic Class	Dispensing Fee as % of Rx Class Costs	Dispensing Fee Expense
1	Pain	66.0%	$4,317,155
2	Depression	54.7%	$10,008,232
3	High Blood Pressure/Heart Disease	43.7%	$15,282,524
4	Ulcer Disease	40.5%	$5,093,266
5	Flu	38.0%	$192,533

Additionally, there are insights that can be gained by examining percentage of total spend by therapeutic class. Because savings calculations either involve older summary data that is not broken down by class or rely on NADAC repricing where about 10% of drugs are not allocated, savings estimates cannot be allocated at this level. Total pharmacy costs from claims for managed care members by therapeutic class for both FFS (SFY18) and managed care (SFY17) is found on the next page in Table 6.

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Table 6

Therapeutic Class	FFS % of Spend (SFY18)	MCO % of Spend (SFY17)	Change in Distribution
Asthma	10.0%	10.1%	-0.1%
Attention Disorders	6.0%	7.3%	-1.3%
Chemical Dependence	8.1%	7.4%	0.7%
Contraceptives	1.3%	1.0%	0.3%
Cystic Fibrosis	0.5%	0.4%	0.1%
Depression	2.1%	2.1%	0.0%
Diabetes	11.9%	12.5%	-0.7%
EpiPen (split out as own class)	0.3%	0.7%	-0.4%
Flu	0.1%	0.0%	0.0%
Growth Deficiency	1.0%	1.0%	0.0%
Hereditary Angioedema	0.4%	0.5%	-0.1%
High Blood Cholesterol	1.5%	1.7%	-0.2%
High Blood Pressure/Heart Disease	3.9%	3.6%	0.3%
HIV	2.0%	2.0%	0.0%
Infections	5.3%	4.9%	0.3%
Inflammatory Conditions	6.5%	6.3%	0.3%
Mental/Neurological Disorders	4.5%	5.6%	-1.1%
Miscellaneous Specialty Conditions	0.0%	0.0%	0.0%
Multiple Sclerosis	2.3%	2.8%	-0.5%
Oncology	2.1%	2.1%	-0.1%
Other (Mental Health Related)	0.9%	0.9%	0.0%
Other (Not Mental Health Related)	19.3%	18.5%	0.8%
Pain	0.7%	0.6%	0.2%
Progestational Agents	0.0%	0.0%	0.0%
Pulmonary Arterial Hypertension	0.3%	0.2%	0.1%
Seizures	4.6%	4.2%	0.5%
Transplant	0.1%	0.1%	0.0%
Ulcer Disease	1.5%	1.3%	0.1%
Unclassified	2.5%	1.9%	0.6%
Therapy Class not found	0.3%	0.0%	0.3%