COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

November 27, 2019

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel S. Timberlake
Director, Virginia Department of Planning and Budget

FROM: Karen Kimsey
Director, Department of Medical Assistance Services

SUBJECT: 2019 Report on Pharmacy Program and Design and Fiscal Impact Analysis

Item EE.1. The Department of Medical Assistance Services shall cause its contracted actuary, not later than October 1, 2019, to evaluate and determine the most cost-effective pharmacy benefit delivery model, taking into account cost savings and other considerations such as clinical benefits, for all programs managed or directed by the department. In determining cost savings for each model considered, the actuary shall consider factors including rebates captured by the Commonwealth, decreased capitation rates, drug ingredient costs, generic drug dispensing, dispensing fees, drug utilization, and a single drug formulary (including the existing Common Core Formulary). The department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2019.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/
Enclosure
pc: The Honorable Daniel Carey, MD, Secretary of Health and Human Resources

READY FOR NEXT. TOGETHER.

PHARMACY PROGRAM DESIGN AND FISCAL IMPACT ANALYSIS

FINAL REPORT

NOVEMBER 26, 2019

Virginia Department of Medical Assistance Services

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1
EXECUTIVE SUMMARY

The pharmacy benefit is an important and growing portion of Medicaid costs and many states are exploring new and innovative options to address the rising cost of prescription drugs, reimbursement to pharmacy providers and the cost of pharmacy benefit management over time. Pharmacy Benefit Management (PBM) revenue streams have historically been challenging for managed care organizations (MCOs) or Medicaid programs to quantify and monitor. As a result, many Medicaid programs are exploring or implementing new pharmacy program design models that incorporate increased transparency of PBM revenues, financial terms, pharmacy reimbursement requirements and administrative costs and are working to identify methods to monitor and track the impact that PBM revenues and administrative costs have on total drug costs to the Medicaid program. The Virginia Department of Medical Assistance Services (DMAS) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct a pharmacy program evaluation and fiscal impact analysis of three pharmacy program design models identified by the Virginia General Assembly. The three models included:

1. Mandatory Pass-Through Pricing (Transparent Pharmacy Program Design model) — In a mandatory pass-through pricing program design:

    A. The subcontracted PBM is required to charge the MCO the same amount for a prescription as is paid to the pharmacy provider.

    B. The PBM is required to pass-through 100% of rebates collected from drug manufacturers to the MCO.

    C. The PBM may continue to pay pharmacies based on a negotiated contractual rate.

    D. The PBM earns revenue to fund administrative operations through a transparent mechanism such as a per claim or per member administrative fee.

2. Pharmacy Benefit Carve-Out (Carve-Out model) — In a full pharmacy benefit carve-out program design:

A. All pharmacy services are carved-out of the Medicaid managed care program and would be administered directly by DMAS, its contracted fiscal agent or a DMAS selected pharmacy benefits administrator (PBA).

B. The Commonwealth of Virginia (Commonwealth) has the flexibility to decide which components of pharmacy management would be performed internally with DMAS staff and, which would be outsourced to vendors with expertise.

3. State Mandated Pharmacy Provider Reimbursement (State Mandated Reimbursement model) — In the state mandated pharmacy provider reimbursement program design:

A. MCO contracts would include a clause requiring the MCO's PBM to pay the enrolled pharmacies using the same methodology as the DMAS fee-for-service (FFS) program.

B. The MCOs would remain at risk for the pharmacy benefit and could continue to contract with the MCOs using any contractual administrative fee model (including spread or pass-through).

The objectives of the project included:

- Quantitative Analysis: Completion of an actuarial analysis of the potential fiscal impact of each of the three identified pharmacy program design models.

- Qualitative Analysis: Identification of the advantages, challenges and other considerations associated with the selection of each pharmacy design model, including the projected operational impact to DMAS functions, staff requirements and oversight activities.

POTENTIAL FISCAL IMPACT

Mercer summarized the results of the actuarial analysis for State Fiscal Year (SFY) 2019 (July 1, 2018 to June 30, 2019) of the three models in Table 1. Fiscal estimates represent the combined impact to the Virginia Medicaid program during SFY 2019 and are broken out by state and federal funding sources. The fiscal impacts may be larger in future years as the Expansion population becomes fully integrated into the Virginia Medicaid program.

TABLE 1: SUMMARY OF FISCAL IMPACT ANALYSIS

PHARMACY PROGRAM DESIGN MODEL	TIME PERIOD: SFY 2019			
	ESTIMATED TOTAL $ IMPACT (SAVINGS)/ COST	ESTIMATED TOTAL % IMPACT(SAVINGS)/ COST OF OUTPATIENT PHARMACY EXPENDITURES	ESTIMATED TOTAL $ IMPACT (SAVINGS)/COST STATE SHARE	ESTIMATED TOTAL $ IMPACT (SAVINGS)/COST FEDERAL SHARE
Mandatory Pass-Through Pricing	($10,097,000)	-0.9%	($4,026,000)	($6,071,000)
Pharmacy Benefit Carve-Out	($32,048,000)	-2.8%	($13,983,000)	($18,065,000)
State Mandated Pharmacy Reimbursement with Uniform PDL	$20,329,000	1.8%	$7,597,000	$12,732,000
State Mandated Pharmacy Reimbursement without Uniform PDL	$14,643,000	1.3%	$5,404,000	$9,239,000

- Mercer estimates the pharmacy benefit carve-out model could potentially provide the greatest savings opportunity, but it would require the greatest implementation costs and create potential disruption for members, providers and MCOs. The potential disruption could be mitigated with a robust implementation and transition plan.

- The mandatory pass-through pricing model could potentially save the Virginia Medicaid program $10.1 million. However, it is possible that DMAS could achieve similar savings in the capitation rates by applying an administrative efficiency adjustment without mandating adoption of pass-through PBM contracts.

- The State mandated pharmacy reimbursement program design would potentially increase costs to the Virginia Medicaid program by $20.3 million. This model assumes a full Uniform PDL would be adopted. Without a Uniform PDL, the mandated pharmacy reimbursement model would increase total costs to the Virginia Medicaid program by $14.6 million or $5.4 million state share. Mercer's ability to analyze the potential impact of the full uniform PDL was constrained by limited data on additional supplemental rebate opportunity. Mercer recommends that a more robust

analysis of the supplemental rebate opportunity be completed prior to any decision regarding adoption of a full Uniform PDL. In the absence of a mandated pass-through methodology or administrative efficiency adjustment, Mercer assumes that the PBMs will retain their current amount of administrative revenue through a combination of spread pricing and administrative fees in this pharmacy program pricing model.

To accomplish the quantitative analysis objective, Mercer performed the following steps:

1. Summarized MCO encounter data with dates of service from July 2018 through December 2018.

2. Applied adjustments to this base data to estimate annual managed care pharmacy program costs for the time period between July 1, 2018 and June 30, 2019. These adjustments accounted for:

   A. Relative enrollment changes that occurred through June 2019.

   B. Seasonality to account for cyclical changes not represented in the base data.

Mercer also estimated pharmacy costs for the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) Expansion populations for January 1, 2019 through June 30, 2019. These populations became eligible for Medicaid managed care effective January 1, 2019, and therefore their claim experience were not included in the base data.

The managed care programs in this analysis included:

- Medallion 4.0 — Mothers, Children, Adults Age 18–64.

- CCC Plus — Medically Complex Populations.

- Expansion population (adults with income levels up to 133% of the federal poverty level) enrolled in either Medallion 4.0 or CCC Plus.

Mercer did not include the Family Access to Medical Insurance Security (FAMIS) and FAMIS Moms in the analysis.

- Mercer applied a series of adjustments to the annualized MCO encounter base data to estimate the potential fiscal impact for the pharmacy program design models. Table 2 lists and describes the financial adjustments Mercer considered in the analyses. Adjustments were applied to each model as applicable; Mercer did not apply all adjustments to each model.

TABLE 2: SUMMARY OF QUANTITATIVE CONSIDERATIONS

ADJUSTMENT CATEGORY	CATEGORY DESCRIPTION
Repricing Adjustment	Reflects the difference between the reported value of the encounter pharmacy claim and the amount calculated by applying the DMAS FFS pricing methodology. Mercer further divided the repricing adjustment into the estimated spread amount currently retained by PBMs and the estimated impact to pharmacy providers of the new reimbursement methodology.
Payment from MCOs to PBMs	Reflects an offset to the repricing adjustment to recognize administrative payments between the MCOs and the PBMs that previously were generated by spread pricing.
Member Utilization Management	Reflects changes in drug utilization.
Rebates – Federal	Reflects changes in federal rebate collections from drug manufacturers.
Rebates – MCO Market Share Rebate	Reflects the impact of changes to MCO or PBM market share rebate collections on MCO capitation payment.
Rebates – State Supplemental	Reflects changes in DMAS supplemental rebate collections from drug manufacturers.
MCO Administration Expense	Reflects changes in the amount included in the capitation rate calculation for MCO or PBM administration costs.
Underwriting Gain	Reflects changes in the amount included in the MCO capitation rates for cost of capital and margin for risk or contingency.
Taxes	Reflects taxes paid by the MCO that may be reflected in the capitation rates. • Mercer did not make any adjustment for taxes in these analyses. While there are MCO taxes in Virginia, none pertain to the Medicaid line of business. • Furthermore, Mercer did not adjust its analyses for the impact of the Health Insurance Provider Fee (HIF) tax due to the moratorium that is currently in place.
Data Coordination	Reflects implementation and ongoing costs for data sharing between DMAS and the MCOs.
Vendor Cost	Reflects a change in pharmacy claims processor costs based on anticipated change in claims processing volume.
Staffing	Reflects expenses of staffing changes.

Further details of the methodology of each of the analyses may be found in Section 4 and Appendix A of this report.

QUALITATIVE OBJECTIVE

To accomplish the qualitative objective of the analysis, Mercer performed the following steps:

1. Conducted a comprehensive policy and operational review of the current DMAS pharmacy program design:

    A. Mercer included a detailed review of DMAS current pharmacy benefit design and operational structure in Section 2 of the report. The Section also includes background on the administrative fee structure arrangements used by PBMs.

    B. There are two general forms of PBM contractual administrative fee structures used by PBMs in their contracts with MCOs: 1) pass-through pricing (transparent) and 2) spread pricing (traditional). In a pass-through pricing model, the PBM charges the MCO the same amount as is payed to the pharmacy provider for each prescription. In a spread pricing model, the PBM is able to charge the MCO an amount different from the amount paid to the pharmacy provider. The difference, or spread, is retained by the PBM as revenue to fund clinical or administrative operations. A per claim or per member administrative fee can be assessed by the PBM in either a transparent or traditional structure, although the fee is generally higher in a transparent structure because it is not supplemented by spread revenue.

    C. In the subsequent table, Mercer provides a summary of the current administrative fee structure utilized by each of the DMAS contracted MCOs and their subcontracted PBMs in Table 3 below.

TABLE 3: SUMMARY OF THE CURRENT ADMINISTRATIVE FEE STRUCTURE BY MCO

MCO	SUBCONTRACTED PBM	CURRENT PBM CONTRACT AND ADMINISTRATIVE FEE STRUCTURE	REBATE RETENTION BY PBM
Aetna Better Health of VA	CVS	Pass-through contract; administrative fee per claim	No
Anthem Health Keeper Plus	Express Scripts (through 9/2019) IngenioRx (10/2019 and beyond)	Spread contract; administrative fee per claim	Yes

MCO	SUBCONTRACTED PBM	CURRENT PBM CONTRACT AND ADMINISTRATIVE FEE STRUCTURE	REBATE RETENTION BY PBM
Magellan Complete Care	MagellanRx Management	Pass-through contract; administrative fee per claim	No
Optima Health	OptumRx	Spread contract; no administrative fee	No
United Healthcare Community Plan	OptumRx	Pass-through contract; administrative fee per claim	No
Virginia Premier	EnvisionRx	Pass-through contract; administrative fee per claim	No

2. Performed a comprehensive review of each pharmacy program design model. The review of each option included multiple components:

   A. Medicaid Environmental Scan:

      i. Mercer performed an environmental scan of all Medicaid programs to identify programs that had implemented one of the three selected models. Mercer also provided a summary of the reported financial and/or operational experience of each model.

      ii. Mandatory Pass-Through Pharmacy Program Design Model:

         a. Ohio implemented a mandatory pass-through pharmacy program design model in January 2019. An early report has identified the implementation of the pass-through model resulted in a 5.74% increase in payments to enrolled pharmacy providers.[1] Data on the total financial impact to Ohio's Medicaid program is not yet available.

      iii. Pharmacy Benefit Carve-Out Model:

         a. West Virginia implemented a pharmacy benefit carve-out of managed care to FFS in July 2017.

      iv. State Mandated Pharmacy Provider Reimbursement Model:

[1] https://medicaid.ohio.gov/Portals/0/Resources/PharmacyTransparency/ODM-HDS-Qtr1-Analysis.pdf

a. Mississippi and Louisiana have implemented this model. Since 2011, Mississippi has mandated that pharmacy provider payments in managed care follow the same methodology as the FFS program. Louisiana implemented a similar policy for a subset of independent pharmacy providers in 2018. Managed care capitation rates were adjusted upward to accommodate the new policy. The magnitude of the financial impact for the Mississippi and Louisiana models is not publicly available.

B. Operational Evaluation:

i. Adopting any of the three pharmacy program design models would represent a substantial change for DMAS staff and contracted vendors. Significant planning and resources would be needed for implementing any of the three program design models. Mercer identified and summarized several significant operational considerations in Table 4 below.

TABLE 4: SUMMARY OF OPERATIONAL CONSIDERATIONS

OPERATIONAL IMPACT CATEGORY	MANDATORY PASS-THROUGH PRICING MODEL	PHARMACY BENEFIT CARVE-OUT MODEL	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL
Utilization Management Coordination	No impact.	Increased volume of claims and exception requests to manage.	No impact.
Drug Utilization Review (DUR) Program	No impact.	Simplification of DUR reporting to Centers for Medicare & Medicaid Services (CMS).	No impact.
Rebate Processing	No impact.	Increased efficiency of processing for point of sale pharmacy claims.	No impact.
DMAS Contracting and Reporting Administrative Impact	• Updates to MCO contracts. • Updates to oversight and financial reporting. • Staff training.	• Updates to MCO contracts. • Updates to capitation rates.	• Updates to MCO contracts. • Updates to oversight and financial reporting. • Updates to capitation rates.

OPERATIONAL IMPACT CATEGORY	MANDATORY PASS-THROUGH PRICING MODEL	PHARMACY BENEFIT CARVE-OUT MODEL	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL
Pharmacy Provider Impact	Potential for increased reimbursement for pharmacy providers.	• Potential for disruption at implementation. • Communication and staffing plan required to meet provider needs.	Increased reimbursement for pharmacy providers.
Member Impact	No impact.	Potential for disruption at implementation, particularly for prescriptions requiring authorization.	No impact.
DMAS Staffing Impact	One to two additional staff member(s) or outside contracting may be necessary.	• Up to two additional staff members. • Additional staff members may be needed if pharmacy benefit administration is in-house rather than vendor-managed.	• Realignment of current staff responsibilities. • Two additional staff members.
MCO Oversight Impact	Increased auditing of MCO financial reporting and claims.	• Direct oversight of MCO pharmacy benefit eliminated. • Increased coordination to eliminate member care gaps.	• Increased oversight of pharmacy reimbursement by PBMs. • Communication and coordination plan required.
Reimbursement Report Monitoring	Revised reporting templates and data transmission fields.	Not required in carve-out.	No impact.
Pharmacy Provider Reimbursement Validation/Verification	No impact.	Required during implementation.	• Dissemination of reimbursement methodology to MCOs and process for communicating reimbursement updates.

OPERATIONAL IMPACT CATEGORY	MANDATORY PASS-THROUGH PRICING MODEL	PHARMACY BENEFIT CARVE-OUT MODEL	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL
			• Process for ongoing monitoring of payments to pharmacy providers.
Pharmacy Provider Disputes Submitted to DMAS	No impact.	Potential increased volume of disputes due to claims volume increase.	Potential increased volume of disputes due to multiple PBMs implementing methodology.
DMAS Care Coordination	No impact.	• Pharmacy and member notification of changes. • Additional service authorizations for formulary exceptions in transition period.	No impact.
System (Medicaid Management Information System [MMIS])	No impact.	• Integration of historic encounter claims. • Mechanism for delivery of FFS pharmacy claims to MCO system.	No impact.

Implementation of a program design change would be expected to take between six and 36 months. Implementation of the mandatory pass-through pricing model and the mandated pharmacy provider reimbursement methodology model would be on the low end of that estimate; implementation of a pharmacy benefit carve-out would be on the high end of the range.

- Advantages and Challenges:
  - Mercer identified the advantages and challenges of each pharmacy program design model from the perspective of the DMAS administration, the provider community and enrolled members.
  - A summary of our findings are in the tables below. Additional detail on the analysis of each model is included in the full report.

TABLE 5: ADVANTAGES AND CHALLENGES OF A MANDATORY PASS-THROUGH PRICING MODEL

ADVANTAGES	CHALLENGES
• Transparent PBM costs. • Low implementation burden.	• MCO and PBM contract renegotiation. • Updates to financial monitoring and reporting tools. • Provider reimbursement validation. • Contract auditing and oversight. • Potential for ongoing pharmacy provider reimbursement concerns. • Potential for hidden administrative fees. • Conflict of interest/anti-competitive practices.

TABLE 6: ADVANTAGES AND CHALLENGES OF A PHARMACY BENEFIT CARVE-OUT MODEL

ADVANTAGES	CHALLENGES
• Transparency. • Statewide consistency in reimbursement across pharmacy providers and utilization management. • Pharmacy provider community acceptance. • Efficiency in DMAS decision making. • Potential for increased rebate collections as a result of single comprehensive preferred drug list (PDL). • Potential for rebate processing efficiency. • Potential savings on 340B claims.	• Separation of Management of Retail and Physician Administered Drugs (PADs). • Data coordination for continuity of care and case management. • Loss of budget predictability. • Less opportunity for decentralized innovation. • Potential conflict of interest if contracted PBM is aligned with one of DMAS' contracted MCOs. • Removal of pharmacy benefit from capitation rates.

TABLE 7: ADVANTAGES AND CHALLENGES OF A MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL

ADVANTAGES	CHALLENGES
• Pharmacy provider community acceptance. • Statewide consistency in reimbursement across pharmacy providers. • Potential savings on 340B claims.	• Capitation rate adjustments for administrative and prescription cost. • MCO compliance oversight. • Management of multiple vendor relationships. • Reimbursement across different MCOs or different providers is less flexible. • Elimination of MCO/PBM pharmacy contracting efficiency opportunity

PHARMACY PROGRAM DESIGN REPORT: KEY FINDINGS AND RECOMMENDATIONS

There are many factors that must be considered before the final selection and implementation of a pharmacy program design model. DMAS must align final selection decision with department, agency and state goals. Additionally, fiscal and operational impact considerations must be evaluated. Stakeholder, provider and member concerns and/or suggestions should be considered, but DMAS must prioritize considerations that are most important for the program. For example, if transparency in the pharmacy program is the most important factor for consideration, then a pass-through pricing model or pharmacy benefit carve-out model should be considered. If provider reimbursement is paramount, then a state mandated pharmacy provider reimbursement methodology or pharmacy benefit carve-out model should be considered. Likewise, if DMAS would prefer contracted MCOs to share risk of pharmacy drug costs, then either the mandatory reimbursement methodology or the mandatory pass-through pricing models would be likely options. In the table below, Mercer summarizes the priorities for DMAS consideration and designates whether the pharmacy program design models would support each of those priorities.

TABLE 8: SUMMARY OF PRIORITIES SUPPORTED BY EACH MODEL

DMAS PRIORITY	MANDATORY PASS-THROUGH PRICING MODEL	PHARMACY BENEFIT CARVE-OUT MODEL	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL WITH UNIFORM PDL
Budget Predictability	Yes	No	Yes
MCO Risk Sharing	Yes	No	Yes
PBM Administrative Fee Transparency	Yes	Yes	No
Increased Provider Reimbursement	No	Yes	Yes
Single Point of Decision Making for Program Design Decisions	No	Yes	No
Coordinated MCO Member Experience	Yes	No	Yes
Consistent member and pharmacy provider experiences across MCOs	No	Yes	No

DMAS PRIORITY	MANDATORY PASS-THROUGH PRICING MODEL	PHARMACY BENEFIT CARVE-OUT MODEL	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL WITH UNIFORM PDL
Implementation Timeline	6–12 months	18–36 months	6–12 months
Estimated SFY 2019 Fiscal Impact (Savings)/Cost	($10,097,000)	($32,048,000)	$20,329,000
Estimated SFY 2019 % Fiscal Impact	-0.9%	-2.8%	1.8%
Estimated SFY 2019 Fiscal Impact (Savings)/Cost State Share	($4,026,000)	($13,983,000)	$7,597,000
Estimated SFY 2019 Fiscal Impact (Savings)/Cost Federal Share	($6,071,000)	($18,065,000)	$12,732,000

2
BACKGROUND

PURPOSE AND OBJECTIVE

DMAS engaged Mercer to conduct a pharmacy program design evaluation and fiscal impact analysis for three pharmacy program design models identified by DMAS. The pharmacy program design models are:

1. Mandatory Pass-Through Pricing.
2. Pharmacy Benefit Carve-Out.
3. State Mandated Pharmacy Provider Reimbursement.

The objectives of the project included:

1. Quantitative Analysis: Completion of an actuarial analysis of the potential fiscal impact of each of the three identified pharmacy program design models. Mercer will address the fiscal impact in the final report that will be delivered in November 2019.
2. Qualitative Analysis: Identification of the advantages, challenges and other considerations associated with the selection of each pharmacy design model, including the projected operational impact to DMAS functions, staff requirements and oversight activities. Mercer addresses this second objective within this preliminary report.

To accomplish the qualitative objective, Mercer performed the following steps:

1. Conducted a comprehensive policy and operational review of the current DMAS pharmacy program design.
2. Performed a comprehensive review of each pharmacy program design model. The review of each option included three components:
    A. Medicaid Environmental Scan
    B. Operational Evaluation
    C. Advantages and Challenges

CURRENT DMAS PHARMACY BENEFIT DESIGN STRUCTURE

As of June 2019, DMAS covers 1,386,885 lives under Medicaid and the Children's Health Insurance Program (CHIP).[2] DMAS currently contracts with six MCOs to provide services for its members; approximately 90% of the DMAS Medicaid members are enrolled in MCOs.[3] Under the current structure, the pharmacy benefit is carved into comprehensive MCO contracts. The managed care plans each subcontract with a PBM, which is responsible for processing pharmacy claims and performing other pharmacy benefit functions. In all but two instances, the MCO either owns or is owned by the subcontracted PBM. Of the two PBM subcontractors that do not have an ownership relationship with the MCO, one is owned by another DMAS-contracted MCO and the other is owned by a pharmacy provider organization.

Table 9 below identifies the current DMAS MCOs, MCO-subcontracted PBMs, and the ownership or contractual relationship between the MCO and the MCO-subcontracted PBM.

TABLE 9: CURRENT DMAS PARTICIPATING MCOS AND SUBCONTRACTED PBMS

MCO	MCO-SUBCONTRACTED PBM	PBM OWNERSHIP RELATIONSHIP
Aetna Better Health of VA	CVS	CVS Healthcare is parent company of Aetna.
Anthem Health Keeper Plus	Express Scripts (through 9/30/19). IngenioRx (effective 10/1/19).	Express Scripts was recently acquired by Cigna, a health plan that operates in the commercial and Medicare markets. Anthem is parent company of IngenioRx.
Magellan Complete Care	MagellanRx Management	Magellan Health is parent company of MagellanRx Management.
Optima Health	OptumRx	United Health Group is parent company of OptumRx.
United Healthcare Community Plan	OptumRx	United Health Group is parent company of OptumRx.
Virginia Premier	EnvisionRx	Parent Company of EnvisionRx is Rite Aid.

[2] Virginia Department of Medical Assistance Services (Confirmation from DMAS on 11/14/2019)

[3] Virginia Department of Medical Assistance Services (Confirmation from DMAS on 11/14/2019)

DMAS MCO/PBM CURRENT SUBCONTRACT STRUCTURE

Mercer worked with DMAS to survey the contracted MCOs to better understand the current MCO payment structure which funds their PBM subcontracts. In particular, MCOs were surveyed about contract provisions that could have the potential to change if Virginia were to adopt a different pharmacy program design. In particular, the MCOs were asked about their rebate retention and contractual administrative fee structures. The services provided by PBMs are generally funded through a mix of rebate retention and administrative revenue collected through spread or some version of a pass-through administrative fee.

Rebate Retention

PBMs commonly receive market share rebates from drug manufacturers. In Virginia, MCOs or their subcontracted PBMs can negotiate and receive market share drug rebates from manufacturers of drugs in open classes on the Common Core Formulary (CCF). Depending on the contract agreed to by the MCO and PBM, the PBMs may pass the entirety of collected market share drug rebates directly to the MCO or a PBM can retain a portion of the collected rebates as revenue.

Administrative Fee Structure

In addition to rebate retention, PBMs earn operational revenue based on an administrative fee structure. The two most common contractual administrative fee structures are pass-through and spread. In a spread model, the PBM uses the difference between what it charges the MCO for the drug and what it reimburses the pharmacy provider for the drug to cover its administrative costs. In a pass-through model, also known as a transparent model, the PBM charges the MCO what it reimburses the pharmacy provider for the drug. To cover administrative costs in a pass-through model the MCO charges a per claim, per member or flat fee for PBM services to the MCO. These models are described in further detail in Section 3. In some instances, the PBM contract utilizes both spread and a per claim or per member administrative fee. In addition to an administrative fee for basic claims processing, many PBMs charge additional per unit or per member fees for clinical or utilization management services such as prior authorization review and processing or disease management.

Table 10 below summarizes rebate retention practices and administrative fee structure currently utilized by each DMAS MCO-subcontracted PBM according to the results of the recent survey. All but one MCO-reported that 100% of market share drug rebates are passed through from the PBM to the MCO. Two of the MCOs reported a spread contract structure, and all but one MCO reported paying the PBM an administrative per claim fee. Managed care rates are developed to include an offset for drug manufacturer rebates based on the amount of rebate that is attainable in the marketplace for an efficient MCO. There is no upward rate adjustment provided for situations in which the PBM retains a portion of the rebate.

TABLE 10: DMAS MCO REBATE RETENTION AND FEE STRUCTURE

MCO	REBATE RETENTION BY PBM	CURRENT PBM CONTRACT & ADMINISTRATIVE FEE STRUCTURE	AMOUNT REPORTED ON MCO PRESCRIPTION ENCOUNTER CLAIM
Aetna Better Health of VA	No	Pass-through contract; administrative fee per claim.	Amount paid to the pharmacy.
Anthem Health Keeper Plus	Yes	Spread contract; administrative fee per claim.	Price charged to MCO, including spread.
Magellan Complete Care	No	Pass-through contract; administrative fee per claim.	Amount paid to the pharmacy.
Optima Health	No	Spread contract; no administrative fee.	Price charged to MCO, including spread.
United Healthcare Community Plan	No	Pass-through contract; administrative fee per claim.	Amount paid to the pharmacy.
Virginia Premier	No	Pass-through contract; administrative fee per claim.	Amount paid to the pharmacy.

Current Administrative and Oversight Structure

Under the current structure, DMAS provides pharmacy administrative services and oversight functions through multiple departments including Health Care Services (HCS), Integrated Care (IC), Provider Reimbursement Group (PRG) and the Pharmacy Department. The departments function independently but have to coordinate projects with one another to ensure appropriate oversight. DMAS does not currently contract with external vendors for support with MCO administrative and oversight functions.

HCS and IC

The HCS and IC departments review pharmacy encounter claims by validating that all data fields are populated and in the correct file format. HCS and IC work with other departments when claims error out. At present, reasonability checks of the pharmacy encounter data do not occur due to constraints on data fields to perform reasonability checks. Additionally, pharmacy subject matter expertise does not currently exist with the HCS and IC departments.

Provider Reimbursement Group

Health Care Services (Medallion) and Integrated Care (CCC Plus) divisions are tasked with the majority of MCO oversight functions. MCO oversight and contract management functions ensure enrolled members have access to pharmacy services and MCOs are in compliance with contract requirements. Recent guidance from CMS regarding MCO medical loss ratio (MLR)

reporting — including how to handle PBM spread in MLR calculation — are supported by PRG. With the introduction of the MCO CCF, PRG began working more closely with the DMAS Pharmacy Department.

Pharmacy Department

The Pharmacy Department manages drug utilization reviews, the rebate program, the CCF, FFS reimbursement, MCO coordination and compliance, pharmacy vendor contract management and oversight and more. The pharmacy program is overseen by the pharmacy manager that reports to the Chief Medical Officer. The team, including the pharmacy manager, is comprised of three pharmacists and one pharmacy technician. The Pharmacy Department is searching for a candidate with a background in pharma economics and/or healthcare data analytics to fill a currently vacant position.

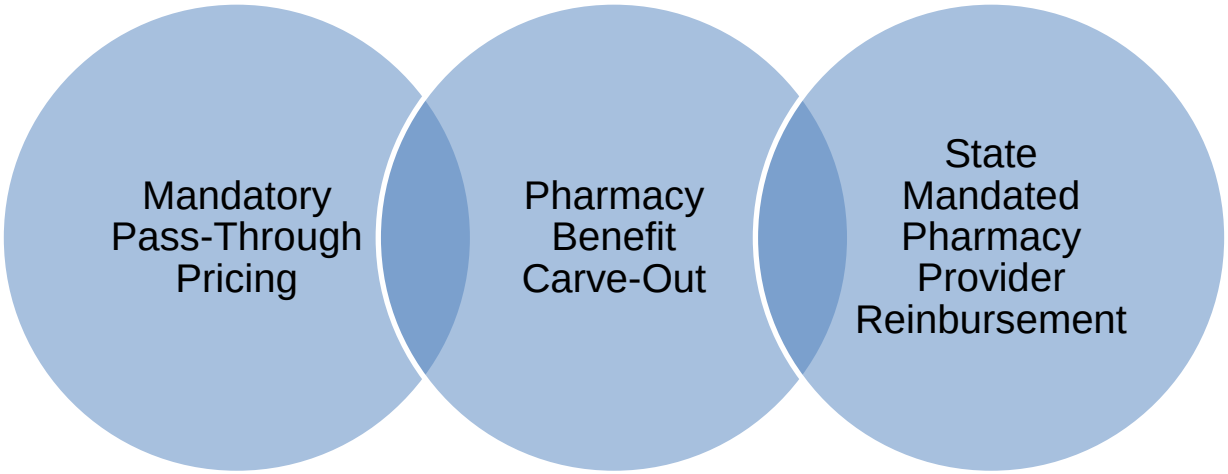
At this time, these DMAS departments do not perform oversight functions related to the MCO PBM contractual administrative structure as the MCOs are allowed flexibility in their PBM contracts. MCO and PBM oversight continues to evolve at DMAS. For example, DMAS collects data and publishes an annual pharmacy transparency report. Additionally, staff is exploring other oversight processes and structures, which would require collaboration with additional DMAS divisions and provide an opportunity for increased oversight of MCO and PBM functions related to pharmacy.

DMAS, like many state Medicaid agencies, has heard concerns from pharmacy provider stakeholders regarding the current MCO and PBM structure. Stakeholder concerns center around the practice of PBM spread pricing and low reimbursement contracts for pharmacists. Growth of oversight functions within DMAS, potentially coupled with an updated pharmacy program design, could help DMAS address stakeholder concerns while ensuring value and efficiency for the pharmacy program.

3
PHARMACY BENEFIT PROGRAM DESIGN OPTIONS

Mercer evaluated three different pharmacy program design models as requested by DMAS, identified in Figure 1 below. Each model is described in detail and analyzed in the subsequent sections of this report. In addition to performing a policy and operational review, Mercer performed an environmental scan of the current landscape to identify other states which have implemented each of the program design models below. Mercer identified the advantages and challenges presented by each model for DMAS to consider in pharmacy program design selection.

FIGURE 1: PHARMACY PROGRAM DESIGN MODELS FOR DMAS CONSIDERATION



MANDATORY PASS-THROUGH PRICING

Background

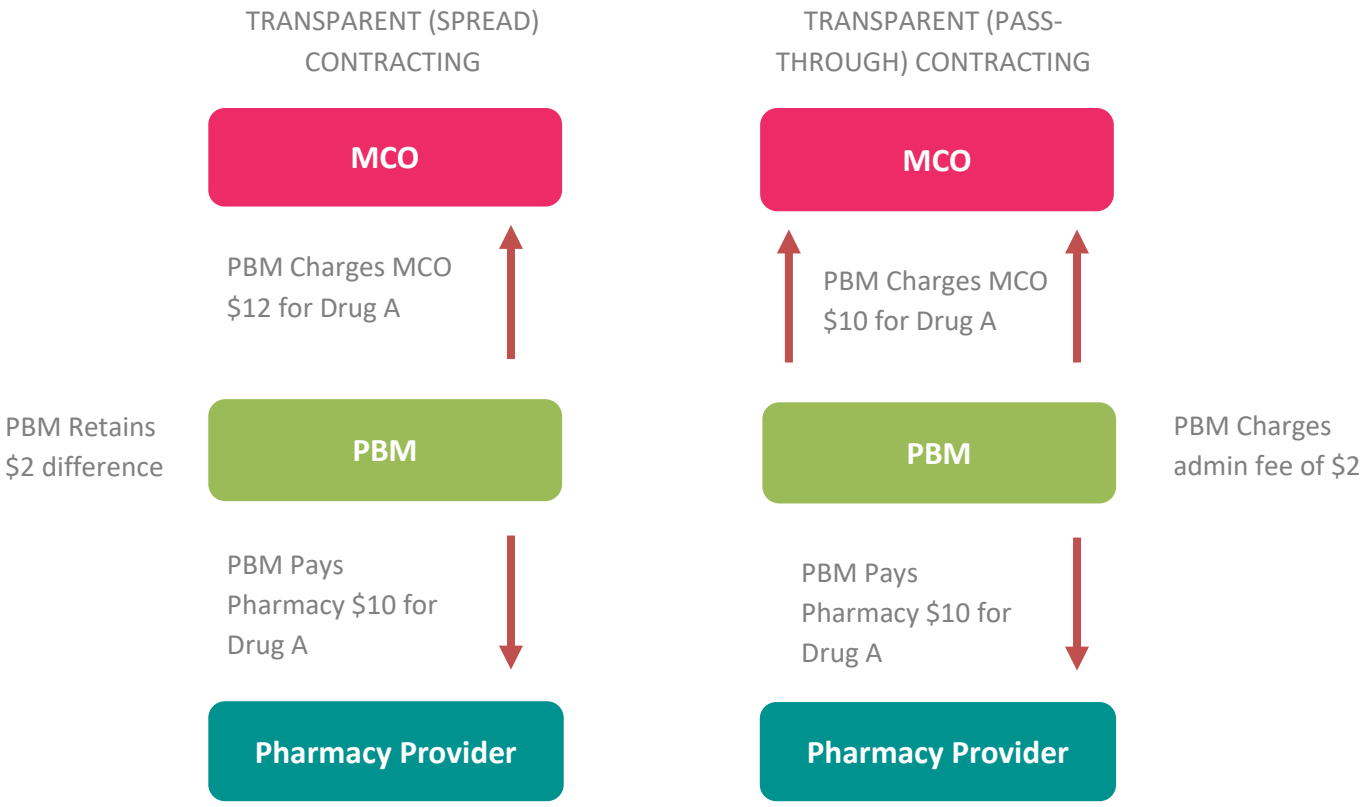
Pass-Through Pricing versus Spread Pricing

As described in Section 2 of this report, there are two general forms of PBM contractual administrative fee structures used by PBMs in their contracts with MCOs: 1) pass-through pricing (transparent) and 2) spread pricing (traditional). Table 11 below provides a summary of the elements of the two structures.

TABLE 11: PBM CONTRACTUAL ADMINISTRATIVE FEE STRUCTURES

	SPREAD MODEL (TRADITIONAL MODEL)	PASS-THROUGH MODEL (TRANSPARENT MODEL)
Price charged to MCO	Agreed-upon amount based on contractual guarantees.	Amount paid to pharmacy.
Price paid to pharmacy	Contractual rate between the PBM and the pharmacy provider, which in some instances is lower than the amount charged to the MCO.	Contractual rate between the PBM and the pharmacy provider, 100% of which is passed on to the MCO.
PBM revenue source for funding operations	Spread (difference) between amount paid to pharmacy and amount charged to MCO.	Administrative fee. Options include: • Per transaction. • Per member per month (PMPM). • Flat fee per quarter or per year.
Potential additional PBM revenue streams	• Retention of a portion of market share rebates. • Direct and indirect remuneration (DIR) fees. • Generic Effectiveness Rate (GER). • Manufacturer Administrative Fees (MAF). • Other contractual arrangements that impact final payment to pharmacy by the PBM.	• DIR. • GER. • MAF. • Other contractual arrangements that impact final payment to pharmacy by the PBM outside of individual claim payment.

The diagram below illustrates the two different contract models and the flow of funds between the MCO, the PBM and the pharmacy provider:



Other Potential PBM Revenue Streams

Outside of rebate retention and contractual administrative fee structures, PBMs will sometimes employ additional mechanisms to earn revenue or offset the cost of PBM operations. Such mechanisms may take the form of price adjustments that are excluded from PBM financial contract guarantees and are not passed on to the MCO. These price adjustments can be provided on a monthly, quarterly or annual basis and have varied forms including but not limited to:

- **DIR** — This term originated in Medicare Part D, but has moved into other payer arenas. DIR is a general term that includes many types of fees or bonus payments between the PBM and the pharmacy provider outside of the point of sale transaction. For example, pharmacies may pay PBMs/plans to participate in a specific network, the pharmacies may be charged fees for not meeting certain clinical measurements (or receive bonuses if they do), or there may be reconciliations of financial guarantees between the PBM and the pharmacy.
  - A common example is reconciliation to a GER. The GER defines the average allowable ingredient cost the pharmacy will receive for the term of the contract. The GER is typically

expressed as a discount off of a widely used benchmark. For example, the GER in a pharmacy's contract may be average wholesale price (AWP)– 80%. However, the PBM does not generally pay for every generic prescription using the GER discount; a maximum allowable cost (MAC) methodology is much more commonly used. After a set period, the PBM will review the payment for generic drugs in aggregate against the GER rate and if the amount paid exceeds the GER aggregate, the pharmacy is required to pay the PBM for the difference.

- **MAF** — PBMs collect these fees from drug manufacturers for providing services related to market share rebate invoicing and processing. These fees can be significant, ranging between 1% and 6% of WAC of branded products. The fees are not generally considered rebates and are not passed through to the MCO.

PBM revenue streams outside of per transaction or per member fees can be challenging for MCOs or Medicaid programs to quantify and monitor over time. As a result, many Medicaid programs are exploring or implementing new pharmacy program design models that include transparency of all financial terms and are working to identify methods to monitor and track the impact that PBM revenues and administrative costs have on total drug costs to the program over time.

Proposed DMAS Mandatory Pass-Through Pricing Model

In the proposed DMAS mandatory pass-through program design, the subcontracted PBMs would be required to pass-through the cost of prescriptions to the contracted MCO with no spread added to the claim cost. In addition, the subcontracted PBMs would be required to pass-through 100% of collected market share rebates to the MCO.

PBMs could continue to pay pharmacies based on the negotiated contractual rate; there would be no requirement for the PBM to pay the pharmacy a certain amount in ingredient cost or dispensing fee.

PBMs could continue to collect MAF and continue to assess DIR fees to pharmacies for GER reconciliation or other contract terms; however, all PBM administrative revenue streams would be reported to the MCO and to DMAS for monitoring of financial performance and rate setting.

State Medicaid Environmental Scan

As the debate around the rising cost of prescription drugs has grown in volume and scope in recent years, more policy makers are asking questions about the impact of (and transparency of) PBM contract models. A few states have released reports on their findings, which have prompted others to request their own investigations, mandate reporting on PBM spread contracts or even prohibit PBM spread contracts all together. In April of 2019, Senators Chuck Grassley and Ron Wyden, the Chairman and Ranking Member of the Senate Committee on Finance, wrote a letter to the Office of

the Inspector General asking for additional transparency and oversight of PBM practices.[4] Furthermore, on May 15, 2019, CMS released an informational bulletin entitled "Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors".[5] The guidance intends to bring more transparency to pharmacy costs incurred by MCOs and their subcontracted PBMs. According to the guidance, the MLR "represents the percent of premium revenue that goes toward actual claims and activities that improve healthcare quality, as opposed to administrative costs and profits."[6] The CMS guidance addresses ambiguity regarding PBM spread and rebates retained by PBMs for MLR categorization and clarifies how Medicaid programs should treat payments to PBMs when calculating an MCO MLR.

Case Study: Mandatory Pass-Through Pricing — Ohio

The State of Ohio produced a highly publicized PBM spread report in 2018. At the request of the Ohio General Assembly, the Auditor of the State analyzed several issues related to the Medicaid managed care pharmacy benefit, including the use of PBM spread in the Medicaid managed care contracts. At the same time, the Ohio Department of Medicaid contracted with an independent vendor to analyze Medicaid pharmacy spread. The Auditor of the State released its report in August of 2018, which included its findings as well as those from the Department's contracted vendor. The Auditor reported a total of $224.8 million (or 8.9% of the total amount paid by the MCOs for the pharmacy benefit) in PBM contract pharmacy spread across a one-year period. The Department's vendor reported similar findings, including an average PBM spread of 8.8% of the total amount paid across Medicaid managed care prescription drug claims.[7] The Ohio State auditors noted that the spread was highest (as a percentage) for generic drugs, accounting for 31.4% of the total amount paid for generic drug claims.

The Ohio Auditor's report also recommended that the State perform an analysis of requiring a 'pass-through' contracting model for pharmacy services delivered to Medicaid members.[8] Shortly after the report's release, the Department announced it would prohibit PBM spread contracts in

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[4] Grassley, Charles E, and Ron Wyden. "Letter to Inspector General Levinson". April 8th, 2019.

[5] CMCS Informational Bulletin: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf

[6] CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers. CMS Press Release. May 15, 2019. https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not

[7] Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period. Press Releases- Ohio State Auditor. August 16, 2018 https://ohioauditor.gov/news/pressreleases/Details/5042

[8] Auditor of the State Report. Ohio's Medicaid Managed Care Pharmacy Services. August 16, 2018. https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

future Medicaid managed care contracts as of January 1, 2019. A report analyzing the results of the mandatory pass-through pricing model was released on September 10 and showed that payment to pharmacies, on average, increased by 5.74% since implementation of the mandatory pass-through pricing model. The report did not calculate the total financial impact to the State Medicaid program of the program design change.[9]

While not all inclusive, Table 12 below summarizes other recent state policy and regulatory activity relating to PBM administrative fee structures.

TABLE 12: RECENT STATE SPONSORED PBM ACTIVITY

STATE	ACTIVITY
California	Enacted AB 315 (2018), which requires PBM pharmacy provider payment reporting and creates a 'Pharmacy Benefit Management Reporting' task force by July 2019.
Louisiana	Enacted SB 130 (2018), requiring PBMs serving Medicaid MCOs be compensated only on a transaction-fee-per-claim basis based on a set rate established by the Louisiana Department of Health.
Massachusetts	Massachusetts Health Policy Commission released a PBM pricing report for generic drugs in June 2019. The report was focused on spread pricing in both Medicaid and Commercial markets.
Montana	Enacted SB 71 (2019), which prohibits spread pricing agreements between PBMs and health benefit plans for generic drugs.
New York	State Senate Committee on Investigations and Government Operations published PBM investigative report in coordination with the Committee on Health in May 2019.
North Dakota	Enacted SB 2301 (2017), requiring spread pricing disclosure to payers for pharmacies in which the PBM has an ownership interest. It also restricts PBM specialty pharmacy accreditation practices and requires fiduciary duty in certain PBM-owned pharmacy network scenarios. Applies to health plans in the individual market.
Pennsylvania	Auditor General's office issued special reports, *Bringing Transparency* and *Accountability to Drug Pricing*, focusing on different PBM practices in December 2018 and February 2019.

Mandatory Pass-Through Pricing: DMAS Operational Impacts

With the implementation of a mandatory pass-through pricing model (otherwise known as the "transparent PBM" model), DMAS would have to ensure their MCO contracts include provisions that directly prohibit PBM spread and rebate retention and require transparency of the amounts paid to

[9] https://medicaid.ohio.gov/Portals/0/Resources/PharmacyTransparency/ODM-HDS-Qtr1-Analysis.pdf

pharmacy providers. As was done in Ohio, a mandatory pass-through pricing model could be operationalized through an MCO contract amendment.

Following enactment of the necessary contract amendment, DMAS would need to expand focus towards the financial review components of MCO and PBM oversight. DMAS pharmacy staff would need to liaise with DMAS PRG staff to ensure that the MCO contract requirements provide the State authority to obtain pharmacy financial information such as PBM administration fees and MCO/PBM rebate information as well as monitor plans through financial reporting tools.

Operational impacts are an important consideration for any program design change. Mercer analyzed the potential impacts in several operational areas.

Table 13 below provides a summary of potential DMAS Operational Impacts. Additional descriptions of the projected impacts are provided in the text following the table.

TABLE 13: POTENTIAL OPERATIONAL IMPACTS

OPERATIONAL IMPACT CATEGORY	MANDATORY PASS-THROUGH PRICING MODEL IMPACT
Utilization Management Coordination	No impact.
Pharmacy Provider Impact	Potential for increased reimbursement for pharmacy providers.
Member Impact	No impact.
DMAS Staffing Impact	One to two additional staff member(s) or outside contracting may be necessary.
DMAS Contracting and Reporting Administrative Impact	• Updates to MCO contracts. • Updates to oversight and financial reporting. • Staff training.
Reimbursement Report Monitoring	Revised reporting templates and data transmission fields.
MCO Oversight Impact	Increased auditing of MCO financial reporting and claim level details.
Rebate Processing	No impact.
System (MMIS)	No impact.

Utilization Management Coordination
The movement to a mandatory pass-through pricing model is not expected to disrupt any existing PBM utilization management activities.

Pharmacy Provider Impact
Based on the recent experience seen in Ohio, it is possible (though not required or guaranteed) that a transition to a mandatory pass-through pricing model could create an increase to the reimbursements that pharmacy providers receive from PBMs. While the data produced in Ohio was not detailed enough to confirm or dispute, it is possible that at least some of the increase in pharmacy payments as a result of the move to a mandatory pass-through pricing model were due to a PBM paying pharmacies under the PBM's ownership a higher amount than was paid under the spread model.

DMAS Staffing
The development and maintenance of the mandatory pass-through pricing will require additional DMAS MCO oversight staff. DMAS could explore adding one to two full-time employees. Mercer recommends that qualified staff would have experience in one or more of the following areas: pharmacy audit, program integrity, project and contract management, data and analytical reporting or commercial contracting. The staff would reside in the PRG or Pharmacy Department, but would need to work across all departments to support and relay information. Alternatively, DMAS may consider contracting with a vendor to analyze the collected transaction and fee data to ensure compliance with contract requirements.

System (MMIS)
MCO pharmacy encounter processing should not be significantly impacted with implementation of the transparency model. However, additional fields may be required to ensure transparency requirements are met.

DMAS Contract Management and Reporting Administrative Impact
Administrative procedures and policies that directly relate to contract management, MCO oversight and financial monitoring may have to be revised and updated. Internal procedures and processes will have to be updated to incorporate the additional operational functions as a result of the MCO contract amendments.

New DMAS Oversight Activities
Adopting a transparent mandatory pass-through pricing model would require a variety of new DMAS operational oversight activities to monitor transparency and pass-through of ingredient cost, dispensing fees, administration fees and manufacturer drug rebates to ensure compliance with contract provisions. Mercer recommends the following oversight structure and process upon adoption of a mandatory pass-through pricing model.

Reimbursement Report Monitoring
Current contracts should be amended to prohibit spread pricing and require full transparency. MCO reporting and financial monitoring tools should be revised to include the new (PBM agreed upon) negotiated administration fees and pharmacy reimbursement methodology. Current financial data templates should be modified to ensure accurate and comprehensive reporting of fees paid by the

MCO to the PBM. DMAS will need to ensure it is receiving the claim level data field that represents the amount(s) that the PBM pays to the pharmacy provider. If the field is not in the encounter data, a process will need to be developed that reconciles a file from the PBM that contains this field with the encounter data.

MCO Oversight Impact

There will be a significant increase in the need for MCO oversight to ensure compliance with the contract provisions. Periodic audits of MCO financial reporting, along with review of claims, should be performed. These audits should include:

- Tracking of the PBM payment to a pharmacy provider for prescription reimbursement.
- Verification of the exact amount charged to the MCO by the PBM for the prescription.
- Verification of the administrative fee component, if applicable.

Additional optional review of administrative fees associated with pharmacy services expenses could include:

- Fees associated with claims adjudication.
- Fees for prior authorization facilitation.
- Per member or per encounter fees for pharmacy provider call center.
- Account management fees.

Additionally, as part of this oversight process, it would be important for DMAS to monitor the utilization of DIR fees such as GER reconciliation, MAF or other PBM revenue streams. Finally, DMAS should monitor for attempts to delay adjustment payment to pharmacy providers in order to avoid pass-through of the adjustments during the reporting period.

Mandatory Pass-Through Pricing: Qualitative Considerations

In addition to evaluating the DMAS operational impact, Mercer identified non-operational advantages and challenges that could be expected upon implementation of a mandatory pass-through pricing model.

Table 14 below summarizes the advantages and challenges of an MCO mandatory pass-through pricing model at a high level.

TABLE 14: ADVANTAGES AND CHALLENGES OF A MANDATORY PASS-THROUGH PRICING MODEL

ADVANTAGES	CHALLENGES
• Transparent PBM costs. • Low implementation burden.	• MCO and PBM contract renegotiation. • Updates to financial monitoring and reporting tools. • Provider reimbursement validation. • Contract auditing and oversight. • Ongoing pharmacy provider reimbursement concerns. • Potential for hidden administrative fees. • Conflict of interest/anti-competitive practices.

Mandatory Pass-Through Pricing Model Advantages

There has been criticism from law makers and pharmaceutical payers about the complex and opaque nature of the current prescription drug marketplace. Complexity and obscure details in pricing contracts has created concerns regarding inflated drug costs in spread pricing contracts. In addition, spread pricing contracts make it difficult for Medicaid programs to monitor pharmacy provider payments or the true costs associated with administering the pharmacy benefit.

The most significant advantage of a mandatory pass-through pricing model is the transparency of the magnitude and purpose of payments made to the PBMs by the MCOs. Transparency allows a Medicaid agency to see what portion of their payment to the MCO is going toward the pharmacy provider payment and what portion is going toward administrative costs, PBM expenses, marketing and/or profit. The distinction leads to advantages in reporting and oversight.

Another advantage of the mandatory pass-through pricing model compared to a pharmacy benefit carve out is the comparatively low implementation burden. Major systems changes or transition of large number of members into a different delivery system are not required.

Mandatory Pass-Through Pricing Model Challenges

There is a myriad of challenges that may occur during the implementation and ongoing maintenance of a mandatory pass-through pricing pharmacy program design model. The majority are related to the development of new contracting, reporting and data oversight.

MCO and PBM Contract Renegotiation

Current contracts will require renegotiation and implementation. Contract language will need to be thoroughly detailed to include stipulations regarding MCO/PBM delivered pharmacy programs and the associated fees and expenses. The fees and expenses must then be accounted for in the financial reporting and monitoring documents. Explicit contract and reporting instructions would be

required to track or limit the PBMs ability to collect and retain undisclosed rebates or fees such as DIR, MAF or payment for clinical or utilization management programs.

Updates to Financial Monitoring and Reporting Tools

As the agency moves to a mandatory pass-through pricing model, updates to the DMAS financial monitoring and reporting tools will likely be required. MCOs and PBMs will need to update their processes and procedures for populating the reporting tools. MCOs may resist the new requirements or request for additional administrative funding to comply.

Contract Auditing and Oversight

As new processes and templates for reporting are developed, new oversight models will be necessary. An internal or external auditing consultant may need to be engaged for select oversight tasks including review of the amended MCO contracts and to ensure DMAS pharmacy or other assigned commonwealth staff are trained in new oversight duties.

Conflict of Interest/Anti-Competitive Practices

Many PBMs have ownership or preferential contracting relationships with particular chain pharmacies. It is possible that upon implementation of a mandatory pass-through pricing model PBMs would begin paying their owned pharmacies at a lower discount (higher reimbursement rate) in order to make up for lost PBM spread. In particular, PBMs may have an incentive to steer more prescriptions to owned or captive specialty pharmacies, or may attempt to drive more drugs or drug categories to their preferred specialty network pharmacies. Contracting should include language to ensure a fair reimbursement practice throughout the pharmacy network regardless of pharmacy ownership. In addition, DMAS may want to pursue standardization of the definition of the specialty drug to ensure that utilization of specialty pharmacies across drugs and drug categories is consistent across MCO and PBMs.

Pharmacy Provider Reimbursement Concerns

A mandatory pass-through pricing model as proposed in Virginia will not necessarily impact or change the current reimbursement to a particular the pharmacy provider as there is no requirement for the PBM to pay the pharmacy provider a specific rate and no requirement for the PBM and pharmacy to renegotiate existing contracts. However, as seen in early Ohio experience, it is possible that movement to a mandatory pass-through pricing model may have the effect of increasing pharmacy payments in the aggregate. A mandatory pass-through pricing model provides DMAS the ability to validate that the amount the PBM pays to the pharmacy provider equals the amount billed to the MCO and may make it easier for DMAS to respond to pharmacy provider concerns about reimbursement

Potential for Hidden Administrative Fees

Despite the additional transparency inherently included in a mandatory pass-through pricing model, a requirement for pass-through may not uncover hidden administrative fees such as DIR, GER and

MAF fees unless DMAS establishes specific guidance and contract requirements regarding all sources of PBM revenue.

In summary, implementing a mandatory pass-through pricing model requires a contract amendment, clear guidance to contracted MCOs and PBMs, updated processes and procedures and ongoing modification of reporting and data collection structures. However, once implemented, the mandatory pass-through pricing model can offer the State additional insight into pharmacy provider and PBM payments, which will help address the transparency concerns raised by policymakers and stakeholders. Depending on how the individual MCO PBM subcontracts are structured, a mandatory pass-through pricing model may or may not create financial savings for DMAS as the MCOs and PBMs are allowed to negotiate their own payment arrangements within the pass-through construct.

PHARMACY BENEFIT CARVE-OUT OF MANAGED CARE

Background

Pharmacy Benefit Carve-out Model Description

In a full pharmacy benefit carve-out model, all pharmacy services will be administered directly by DMAS, its contracted fiscal agent or a DMAS selected PBA. In a carve-out model, the Commonwealth has the flexibility to decide which components of pharmacy management would be performed internally with DMAS staff and, which would be outsourced to vendors with expertise.

State Medicaid Environmental Scan

Mercer performed a market assessment and environmental scan to identify which state Medicaid pharmacy programs currently utilize a managed care carve-out model for the pharmacy benefit. The map below highlights which state pharmacy programs have a full managed care carve-in, full pharmacy benefit carve-out, partial pharmacy benefit carve-out or other alternative. Five states, or approximately 10% of State Medicaid programs[10] (including most recently West Virginia), have a full pharmacy benefit carve-out of managed care with 12 more states and the District of Columbia (DC) partially carving pharmacy out of managed care plans.

Recently, several states; California, Michigan and North Dakota, have publicly announced intention to implement full pharmacy benefit carve-outs from managed care to FFS. In January 2019, California Governor Gavin Newsom issued an executive order to carve-out Medicaid pharmacy benefits by January 2021.[11] Michigan announced that all pharmacy drug coverage will be

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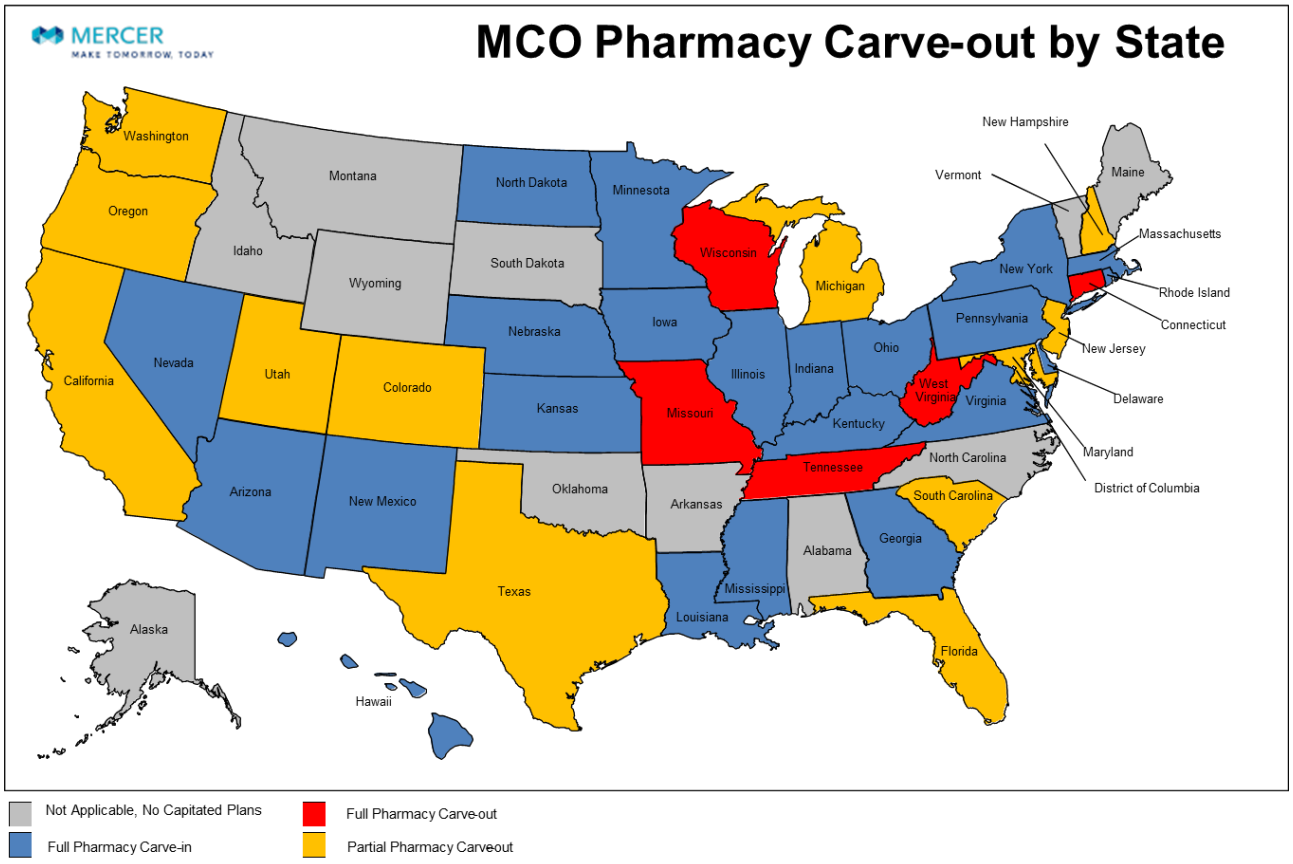
[10] http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019

[11] Analysis of the Carve Out of Medi-Cal Pharmacy Services from Managed Care. Legislative Analyst's Office (LAO). The Californian Legislature's Nonpartisan Fiscal and Policy Advisor Report. April 5, 2019

https://lao.ca.gov/Publications/Report/3997

transitioned to FFS Medicaid by February 29, 2020.[12] [13] The North Dakota Medicaid program issued a public notice that as of January 1, 2020, pharmacy benefits for the North Dakota Medicaid Expansion population will be administered through the FFS Medicaid administration.[14]

FIGURE 2: MAP — PHARMACY BENEFIT DESIGN LANDSCAPE



[12] Michigan Department of Health and Human Services. Notice of Proposed Policy- "Medicaid Health Plan Pharmacy Drug Transition." September 30, 2019. https://www.michigan.gov/documents/mdhhs/1936-Pharmacy-P_667227_7.pdf

[13] Greene, Jay. Michigan plans another go at shifting drug coverage away from Medicaid health plans. October 3, 2019. https://www.crainsdetroit.com/health-care/michigan-plans-another-go-shifting-drug-coverage-away-medicaid-health-plans

[14] North Dakota Human Services. Public Notice-North Dakota Medicaid Program. August 19, 2019. https://www.nd.gov/dhs/info/publicnotice/2019/8-19-1915b-waiver-nd-medicaid-expansion.pdf

Case Study: MCO Pharmacy Benefit Carve-Out — West Virginia

In July 2017, the West Virginia Bureau for Medical Services transitioned the management of its Pharmacy drug benefit from a managed care program directly to a traditional FFS program.[15] The State moved forward with this carve-out option with reliance on an actuarial study which forecasted a $30 million savings.[16] In March 2019, a report released by Navigant showed calculated actual savings of $54.4 million to the State Medicaid program for the first year (SFY 2018) of pharmacy benefit carve-out from managed care, a savings of approximately 9.5%. The report also notes that in addition to the savings, the prescription drug benefit carve-out resulted in a total of $122.5 million paid to West Virginia pharmacies in the form of professional dispensing fees of $10.49 per prescription using the FFS methodology. Prior to the pharmacy benefit carve-out, it was estimated that the West Virginia MCOs were paying pharmacies an average dispensing fee of $0.59 per prescription.[17]

The majority of the calculated savings achieved through West Virginia's pharmacy benefit carve-out was due to an elimination of the pharmacy administration component from the managed care capitation rates, which was offset only partially by increased staffing and operational costs for the State.

Navigant estimated that 89.27% 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. As a result, the calculated savings to the state's annual budget is estimated to be approximately $5,840,000.

Pharmacy Benefit Carve-Out: DMAS Operational Impacts

A Medicaid program must plan not only for financial impact, but also non-financial policy and operational considerations to ensure a successful transition and implementation of a pharmacy

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[15] West Virginia Medicaid Provider Newsletter Qtr. 2. 2017 West Virginia Department of Health & Human Resources Bureau for Medical Services.
https://dhhr.wv.gov/bms/BMSPUB/Documents/Quarter22017ProviderNewsletter%20final%20approved%20version.pdf

[16] West Virginia Medicaid saves S54.4 million with prescription drug carve-out.

https://www.ncpanet.org/newsroom/news-releases/2019/03/13/west-virginia-medicaid-saves-$54.4-million-with-prescription-drug-carve-out

[17] Pharmacy Savings Report. Navigant on behalf of West Virginia Medicaid. February 25, 2019 (Amended April 2, 2019).

https://dhhr.wv.gov/bms/News/Documents/WV%20BMS%20Rx%20Savings%20Report%202019-04-02%20-%20FINAL.pdf

benefit carve-out program design. Operationalizing this plan will take significant planning and resources to ensure every facet of the pharmacy program is considered and included.

Table 15 below provides a summary of potential DMAS Operational Impacts. Additional descriptions of the projected impacts are provided in the text following the table.

TABLE 15: POTENTIAL DMAS OPERATIONAL IMPACTS

OPERATIONAL IMPACT CATEGORY	PHARMACY BENEFIT CARVE-OUT MODEL IMPACT
Utilization Management Coordination	Increased volume of claims and exception requests to manage.
DUR Program	Simplification of DUR reporting to CMS.
Rebate Processing	Increased efficiency of processing for Point of Sale pharmacy claims.
MCO Oversight Impact	• Direct oversight of MCO pharmacy benefit eliminated. • Increased coordination to eliminate member care gaps.
System (MMIS) Impact	• Integration of historic encounter claims. • Mechanism for delivery of FFS pharmacy claims to MCO system.
DMAS Care Coordination	• Pharmacy and member notification of changes. • Additional service authorizations for formulary exceptions in transition period.
Pharmacy Provider Impact	• Potential for disruption at implementation. • Communication and staffing plan required to meet provider needs.
Member Impact	• Potential for disruption at implementation, particularly for prescriptions requiring authorization.
DMAS Staffing Impact	• Up to two additional staff members. • Additional staff members may be needed if pharmacy benefit administration is in-house rather than vendor-managed.

Utilization Management Coordination

Utilization management FFS tools already in place would continue without any disruption. However, DMAS and its contracted vendor would need to ensure that there is sufficient bandwidth in the

existing systems to accommodate the additional lives that would move into FFS in a pharmacy benefit carve-out scenario. An important consideration is to ensure that both providers and members are well aware of the fee for service utilization management policies and requirements. Alternatively, any newly procured PBA must have the ability to develop and manage a DUR program for all new FFS pharmacy claims. Additional DMAS or contractor staff time may be required due to the increase in FFS managed pharmacy claims.

Drug Utilization Review

The incorporation of the managed care lives into the FFS pharmacy program would allow for DMAS to apply robust retrospective DUR consistently to all prescription claims across the pharmacy benefit. DMAS would no longer be required to coordinate an annual DUR report with the MCOS; only one DUR report would need to be submitted to CMS each year.

Rebate Processing

While the volume of rebate dollars invoiced would increase significantly, there may be an efficiency gain as the rebate processing vendor would only have to obtain claim file feeds from a single source for pharmacy claims. This may ease the process of identifying drugs purchased under the 340B drug discount program, performing data validation and ultimately manufacturer invoicing. However, unless DMAS elects to carve physician-administered drugs out of managed care, the rebate vendor would still need to use medical encounter data from each of the MCOs for physician-administered rebate invoicing.

MCO Oversight

MCO oversight functions in regards to the pharmacy benefit would be reduced. The annual PBM transparency report would no longer need to be published. However, DMAS coordination efforts with the MCO would increase. Communication with MCOs regarding pharmacy benefit changes/decisions as well as FFS pharmacy daily data feeds would be necessary to ensure continued MCO member care coordination and management. In addition, clear oversight would be required to coordinate with the MCOs regarding the responsibility of coverage for physician-administered drugs.

New DMAS Oversight Activities

As with the previous model, there are some new functional changes that will be required by DMAS in order to implement the pharmacy benefit carve-out model. These functions will be similar to those already performed by DMAS for the FFS pharmacy model currently managed through FFS pharmacy claims processing vendor. New activities which may be required are discussed below.

System (MMIS) Impact

Whether a fiscal agent, a claims processing vendor, or a PBA, the Commonwealth’s vendor must be prepared for the additional volume associated with a pharmacy benefit carve-out. Adequate testing would be required to that ensure that the increased volume of claims can be processed accurately

and efficiently. This is to not only prevent disruptions in care, but to ensure correct provider reimbursements.

In order for MCO care management programs to continue for DMAS managed care enrolled members, FFS pharmacy claim data must be delivered to the MCOs in a timely fashion. A daily transmission of prescription claims data will need to be established in order for the MCOs to facilitate member services and case management. The resource commitment will be highest during the initial development of this process; however, periodic review of the data delivery should be established to ensure accuracy.

DMAS may need to shift additional data management staff initially to ensure appropriate set up of the necessary data delivery structure, method and delivery schedule between the MCOs and the prescription claims processor. Delivery should also be specific for members enrolled in individual MCOs. Contingency plans should be developed prior to initiation for unexpected/planned service outages. Additional staff may need to be trained to ensure redundancy in the data delivery process. A timely flow of medical encounter data will also need to occur from the MCO to DMAS and be incorporated into the appropriate systems for deployment of any pharmacy-related care management programs being operated by the Commonwealth or the vendor tasked with pharmacy utilization or care management. DMAS may want to explore the possibility of hosting a real-time web application, which would allow MCOs to view pharmacy claim data without the need for a daily claims transmission.

DMAS Care Coordination

The greatest operational impact for DMAS, particularly in the implementation phase (but continuing over time), will be in ensuring consistent coordination of care across the MCOs and the pharmacy claims processing vendor, fiscal agent or PBA.

Transition of Care from MCO Management to FFS

A transition of care plan would need to be developed and monitored to ensure a smooth transition of benefits for members as pharmacy services transfer into the FFS Pharmacy program. Similar to any transition from one claims processing vendor to another, the transfer of encounter data from the MCOs' subcontracted PBMs to the appropriate FFS program vendor will need to occur (some downtime may be expected on the final day of transition to allow for this change). Pharmacy providers should be notified in advance of the date and time of the change and the expectations for ensuring continuity of care for members. DMAS staff will be needed to coordinate and liaise between the MCOs and the FFS program vendor(s).

Furthermore, continuity of care plans for members already established on a medication will be required to ensure limited interruption of therapies. Historical encounter data will need to be shared with the FFS contracted vendor to ensure continuity of care. For example, DMAS staff should perform a formulary or preferred product check against historical managed care claims to identify

ongoing therapy with products which may require approvals to be in place to ensure continuity of care. It may be possible for the vendor to pre-load temporary approvals into the system to facilitate transition of care with minimal disruption to members and providers. Another option would be for DMAS to load previous managed care claims into the system to be used in lookback criteria to allow for grandfathering of existing therapy. The FFS contracted vendor would likely require additional time and resources to implement any service authorizations in advance of the switchover date.

Member Impact
Disruption to member care is the most important potential impact to mitigate. Prior to implementation, members should be notified of the upcoming change to their pharmacy benefits and provided with new identification cards. The member communication plan should include, at a minimum:

- Information about the switch from their current MCO pharmacy benefit to FFS.
- Member-specific communication identifying non-preferred products currently being used.
- Information about how to obtain a prior authorization or transition to a preferred product.
- Clarification that only the pharmacy benefit delivery system is changing — the member will remain in the currently enrolled MCO.
- Information about how the member should contact customer service.

DMAS should ensure that call center staff across all sectors are aware of the changes and have steps outlined to direct members to the correct area for assistance during the transition period.

Providers and health systems should also be notified in order to familiarize themselves with any potential changes to the PDL, specifically for open classes on the CCF where MCO-preferred agents may not be the same as DMAS-preferred agents.). Additionally, providers will need to familiarize themselves with any DMAS FFS prior authorization or utilization management requirements. This notification period will afford the provider community the necessary lead time to ensure members have enough medication during this transition period. Provider offices must ready their staff in preparation for the transition of members currently in their care. Modes of communicating to the provider community include, but are not limited to:

- Provider notices.
- Targeted email or mailing to enrolled providers.
- Publications or announcements produced by professional organizations (such as the Medical Association).

- Public stakeholder meeting(s) and/or webinar(s).

DMAS Anticipated Staffing Changes

The infrastructure and processes for a FFS pharmacy environment already largely exist within DMAS. Most additional staffing needs will occur within the contracted pharmacy benefit administrator. The pharmacy benefit administrator would need additional staff to support the increase in members. DMAS may need up to two full-time employees to assist with increases in call volume, triaging work and expanding the volume of current responsibilities. Mercer recommends that qualified individuals would have experience in one or more of the following areas: drug utilization review, customer service, project and/or contract management. DMAS would need additional staff support if it implements the pharmacy benefit carve-out model using commonwealth staff rather than a vendor. Additionally, DMAS staffing needs would be increased if additional clinical programs are to be implemented by DMAS to replace any current programs performed by an MCO's PBM.

Role of Pharmacy Benefit Administrator or Fiscal Agent versus Role of DMAS

The current pharmacy benefit administrator is responsible for pharmacy claims processing, prescription service authorizations, maintaining the preferred drug list, call center and managing the DUR program (these roles could potentially remain with the current vendor). The role of DMAS would be the same as for the current FFS program and would largely remain an oversight function. Additional resources may be required during the transition period, especially for functions such as the call center, which can expect an increased call volume. Service authorizations will also require additional resources with the highest volume also occurring during the initial transition period.

Pharmacy Benefit Carve-Out: Qualitative Considerations

Many factors must be considered in a pharmacy benefit carve-out decision; in addition to the operational impacts to DMAS, Mercer identified advantages and challenges arising from implementing a carve-out pharmacy benefit program design model.

Table 16 below summarizes some of the identified advantages and challenges of a pharmacy benefit carve-out model. The text following the table provides additional detail regarding the advantages and challenges.

TABLE 16: ADVANTAGES AND CHALLENGES OF PHARMACY BENEFIT CARVE-OUT MODEL

ADVANTAGES	CHALLENGES
• Transparency. • Statewide consistency in reimbursement across pharmacy providers. • Statewide consistency in application of utilization management. • Pharmacy provider community acceptance. • Efficiency in DMAS decision making. • Potential for increased rebate collections as a result of single comprehensive PDL. • Potential for rebate processing efficiency. • Potential savings on 340B claims.	• Separation of Management of Retail and PADs. • Data coordination for continuity of care and case management. • Loss of budget predictability. • Transition care planning. • Less opportunity for decentralized innovation. • Potential conflict of interest if contracted PBM is aligned with one of DMAS' contracted MCOs. • Removal of pharmacy benefit from capitation rates.

Pharmacy Benefit Carve-Out Advantages

Transparency

A pharmacy benefit carve-out model provides the highest level of transparency of any model as the state is directly managing the benefit of holding the contract with the fiscal agent, claims processor or PBA. In a pharmacy benefit carve-out arrangement, the state knows how much the contractor is being paid and how much the pharmacies are being paid without the need for extensive reporting.

Provider Community Acceptance

Provider administrative burden, both at the physician and pharmacy level, may be reduced based on a single FFS vendor rather than adapting to multiple PBM administrative processes. Pharmacy providers will also experience more consistent reimbursement levels as they will be reimbursed using the FFS payment methodology. Additionally, FFS Medicaid has a larger dispensing fee than is typically paid by a subcontracted PBM. While the higher dispensing fee payment may add to the overall program costs, it may help ensure continuity of a robust pharmacy network.

Efficiency in DMAS Decision Making

With a pharmacy benefit carve-out model, DMAS would have greater control of their pharmacy benefit plan design. Sole decision making authority is retained by DMAS. This allows DMAS to design a pharmacy benefit that will be responsive to competing federal, state and local provider and member concerns.

Potential for Rebate Processing Efficiency

Rebate processing may gain efficiencies as rebate processing vendors would only be receiving claim files from a single source for point of sale pharmacy claims. This may ease the process of

data validation and submission for rebates to manufacturers — ultimately reducing manufacturer rebate disputes.

Potential for Increased Rebate Collections

In a pharmacy benefit carve-out model, the formulary and preferred drug selections will be consistent across the entire membership and all therapeutic drug classes. As a result, DMAS may have the opportunity to collect more federal and supplemental rebates than in the current environment (where the CCF does not apply to all classes).

Potential Savings on 340B claims

In a pharmacy benefit-carve out model, 340B providers will be paid using the actual acquisition cost plus dispensing methodology as required by the Virginia Medicaid State Plan. The FFS 340B methodology may represent significant savings compared to the methodology used by the MCO subcontracted PBMs.

Pharmacy Benefit Carve-Out Challenges

There is a myriad of challenges that may occur in the implementation of a pharmacy benefit carve-out model.

Separation of Management of Retail and PADs

Many drug products, including many high cost specialty drug products, can be administered in an office setting or self-administered by the member at home. In a FFS carve-out model, DMAS needs to establish clear expectations related to whether the FFS vendor or the health plan is responsible for physician-administered drugs or drugs dispensed along with durable medical equipment. In the absence of clear expectations, guidance and a post-payment review procedure, there is a risk for duplicative billing and adverse incentives for shifting utilization from medical to pharmacy (and vice-versa).

Data Coordination for Continuity of Care and Case Management

The need for frequent and ongoing data flow between the MCOs, DMAS and any contracted pharmacy vendor will create a challenge. However, these challenges can be overcome through implementation of a robust data sharing plan and implementation prior to the go live date. The absence of a robust data sharing plan may lead to breakdowns in member service and care.

Loss of Budget Predictability

Managed care capitation rates offer states budget predictability and eliminate volatility in prescription drug spend (especially for high cost drugs). In a pharmacy benefit carve-out model, the state accepts the risk and inherent volatility of drug costs that fluctuate over time.

In addition to budget volatility on the prescription drug spend, there may also be differences in the amount of federal funding available for the administrative costs associated with the pharmacy

benefit. In a full-risk managed care model, the state receives the (FMAP) matching rate for the entire capitation expense, which includes both the medical spend and the managed care administrative costs. In a pharmacy benefit carve-out model, the state receives the FMAP rate only on payment for prescriptions and associated pharmacy services. The cost of the administration of the pharmacy benefit would be matched at the administrative rate, which is typically lower unless the state can secure enhanced match by tying the claims processing and administrative activities to MMIS implementation work.

Transition Care Planning

The implementation period will present several challenges related to the transition of care for the enrolled membership. To ensure transition of care challenges are addressed, DMAS must provide the pharmacy benefit administrator ample time to develop a readiness plan to ensure that sufficient staff will be available during the transition phase to support both members and providers.

DMAS should ensure that an action plan is put in place to ensure members have access to their current medication regimens through the transition phase. DMAS should also develop a method to ensure plans receive timely pharmacy policy/benefit decisions that may impact the care of members through the medical benefit they administer.

Less Opportunity for Decentralized Innovation

In the current structure, individual MCOs have the ability to innovate and pilot different clinical programs, network management strategies and provider/member outreach efforts. In a pharmacy benefit carve-out model, all program design decisions must be made directly by DMAS. While a single point of authority will ensure consistency, it may also slow the opportunities for innovation given the limited bandwidth available within DMAS.

Additionally, a FFS pharmacy program is bound by the reimbursement requirements of the covered outpatient drug rule, so fewer options are available for reimbursement structure modifications.

Potential Conflict of Interest

If DMAS were to procure a single PBA or claims processor, it is possible that the vendor selected would have an ownership relationship with one or more of the existing MCOs. There is also the potential for a real or perceived conflict of interest arising if the state were to select a single PBA that is financially aligned with one of the existing MCOs, either through ownership structure or contracted arrangement.

Removal of Pharmacy Benefit from Capitation Rates

The adoption of a pharmacy benefit carve-out model would require an update to the managed care capitation rates to reflect the removal of the pharmacy benefit from managed care.

In summary, implementing a pharmacy benefit carve-out model requires thorough planning to not only ensure a successful implementation, but to minimize disruption to member care. Data sharing is of utmost importance during the planning phase; an actionable data sharing process plan must be developed with input from all parties involved in order to mitigate issues during the implementation (and ultimately, operation) phase. The pharmacy benefit carve-out model's greatest potential for savings would be through the elimination of the pharmacy administration component from the managed care capitation rates (and potentially from the availability of increased rebates). The greatest potential for increased cost in a pharmacy benefit carve-out model is from the increased pharmacy reimbursement — particularly the higher dispensing fees — that the FFS program would be required to pay.

STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT METHODOLOGY

Background

Description of State Mandated Pharmacy Provider Reimbursement Model

In the state mandated reimbursement model proposed by DMAS, the MCOs would remain at risk for the pharmacy benefit and could continue to contract with the MCOs using any contractual administrative fee model (including spread or pass-through). MCO contracts would include a clause requiring the MCO's PBM to pay the enrolled pharmacies using the same methodology as the DMAS FFS program. Pharmacy provider disputes regarding reimbursement would be the responsibility of DMAS to troubleshoot and resolve.

State Medicaid Environmental Scan

As previously described, current PBM contracting methodologies and continuing transparency concerns have created interest in new pharmacy program design models. One emerging model is the state mandated pharmacy provider reimbursement model, under which states are incorporating FFS pharmacy reimbursement methodologies within MCO contracts. A state mandated reimbursement methodology combines MCO responsibility and risk for the prescription drug benefit with a requirement that pharmacies be paid using the state's FFS reimbursement methodology. The state is responsible for developing the reimbursement structure and communicating updates with the MCOs and/or their subcontracted PBMs. A state example of this pharmacy program design model is Mississippi, who coordinates the FFS reimbursement methodology across three MCOs and their contracted PBMs.

Case Study: State Mandated Pharmacy Provider Reimbursement Methodology — Mississippi

In the State of Mississippi, the three MCO's contracted to administer the Medicaid pharmacy benefit are mandated to pay pharmacies based on the current Mississippi Division of Medicaid, FFS reimbursement methodology. Mississippi has mandated that MCOs follow their FFS pharmacy methodology in reimbursing pharmacy providers for prescribed drugs as described in Mississippi's

State Plan[18] since at least 2011. Mississippi's current pharmacy methodology is explicit as it pertains to brand and generic drugs, including those dispensed in long-term care pharmacy. Reimbursement methodology for 340B, Specialty Drug (including clotting factor) and PADs are also all delineated in the State Plan. Additionally, Mississippi MCOs are mandated to adhere to the State's FFS PDL and PA criteria.[19]

Other State Medicaid Use and Experience

The State of Louisiana implements a component of the state mandated pharmacy provider reimbursement methodology with a "hybrid" approach.

Effective August 1, 2018, Louisiana enacted SB130 (2018). In addition to requiring a pass-through pricing and administrative fee model for the PBMs serving Medicaid MCOs, the bill also directs the PBMs to pay pharmacies meeting the "local pharmacy" criteria (primarily independent and rural pharmacies) no less than the Louisiana Medicaid FFS rate.[20] The Louisiana program combines components from two separate benefit designs mentioned in this report: 1) the mandatory pass-through pricing model methodology and 2) the state mandated pharmacy provider reimbursement methodology.

CCF versus Single FFS Uniform PDL Impact within a State Mandated Pharmacy Provider Reimbursement Program Design

Mississippi, as part of its state mandated reimbursement policy, requires its three MCOs to align with its full FFS PDL.

While DMAS implemented a CCF in phases throughout 2018, the CCF includes only a subset of drugs and therapeutic classes that would be included on a full Uniform PDL.

In the Mississippi uniform PDL model, MCOs are not allowed to collect market share rebates for any drug products. In contrast, under the CCF, MCOs are only prohibited from collecting rebates for closed drug classes. In addition, while MCOs are allowed to add additional preferred drugs to open classes under the CCF, an option to add additional drugs is generally not allowed under a full uniform PDL model such as Mississippi's.

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[18] State Plan Under Title XIX of the Social Security Act Medical Assistance Program State of Mississippi Methods and Standards for Establishing Payment Rates- Other Types of Care. https://medicaid.ms.gov/wp-content/uploads/2019/09/Pharmacy-Pages-from-Attachment_4.19-B.pdf

[19] Mississippi Division of Medicaid Universal Preferred Drug List. https://medicaid.ms.gov/wp-content/uploads/2019/04/MSPDLeffective07012019.pdf

[20] https://legiscan.com/LA/text/SB130/2018

States have a number of reasons for implementing a uniform PDL. However, the most important consideration for transition to a uniform PDL is the State's ability to maximize supplemental rebates on certain brand drugs and ensure utilization across therapeutic categories is concentrated in the drugs with the lowest net rebate cost to the program.

Summarized in Table 17 below are advantages and challenges of implementing a single PDL versus maintaining the CCF in a state mandated pharmacy provider reimbursement methodology.

TABLE 17: ADVANTAGES AND CHALLENGES OF SINGLE PDL VERSUS CCF

ADVANTAGES	CHALLENGES
• Potential for increase in supplemental rebates. • Rebate transparency. • Consistent pharmacy clinical coverage criteria requirements across all Medicaid members. • Reduced medications transitions for members. • Reduced administrative burden for providers; need to reference only one PDL or prior authorization requirements for members.	• Preferred brands increase reimbursement payments to pharmacies. • Potential increase in capitation rates. • May increase PBM administrative costs. • Increased need for DMAS staff MCO oversight and coordination efforts. • Coordination efforts with MCOs and their PBMs. • MCO resistance.

State Mandated Pharmacy Provider Reimbursement: DMAS Operational Impacts

Significant planning must take place to ensure the successful implementation of a state mandated pharmacy provider reimbursement methodology program design. Operational impacts are an important consideration for any program design change. Mercer analyzed the potential impacts in several operational areas. Table 18 below summarizes potential DMAS Operational Impacts. Additional descriptions of the projected impacts are provided in the text following the table.

TABLE 18: POTENTIAL DMAS OPERATIONAL IMPACTS

OPERATIONAL IMPACT CATEGORY	STATE MANDATED REIMBURSEMENT MODEL IMPACTS
Utilization Management Coordination	No impact.
Rebate Processing	No impact.
DMAS Contracting and Reporting Administrative Impact	• Updates to MCO contracts. • Updates to oversight and financial reporting. • Updates to capitation rates.
Pharmacy Provider Impact	Increased reimbursement for pharmacy providers.
Member Impact	No impact.

OPERATIONAL IMPACT CATEGORY	STATE MANDATED REIMBURSEMENT MODEL IMPACTS
MCO Oversight Impact	• Increased oversight of pharmacy reimbursement by PBMs. • Communication and coordination plan required.
DMAS Staffing Impact	• Realignment of current staff responsibilities. • Two additional staff members.
Pharmacy Provider Reimbursement Validation/Verification	• Dissemination of reimbursement methodology to MCOs and process for communicating reimbursement updates. • Process for ongoing monitoring of payments to pharmacy providers.
Pharmacy Provider Disputes Submitted to DMAS	Potential increased volume of disputes due to multiple PBMs implementing methodology.

DMAS Contracting and Reporting Administrative Impact

Administrative procedures and policies that directly relate to MCO oversight and financial monitoring may have to be revised and updated. Internal procedures and processes will have to be updated to incorporate the additional operational functions as a result of implementation of the state mandated pharmacy provider reimbursement requirements. In particular, DMAS will need to develop a mechanism to regularly share the FFS reimbursement rate for all drugs, including MAC rates, with the MCO providers to ensure consistent application of the FFS methodology.

Pharmacy Provider Impact

Moving to a state mandated pharmacy provider reimbursement model is expected to increase the payments to pharmacy providers, particularly for generic drugs given the professional dispensing fee incorporated into the FFS methodology. All pharmacy providers would be paid using the same methodology regardless of the subcontracted PBM administering the MCO pharmacy benefit.

MCO Oversight Impact

Validating MCOs are reimbursing at the mandated state pharmacy provider reimbursement methodology will be the most important MCO oversight activity required. This requirement will lead to an increase in current MCO oversight functions. In order for DMAS to successfully undertake this endeavor, detailed communication and coordination procedures with clear documentation must be developed. Procedure documentation and implementation will be key in ensuring all MCOs receive necessary pharmacy reimbursement information such as PDL files, MAC lists, covered products list, pharmacy fee schedules and rate files.

DMAS Staffing Impact

Current staff responsibilities will need to be realigned to operate a state mandated pharmacy provider reimbursement program design model. These realigned responsibilities will focus on the coordination and communication of state reimbursement methodology changes and/or updates with DMAS contracted MCOs. There is, however, a potential to add two additional staff members for MCO compliance and oversight. The qualified individuals would have experience comparable to recommended staffing needs described in the mandated pass-through pricing model. Experience could include pharmacy audit, program integrity, project and/or contract management, data and analytical reporting. Again, DMAS may consider contracting with a vendor to support implementation and ongoing monitoring of the MCOs for compliance to the DMAS FFS environment.

Pharmacy Provider Reimbursement Validation/Verification

In a state mandated pharmacy provider reimbursement model, DMAS Pharmacy staff would be tasked in validating that MCOs are reimbursing at the FFS methodology. DMAS staff would ensure that the pharmacy reimbursement methodology and any associated rate schedules are appropriately documented and updated as necessary. DMAS would also coordinate the dissemination of any changes to the pharmacy reimbursement methodology in a timely manner to the MCOs. DMAS would need to develop a process for monitoring and reviewing MCO operational policies and procedures for incorporating a state mandated pharmacy provider reimbursement requirement. Periodic audits and review of encounter pharmacy detail will validate and verify that the state mandated pharmacy methodology is followed appropriately by the MCOs.

Pharmacy Provider Disputes Submitted to DMAS

Under a state mandated pharmacy provider reimbursement methodology model, DMAS would be responsible for mediating, mitigating and/or resolving any provider reimbursement disputes pertaining to rate changes or perceived underpayment. DMAS would need to ensure that their pharmacy, financial and provider reimbursement staff are trained and prepared to assist with the pharmacy provider disputes upon implementation.

Additionally, a new competitively procured pharmacy reimbursement contract or contract amendment may be necessary to move forward with a mandated reimbursement methodology program design. The new contract would need to provide the vendor with the capacity necessary to accommodate the anticipated volume increase in pharmacy provider calls related to reimbursement inquiries and disputes.

State Mandated Pharmacy Provider Reimbursement Methodology: Qualitative Considerations

In addition to evaluating the DMAS operational impact, Mercer identified non-operational advantages and challenges that could be expected upon implementation of a state mandated

pharmacy provider reimbursement model. Table 19 below summarizes the advantages and challenges of a state mandated pharmacy provider reimbursement model at a high level.

TABLE 19: ADVANTAGES AND CHALLENGES OF A STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT MODEL — HIGH LEVEL

ADVANTAGES	CHALLENGES
• Pharmacy provider community acceptance. • Statewide consistency in reimbursement across pharmacy providers. • Potential savings on 340B claims.	• Capitation rate adjustments for administrative and pharmacy benefit. • MCO compliance oversight. • Management of multiple vendor relationships. • Reimbursement across different MCOs or different providers is less flexible. • Elimination of MCO/PBM pharmacy contracting efficiency opportunity.

State Mandated Pharmacy Provider Reimbursement Methodology Advantages
Having a state mandated pharmacy provider reimbursement across MCOs provides an advantage in consistent and transparent pharmacy reimbursement levels for the provider community (pharmacy provider groups would be appreciative of this change). In addition, the consistent reimbursement methodology across pharmacy types would eliminate any perception that pharmacies under the same ownership of the PBM are being paid a more favorable rate than independent or other non-PBM owned pharmacies. If the state mandated pharmacy provider reimbursement methodology is extended to 340B claims, there is potential that capitation rates could be decreased to reflect the 340B savings opportunity.

State Mandated Pharmacy Provider Reimbursement Methodology Challenges
The implementation and coordination of a state mandated pharmacy provider reimbursement methodology may create challenges for DMAS. These challenges are attributed to increased need for DMAS coordination due to increased demand for MCO oversight responsibilities as well as assuming the responsibility of mediating and resolving provider disputes.

Capitation Rate Updates
The adoption of a state mandated pharmacy provider reimbursement model would likely require an update to the managed care capitation rates to reflect the increased dispensing fee costs that PBMs would be required to pay to pharmacy providers.

MCO Compliance Oversight
DMAS may be required to increase coordination efforts between the state and contracted vendors to ensure correct transmission of reimbursement methodology (including rate adjustments and

preferred products). DMAS will need to develop a plan to ensure MCOs comply with reimbursement mandates.

Management of Multiple Vendor Relationships

Ensuring that all MCOs get the required reimbursement/methodology information may present some initial challenges. However, DMAS should be able to leverage staff experience with the previous implementation and coordination of CCF to help mitigate this challenge.

Reimbursement Across Different MCOs or Different Providers is Less Flexible

In a state mandated pharmacy provider reimbursement model, the PBMs no longer have an opportunity to vary the pharmacy reimbursement methodology across providers to reflect differences in quality, service, or location (or to drive efficiency in pharmacy contracting).

In summary, implementing a state mandated reimbursement methodology requires a thorough communication, coordination and implementation plan. The coordination and transmittal of reimbursement rate and methodology to contracted MCOs is crucial. Preparation for initial rate file inputs and subsequent rate updates and/or changes must be approached methodically in a coordinated effort with all MCOs and rate setting vendors to mitigate issues during transition and ultimately during the operational phase. A state mandated reimbursement methodology may not necessarily generate savings, but would provide pharmacy providers with more consistent payment levels across MCOs.

4

FISCAL IMPACT

Mercer presents a methodology overview and the estimated fiscal impact for SFY 2019 of the three pharmacy program designs models:

1. Mandatory pass-through pricing.

2. Pharmacy benefit carve-out of managed care.

3. State mandated pharmacy provider reimbursement methodology.

The methodology overview provides information on the base data Mercer used and describes the financial adjustments Mercer considered in calculating the fiscal estimate for each of the program design models.

METHODOLOGY OVERVIEW

Mercer reviewed and summarized historical MCO pharmacy encounter claims with dates of service from July 1, 2018 to December 31, 2018.

Mercer applied adjustments to the July 1, 2018 to December 31, 2018 base data to estimate managed care pharmacy program costs for SFY 2019. These adjustments accounted for:

- Relative enrollment changes that occurred through June 2019.

- Seasonality to account for cyclical changes not represented in the base data.

Mercer also estimated pharmacy costs for the Medallion 4.0 and CCC Plus Expansion populations for January 1, 2019 through June 30, 2019. These populations became eligible for Medicaid managed care effective January 1, 2019, and therefore their claim experience were not included in the base data.

The managed care programs in this analysis included:

- Medallion 4.0 – Mothers, Children, Adults Age 18–64.

- CCC Plus – Medically Complex Populations.

- Expansion population (adults with income levels up to 133% of the federal poverty level) enrolled in either Medallion 4.0 or CCC Plus.

Mercer did not include the FAMIS and FAMIS Moms in the analysis.

Fiscal estimates represent the combined impact to the Virginia Medicaid program during SFY 2019 and are broken out by state and federal funding sources.[21] The fiscal impacts may be larger in future years as the Expansion population becomes fully integrated into the Virginia Medicaid program.

Mercer applied a series of adjustments to the annualized MCO encounter base data to estimate the potential fiscal impact for the pharmacy program design models. Table 20 below lists and describes the financial adjustments Mercer considered in the analyses. Adjustments were applied to each model as applicable; Mercer did not apply all adjustments to each model.

TABLE 20: FINANCIAL IMPACT ADJUSTMENT CONSIDERATIONS

ADJUSTMENT CATEGORY	CATEGORY DESCRIPTION
Repricing Adjustment	Reflects the difference between the reported value of the encounter pharmacy claim and the amount calculated by applying the DMAS FFS pricing methodology. Mercer further divided the repricing adjustment into the estimated spread amount currently retained by PBMs and the estimated impact to pharmacy providers of the new reimbursement methodology.
Payment from MCOs to PBMs	Reflects an offset to the repricing adjustment to recognize administrative payments between the MCOs and the PBMs that previously were generated by spread pricing.
Member Utilization Management	Reflects changes in drug utilization.
Rebates – Federal	Reflects changes in federal rebate collections from drug manufacturers.
Rebates – MCO Market Share Rebate	Reflects the impact of changes to MCO or PBM market share rebate collections on MCO capitation payment.
Rebates – State Supplemental	Reflects changes in DMAS supplemental rebate collections from drug manufacturers.

[21] For the Expansion population, Mercer used the Federal Medical Assistance Percentage (FMAP) rate of 93% that was effective January 1 – June 30, 2019. In 2020 and beyond, the FMAP rate for the Expansion population will decrease to 90% and the fiscal impact will shift from the Federal government to the State General Fund.

ADJUSTMENT CATEGORY	CATEGORY DESCRIPTION
MCO Administration Expense	Reflects changes in the amount included in the capitation rate calculation for MCO or PBM administration costs.
Underwriting Gain	Reflects changes in the amount included in the MCO capitation rates for cost of capital and margin for risk or contingency.
Taxes	Reflects taxes paid by the MCO that may be reflected in the capitation rates. • Mercer did not make any adjustment for taxes in these analyses. While there are MCO taxes in Virginia, none pertain to the Medicaid line of business. • Furthermore, Mercer did not adjust its analyses for the impact of the HIF tax due to the moratorium that is currently in place.
Data Coordination	Reflects implementation and ongoing costs for data sharing between DMAS and the MCOs.
Vendor Cost	Reflects a change in pharmacy claims processor costs based on anticipated change in claims processing volume.
Staffing	Reflects expenses of staffing changes.

The following sections provide the estimated fiscal impact for each of the three models. More detailed information about the methodology of determining the repricing adjustment, exclusions and data sources is located in Appendix A.

MANDATORY PASS-THROUGH PRICING

In a mandatory pass-through pricing program model, the state requires the MCO-contracted PBMs to charge the MCO the same amount it reimburses the pharmacy providers. The PBM is compensated for administering the pharmacy benefit through a transparent administration fee structure rather than retaining the spread between the pharmacy reimbursement amount and the MCO charged amount as administrative revenue. Additionally, in a pass-through pricing model the PBM is required to pass all market share rebates to the MCO. Currently, four of the six DMAS MCOs reportedly operate under a pass-through model. Only Anthem (PBM is ESI) and Optima (PBM is OptumRx) reported they currently have traditional pricing designs and would be required to migrate to a pass-through arrangement under this program design.

Approach

Mercer reviewed and summarized the reported PBM revenue source information submitted in the MCO questionnaires and completed an environmental scan of typical pass-through pricing and traditional spread pricing arrangements.

The information provided in the questionnaire included administrative fees paid by each MCO to its subcontracted PBM as well as any market share rebates retained by the PBM. PBM spread per claim is considered confidential information and was not provided in the questionnaire.

PBM spread is the difference between what the MCO pays the PBM and what the PBM pays the pharmacy provider. DMAS encounter data includes only the amount the MCO pays the PBM and does not include what the PBM pays the pharmacy provider. Mercer estimated PBM spread for Anthem (ESI) and Optima (OptumRx) based on spread per claim amounts published in recent publicly available reports, other Mercer client experiences and the DMAS PBM transparency report.

Table 21 displays estimated combined revenue sources for the traditional (Spread) plans and the pass-through pricing plans for July 1, 2018 through December 31, 2018. Mercer calculated the MCO-estimated base administration fees using the MCO reported per claim fee paid to the PBM multiplied by the MCO's encounter claim volume. Other fees may be charged by the PBM for additional clinical or administrative services, and those fees were not included in Table 21. These other services may include paper claim fees, ad-hoc reporting charge, medication therapy management fees, etc.

The qualitative portion of the report described other potential PBM revenue streams such as MAF and DIR fees. These additional revenue streams are not included in the estimated PBM administration fee as they occur after the point of sale and often vary in magnitude across time periods. There is no transparent system to capture these dollar amounts; therefore, the total impact of these fees is unknown and also not included in Table 21. Due to the lack of transparency, Mercer is unable to estimate the fiscal impact of MAF and DIR fees. In the absence of explicit contractual direction from DMAS, it is likely that the existence of MAF and DIR fees would continue in a pass-through model.

TABLE 21: ESTIMATED REVENUE FOR DMAS PLANS DURING JULY 1–DECEMBER 31, 2018

PBM REVENUE SOURCE EVALUATED	TIME PERIOD:JULY 1–DECEMBER 31, 2018	
	TRADITIONAL (SPREAD) MODELS	PASS-THROUGH MODELS
Payment from MCOs to PBMs – Encounter Data	$215,714,000	$195,068,000
Estimated PBM Spread	$9,667,000	$0
MCO Estimated Base Administration Fee for PBM Services	$438,000	$3,138,000
Retained Market Share Rebates as Reported by MCO	$154,000	$0

PBM REVENUE SOURCE EVALUATED	TIME PERIOD:JULY 1–DECEMBER 31, 2018	
	TRADITIONAL (SPREAD) MODELS	PASS-THROUGH MODELS
Total PBM Revenue	**$10,259,000**	**$3,138,000**
Revenue as a Percentage of MCO Paid Amount	4.8%	1.6%

Mercer actuaries who calculate the DMAS managed care capitation rates reviewed the historical PBM revenue information. They evaluated whether the total base administrative revenue paid to the traditional PBMs was efficient compared to amount paid to the PBMs already operating under a pass-through model. Specifically, Mercer actuaries evaluated whether the elimination of estimated PBM spread and retained market share rebates would likely be converted into an equivalent transparent administrative fee structure, and if the transition to pass-through would be likely to have a material impact on the capitation rates.

Estimated Financial Impact of the Mandatory Pass-Through Pricing Model

Mercer determined that there **would likely be an impact to the capitation rates** should DMAS move to a mandated pass-through pharmacy program design model. Comparing the Total PBM Revenue of the two traditional (spread) plans and the four pass-through plans, Mercer estimates the **DMAS program could save $10.1 million,** or -0.9% of total estimated drug spend, by applying an administrative fee efficiency adjustment to account for the removal of spread pricing as part of capitation rate development. It is worth noting that it would be possible for DMAS and Mercer to use updated information similar to the information collected for this report to apply an administrative efficiency adjustment to capitation rates independent of requiring a mandatory pass-through pricing model program design.

Table 22 below shows the estimated reduction to the managed care capitation rates for applying an administrative fee efficiency adjustment by population.

TABLE 22: ESTIMATED FINANCIAL IMPACT OF THE MANDATORY PASS-THROUGH PRICING MODEL

POPULATION	TIME PERIOD: SFY 2019		
	ADMINISTRATIVE FEE EFFICIENCY ADJUSTMENT ESTIMATES	STATE SHARE	FEDERAL SHARE
CCC Plus and Medallion	($7,720,000)	($3,860,000)	($3,860,000)
Expansion Populations	($2,377,000)	($166,000)	($2,211,000)
Total Estimated SFY 2019 $ Impact (Savings)/Cost	**($10,097,000)**	**($4,026,000)**	**($6,071,000)**
Total Estimated SFY 2019 % Impact	**-0.9%**		

For the mandatory pass-through pricing model, additional staffing would be needed to oversee and monitor MCO contracts and financial reporting. Mercer estimates the additional annual staffing costs would be approximately $250,000. This amount would be incurred outside of the capitation rate and is not included in the fiscal impact estimates noted above.

Key Observations

- Based on Mercer's experience with other Medicaid programs, Mercer has assumed a 3.0% pharmacy administrative expense in this model for an efficiently run MCO/PBM contract.
- Four of the six MCOs currently have a pass-through pricing arrangement with the MCO contracted PBM. Only two plans, Anthem and Optima, would be required to change pricing models if the state enacted a mandatory pass through program.
- Only one MCO indicated a PBM was retaining a portion of the market share rebates.
- The PBM revenue as a percentage of MCO Paid Amount varied greatly among the four pass-through plans, ranging between 0.5% and 3.3%. Mercer recommends that DMAS request additional details about the administration expenses MCOs pay the PBMs for ongoing monitoring and validation. This additional information would also be needed for the next capitation rate development cycle to refine the estimated pharmacy administrative fee efficiency adjustment.
- It is possible that DMAS could achieve similar savings in the capitation rates by applying an administrative efficiency adjustment without mandating adoption of pass-through PBM contracts.

Financial Impact Adjustment Considerations

Table 23 below lists each adjustment category, the financial implication of each category and a brief description to explain how Mercer applied the adjustment in the mandatory pass-through evaluation.

TABLE 23: SUMMARY OF ADJUSTMENTS USED FOR ESTIMATED FINANCIAL IMPACT OF A MANDATORY PASS-THROUGH PRICING MODEL

ADJUSTMENT CATEGORY	MODELED FINANCIAL IMPLICATION	EXPLANATION
Repricing Adjustment	No impact	• While there may be a potential for increased pharmacy provider reimbursement with the elimination of spread retention, the impacts are not possible to quantify. • Mercer did not apply a repricing adjustment to this model
Payment from MCOs to PBMs	Potential Impact	• Four of the six MCO and MCO–subcontracted PBMs already operate under a pass-through model. The remaining two MCOs would move from a traditional spread model to a pass-through pricing model. • When spread is removed, transparent models are paid a per claim transaction fee or a PMPM fee to cover administrative costs. • In the absence of an administrative efficiency applied to the capitation rates, there would be no rate impact in a pass-through model as MCOs could continue paying PBMs the same amount using a transparent mechanism.
Member Utilization Management	No Impact	• No changes in utilization management as MCOs retain control of pharmacy utilization management.
Rebates – Federal	No Impact	• No changes in federal rebates as utilization or drug product mix is not expected to change.
Rebates – MCO Market Share Rebate	No Impact	• Currently only one PBM is retaining market share rebates. • The market share rebate assumption applied to the capitation rates does not currently assume that market share rebates are retained by the PBM. The current market share rebate adjustment applied to the capitation rate is an estimation of the amount of market share rebates available to an efficiently contracting MCO.

ADJUSTMENT CATEGORY	MODELED FINANCIAL IMPLICATION	EXPLANATION
Rebates – State Supplemental	No Impact	• No changes in state supplemental rebate collections as utilization or drug product mix is not expected to change.
MCO Administration Expense	Savings	• Current experience indicates an administrative efficiency adjustment could be applied to the capitation rates upon implementation of a mandatory pass-through pricing model.
Underwriting Gain	Savings	• If an administrative efficiency adjustment is applied to the capitation rates, there would be a corresponding reduction in the underwriting gain amount built into rates.
Taxes	No Impact	• While there are MCO taxes in Virginia, none pertain to the Medicaid line of business. • The potential impact of the HIF tax was not modeled due to the moratorium that is currently in place.
Data Coordination	No Impact	• DMAS recently implemented requirements for MCOs to report the amount paid to MCO and the amount paid to pharmacy providers. Mercer believes there will be no additional impact for data coordination in a mandatory pass-through pricing model.
Vendor Cost	No Impact	• No changes in pharmacy claims processor cost as there would be no change to the number of members or claims in the FFS environment.
Staffing	Cost	• Additional staffing would be needed to oversee and monitor MCO contracts and financial reporting. • Mercer estimated the cost of two staff members based on the average Pharmacy Department salary provided by DMAS. A 30% markup was applied to the salary to account for benefits.

PHARMACY BENEFIT CARVE-OUT OF MANAGED CARE

In a pharmacy benefit carve-out model, the pharmacy benefit is moved out of the managed care delivery system and into FFS. Payment to pharmacy providers for prescriptions would be required to comply with the FFS reimbursement methodology and would be adjudicated through DMAS' claims processing vendor. The managed care capitation rates would no longer include funding for payment of outpatient prescription drugs or administration of the pharmacy benefit.

Approach

To estimate the fiscal impact of a pharmacy benefit carve-out, Mercer re-priced encounter claims using DMAS' current FFS reimbursement methodology based on National Average Drug Acquisition Cost (NADAC) or WAC prices and a professional dispensing fee (PDF) of $10.65. Mercer compared the aggregated repriced claims to estimated MCO aggregate reimbursement to calculate the fiscal impact of the change in the pharmacy reimbursement methodology and the corresponding impact to managed care capitation rates.

In this analysis, Mercer also adjusted the pharmacy reimbursement logic to account for Usual & Customary (U&C) claims, 340B claims, and the CCF.

Mercer provides further details of the repricing methodology in Appendix A.

Estimated Financial Impact of the Pharmacy Benefit Carve-Out of Managed Care Model

Table 24 below shows the estimated financial impact of the pharmacy benefit carve-out of managed care model. The adjusted base dollars in the table reflect pharmacy drug spend for July 2018 through June 2019 that would be removed from the capitation rate development if the state implemented a pharmacy benefit carve-out program. The adjusted base dollars eligible for repricing are a subset of those total dollars. The eligible dollars are the total pharmacy spend included in the capitation rate development that Mercer re-priced using the FFS pharmacy provider reimbursement methodology. Additional detail about claims that were excluded from the repricing methodology is available in Appendix A.

TABLE 24: ESTIMATED SFY 2019 FISCAL IMPACT OF A PHARMACY BENEFIT CARVE-OUT

FISCAL IMPACT ADJUSTMENTS	CCC PLUS POPULATION (A)	MEDALLION POPULATION (B)	EXPANSION POPULATION (C)	TOTAL POPULATIONS (D = A + B + C)
Adjusted Base Dollars	$515,398,000	$354,147,000	$259,562,000	$1,129,108,000
Adjusted Base Dollars Eligible for Repricing	$487,283,000	$193,082,000	$141,514,000	$821,878,000
ADJUSTMENTS				
Repricing Adjustment	$(12,693,000)	$3,160,000	$(1,736,000)	$(11,270,000)
Estimated PBM Spread	$(11,046,000)	$(8,464,000)	$(6,006,000)	$(25,517,000)
Estimated Impact to Pharmacies	$(1,647,000)	$11,624,000	$4,270,000	$14,247,000
Payment from MCOs to PBMs	$ -	$ -	$ -	$ -

FISCAL IMPACT ADJUSTMENTS	CCC PLUS POPULATION (A)	MEDALLION POPULATION (B)	EXPANSION POPULATION (C)	TOTAL POPULATIONS (D = A + B + C)
Member Utilization Management	$ -	$ -	$ -	$ -
Rebates – Federal	$(2,577,000)	$(1,771,000)	$(1,298,000)	$(5,646,000)
Rebates – MCO Market Share Rebate	$6,185,000	$6,559,000	$4,067,000	$16,810,000
Rebates – State Supplemental	$(5,154,000)	$(3,541,000)	$(2,596,000)	$(11,291,000)
MCO Administration Expense[22]	$(6,442,000)	$(4,427,000)	$(3,245,000)	$(14,114,000)
Underwriting Gain	$(4,969,000)	$(3,556,000)	$(2,614,000)	$(11,138,000)
Taxes	$ -	$ -	$ -	$ -
Data Coordination with MCOs	$127,000	$415,000	$107,000	$649,000
Vendor Cost	$1,689,000	$1,161,000	$851,000	$3,700,000
Staffing	$115,000	$79,000	$58,000	$251,000
TOTAL ESTIMATED IMPACT				
Total Estimated SFY 2019 $ Impact (Savings)/Cost	**$(23,720,000)**	**$(1,922,000)**	**$(6,406,000)**	**$(32,048,000)**
Total Estimated SFY 2019 % Impact	**-4.6%**	**-0.5%**	**-2.5%**	**-2.8%**
Total Estimated SFY 2019 $ Impact (Savings)/Cost State Share	**$(12,343,000)**	**$(1,375,000)**	**$(266,000)**	**$(13,983,000)**
Total Estimated SFY 2019 $ Impact (Savings)/Cost Federal Share	**$(11,377,000)**	**$(547,000)**	**$(6,140,000)**	**$(18,065,000)**

[22] Represents non-spread pricing administrative expenses only.

Mercer estimates moving to a pharmacy benefit carve-out pricing model would potentially **save the Virginia Medicaid program $32.0 million** or 2.8% of outpatient pharmacy expenditures.

Key Observations

- Repricing MCO encounter claims using the FFS reimbursement methodology results in a savings of $11.3 million as shown in the Repricing Adjustment row in the table above. This is happening because:
  - The spread was included in the MCO encounter payments and the repricing exercise removes the spread amount.
  - There is a significant portion of specialty prescriptions, especially in the CCC Plus population. The FFS reimbursement methodology generally pays lower for specialty claims than a typical MCO reimbursement methodology.
- Mercer estimates $4.6 million in additional costs for data coordination with MCOs, vendor costs and staffing.

Financial Impact Adjustment Considerations

Table 25 below lists each adjustment category, the financial implication of each category and a brief description to explain how Mercer applied the adjustment.

TABLE 25: SUMMARY OF ADJUSTMENTS USED FOR ESTIMATED FINANCIAL IMPACT OF A PHARMACY BENEFIT CARVE-OUT

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Repricing Adjustment	Savings	• CMS requires state Medicaid FFS programs to reimburse providers at their average acquisition cost plus a PDF. This is a different reimbursement model than MCOs currently utilize. • FFS ingredient reimbursement is typically lower than MCO ingredient reimbursement; however, MCOs typically pay a significantly lower dispensing fee per prescription to the pharmacy provider than FFS PDFs. • The encounter claims data includes both the pharmacy provider payment amount and the spread retained by the PBMs employing a traditional administrative fee structure.
Payment from MCOs to PBMs	No Impact	• Pharmacy costs are carved out of managed care and MCOs and will no longer contract with PBMs.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Member Utilization Management	No Impact	• DMAS currently requires that MCOs not have more stringent utilization management criteria than FFS. Therefore, Mercer did not model any change for utilization management differences for a carve-out model.
Rebates – Federal	Savings	• The Affordable Care Act (ACA) requires drug manufacturers to pay rebates for pharmacy claims dispensed in the managed care environment. DMAS is already collecting federal rebates on the claims in the MCO programs. • Mercer believes there could be a slight increase in the collection of federal rebates due to the efficiencies gained by having all retail pharmacy claims under one program. However, DMAS will have to continue to rely on MCO encounter data to continue to invoice and collect for rebates on physician administered drugs. • It is also possible that federal rebate collections could increase slightly as all drug utilization would be subject to the DMAS PDL.
Rebates – MCO Market Share Rebate	Cost	• In managed care rate setting, the capitation rates are reduced by an estimated amount of market share rebates believed to be attainable through efficient contracting for the CCF open classes. • In a pharmacy benefit carve-out, the market share rebate reduction would no longer be applied and the capitation rates would increase by this amount.
Rebates – State Supplemental	Savings	• DMAS currently receives supplemental rebates on MCO utilization for closed classes of DMAS' CCF. • Mercer anticipates DMAS to receive additional supplemental rebates due to the increase in claim volume reflecting the MCO pharmacy claims moving to FFS and all currently open drug classes being eligible for state supplemental rebates.
MCO Administration Expense	Savings	• Moving the pharmacy benefit out of managed care will result in a decrease in the capitation rate and lower administrative costs as the MCOs no longer will contract with PBMs. Mercer assumed 3% for administration expenses, inclusive of both PBM spread and administrative fees.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Underwriting Gain	Savings	• Underwriting gains are included in the capitation rate calculation and based on total premium. As the total premium declines due to removal of the pharmacy benefit, the underwriting gain will correspondingly decrease. Mercer modeled a reduction by population: – Medallion 4.0 and Expansion populations: 1% of final premium. – CCC Plus: 0.95% of final premium.
Taxes	No Impact	• While there are MCO taxes in Virginia, none pertain to the Medicaid line of business. • The potential impact of the HIF tax was not modeled due to the moratorium that is currently in place.
Data Coordination	Cost	• The FFS program will need to share pharmacy data with the MCOs to assist with care coordination efforts. • Data sharing fees are often built into the PBM contracts, but can be charged a la carte as well. Mercer estimated approximately $650,000 in additional fees for transmitting data files and offering the MCOs and DMAS access to web portal for care management services.
Vendor Cost	Cost	• The current FFS claims processing vendor would process and support significantly more claim volume if the pharmacy benefit moved from managed care to FFS. • Mercer estimated an increase of approximately $3,700,000 to the current pharmacy claims processing vendor contract.
Staffing	Cost	• Mercer estimated the cost of up to two additional staff members based on the average Pharmacy Department salary provided by DMAS. A 30% markup was applied to the salary to account for benefits.

STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT METHODOLOGY

In a state mandated pharmacy provider reimbursement model, the pharmacy benefit remains in managed care but the MCO sub-contracted PBMs are required to pay pharmacy providers using the FFS reimbursement methodology.

Approach

At a high level, the fiscal impact of a state mandated pharmacy provider reimbursement methodology would be expected to be equivalent to the repricing adjustment from the pharmacy

benefit carve-out model as MCOs would be required to reimburse pharmacy providers using the same methodology as if the claims were paid through FFS. However, unless mandatory pass-through was also required, the PBMs could continue to apply spread pricing by paying the pharmacies the FFS reimbursement rate but charging the MCOs another (higher) rate. Therefore, Mercer added back into this model the estimated spread pricing revenue currently retained by the PBMs operating under a traditional model. In addition to the reimbursement changes and at the request of DMAS, Mercer included in this model the additional impact of moving to a complete uniform PDL.

Estimated Financial Impact of the State Mandated Pharmacy Provider Reimbursement Model

Table 26 below shows the estimated financial impact for SFY 2019 of the state mandated pharmacy provider reimbursement evaluation.

TABLE 26: ESTIMATED SFY 2019 FISCAL IMPACT OF A STATE MANDATED PHARMACY REIMBURSEMENT WITH UNIFORM PDL

FISCAL IMPACT ADJUSTMENTS	CCC PLUS POPULATION (A)	MEDALLION POPULATION (B)	EXPANSION POPULATION (C)	TOTAL POPULATIONS (D = A + B + C)
Adjusted Base Dollars	$515,398,000	$354,147,000	$259,562,000	$1,129,108,000
Adjusted Base Dollars Eligible for Repricing	$487,283,000	$193,082,000	$141,514,000	$821,878,000
ADJUSTMENTS				
Estimated Impact to Pharmacies	$(1,647,000)	$11,624,000	$4,270,000	$14,247,000
Member Utilization Management	$ -	$ -	$ -	$ -
Rebates – Federal	$ -	$ -	$ -	$ -
Rebates – MCO Market Share Rebate	$6,185,000	$6,559,000	$4,067,000	$16,810,000
Rebates – State Supplemental	$(5,154,000)	$(3,541,000)	$(2,596,000)	$(11,291,000)
MCO Administration Expense[23]	$ -	$ -	$ -	$ -
Underwriting Gain	$44,000	$184,000	$84,000	$312,000

[23] Represents non-spread pricing administrative expenses only.

FISCAL IMPACT ADJUSTMENTS	CCC PLUS POPULATION (A)	MEDALLION POPULATION (B)	EXPANSION POPULATION (C)	TOTAL POPULATIONS (D = A + B + C)
Taxes	$ -	$ -	$ -	$ -
Data Coordination with MCOs	$ -	$ -	$ -	$ -
Vendor Cost	$ -	$ -	$ -	$ -
Staffing	$115,000	$79,000	$58,000	$251,000
TOTAL ESTIMATED IMPACT				
Total Estimated SFY 2019 $ Impact (Savings)/Cost	**$(458,000)**	**$14,904,000**	**$5,883,000**	**$20,329,000**
Total Estimated SFY 2019 % Impact	**-0.1%**	**4.2%**	**2.3%**	**1.8%**
Total Estimated SFY 2019 $ Impact (Savings)/Cost State Share	**$(258,000)**	**$7,432,000**	**$422,000**	**$7,597,000**
Total Estimated SFY 2019 $ Impact (Savings)/Cost Federal Share	**$(200,000)**	**$7,472,000**	**$5,461,000**	**$12,732,000**

Mercer estimates moving to a state mandated pharmacy reimbursement model inclusive of a uniform PDL would result in **increased costs of $20.3 million** or 1.8% of outpatient pharmacy expenditures.

Key Observations

- Mercer estimated the spread revenue in total and distributed it across programs by total drug spend.
- In the absence of a mandated pass-through methodology or administrative efficiency adjustment, Mercer assumes that the PBMs will retain their current amount of administrative revenue through a combination of spread pricing and administrative fees.
- The State could consider applying an efficiency adjustment to the capitation rates to remove the spread that is above the amount of administrative expenses for an efficiently managed MCO/PBM contract, similar to what was assumed in the mandatory pass-through model.

- In this model, Mercer assumed the State would adopt a complete Uniform PDL. The capitation rates would increase because MCO retained market share rebates would be removed as the MCOs/PBMs would no longer be able to negotiate and keep those rebates. This cost to DMAS would be offset by the State being able to collect more in supplemental rebates. Mercer's estimate of increased supplemental rebate potential is based on benchmarking current DMAS supplemental rebate collections against similar states with full uniform PDLs. Prior to a decision to implement a uniform PDL, Mercer recommends a more robust analysis at an individual drug and drug category level to calculate the potential for increased supplemental rebate collections.
  - If Virginia Medicaid implemented a mandatory pharmacy provider reimbursement model but did not adopt a complete Uniform PDL, Mercer estimates increased costs of $14.6 million or 1.3% of outpatient pharmacy expenditures. The State share of this cost increase would be $5.4 million.
- Removing the impact of the rebates to the capitation rates would affect the underwriting gain calculation.
- Mercer estimates $250,000 in additional staffing costs to monitor MCOs and PBMs to ensure the correct application of the FFS reimbursement methodology.

Financial Impact Adjustment Considerations

Table 27 below lists each adjustment category, the financial implication of each category and a brief description to explain how Mercer applied the adjustment.

TABLE 27: SUMMARY OF ADJUSTMENTS USED FOR ESTIMATED FINANCIAL IMPACT OF A STATE MANDATED PHARMACY REIMBURSEMENT MODEL

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Estimated Impact to Pharmacies	Cost	• DMAS will require the MCOs to follow the DMAS FFS NADAC and WAC based pharmacy provider reimbursement methodology and a professional dispensing fee of $10.65. • Mercer repriced the encounter claims under the FFS methodology as was done in the pharmacy benefit carve-out model.
Payment from MCOs to PBMs	No Impact	• Unless also mandated, PBMs would be able continue to use spread pricing in this pricing model. Mercer assumed that the PBMs would maintain the same amount of administrative revenue as current state through a combination of spread pricing and administrative fees.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Member Utilization Management	No Impact	• No changes in utilization management as MCOs retain control of pharmacy utilization management.
Rebates – Federal	No Impact	• While it is possible that implementation of the full PDL could increase federal rebate collections along with supplemental rebate collections, Mercer was unable to quantify the potential opportunity.
Rebates – MCO Market Share Rebate	Cost/No Impact	• If DMAS moves to a full uniform PDL, the MCOs will no longer be able to collect market share rebates and the market share rebate reduction to the capitation rates would be removed. • If DMAS does not elect to implement a full uniform PDL, there would be no impact.
Rebates – State Supplemental	Savings/No Impact	• If DMAS moves to a full PDL, DMAS would receive increased supplemental rebates due to more drug classes eligible for state supplemental rebates. • If DMAS does not elect to implement a full uniform PDL, there would be no impact.
MCO Administration Expense	No Impact	• No changes in the MCO administrative expense unless DMAS elects to apply an efficiency adjustment to remove excess PBM administrative revenue.
Underwriting Gain	Savings	• If DMAS implements a full PDL, then the market share rebate reduction would no longer be applied to the capitation rates. Underwriting gain would correspondingly be reduced in capitation rates.
Taxes	No Impact	• While there are MCO taxes in Virginia, none pertain to the Medicaid line of business. • The impact of the HIF tax was not modeled due to the moratorium that is currently in place.
Data Coordination	No Impact	• DMAS would need to continue to share with the MCO plans the CCF preferred drugs and any updates. Assume these costs would be included in the additional staffing costs. • DMAS would need to develop, test, and transmit data files with MCO plans if DMAS established custom pricing outside the standard FFS reimbursement methodology. It is expected that these costs would be absorbed by the current pharmacy claims processing vendor contract.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Vendor Cost	No Impact	• The current FFS claims processing vendor would continue to process the current FFS population with no additional members moved from managed care to FFS.
Staffing	Cost	• Mercer estimated the cost of two additional staff member based on the average Pharmacy Department salary provided by DMAS. A 30% markup was applied to the salary to account for benefits.

5 CONCLUSION

There are many factors that must be considered before the final selection of a pharmacy program design model for implementation. DMAS must align the final selection decision with Departmental, Agency and Commonwealth goals. Additionally, fiscal and operational impact considerations must also be evaluated. Stakeholder, provider and member concerns and/or suggestions should be considered, but DMAS must prioritize considerations that are most important for the goals of program.

For example, if transparency in the pharmacy benefit is the most important factor for consideration, then a mandatory pass-through pricing model or pharmacy benefit carve-out model should be considered. If provider reimbursement is paramount, then a state mandated reimbursement or pharmacy benefit carve-out model should be considered. Likewise, if the State would like contracted MCOs to continue to be at risk for the pharmacy benefit, the best choice would be either state mandated pharmacy provider reimbursement or mandatory pass-through pricing models.

Table 28 below summarizes priorities for DMAS consideration at a high level.

TABLE 28: PRIORITIES FOR DMAS CONSIDERATION — HIGH LEVEL

PRIORITY	MANDATORY PASS-THROUGH PRICING	PHARMACY BENEFIT CARVE-OUT	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT WITH UNIFORM PDL
Budget Predictability	Yes	No	Yes
MCO Risk Sharing	Yes	No	Yes
Transparency	Yes	Yes	No
Provider Reimbursement	No	Yes	Yes
Single point of decision making/control for program design decisions	No	Yes	No

PRIORITY	MANDATORY PASS-THROUGH PRICING	PHARMACY BENEFIT CARVE-OUT	STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT WITH UNIFORM PDL
Coordinated MCO Member Experience	Yes	No	Yes
Consistent member and pharmacy provider experiences across MCOs	No	Yes	No
Implementation Timeline	6–12 months	18–36 months	6–12 months
Estimated SFY 2019 Fiscal Impact (Savings)/Cost	($10,097,000)	($32,048,000)	$20,329,000
Estimated SFY 2019 % Fiscal Impact	-0.9%	-2.8%	1.8%
Estimated SFY 2019 Fiscal Impact (Savings)/Cost State Share	($4,026,000)	($13,983,000)	$7,597,000
Estimated SFY 2019 Fiscal Impact (Savings)/Cost Federal Share	($6,071,000)	($18,065,000)	$12,732,000

Appendix A

BASE DATA

To evaluate the fiscal impact of the three pharmacy program design models, Mercer analyzed DMAS pharmacy encounter claims with dates of service from July 1, 2018 to December 31, 2018. Mercer applied the following adjustments to the base data to estimate SFY 2019 annual costs:

- Relative enrollment changes that occurred through June 2019.
- Seasonality to account for cyclical changes that occurred outside of the base data period.

Mercer also estimated pharmacy costs for the Medallion 4.0 and CCC Plus Expansion populations for January 1, 2019 through June 30, 2019. These populations became eligible for Medicaid managed care effective January 1, 2019, and therefore their claim experience were not included in the base data.

Mercer used this adjusted encounter data representative of SFY 2019 experience for all three models.

CLAIMS NOT ELIGIBLE FOR REPRICING IN ANALYSIS

In Table 29, Mercer summarizes the claim types that were not re-priced, the reason Mercer excluded these claims from the repricing exercise, and their total paid amount and claim counts from the July 2018 through December 2018 base data.

TABLE 29: CLAIMS INELIGIBLE FOR REPRICING SUMMARY

EXCLUSION TYPE	REASON FOR EXCLUSION FROM REPRICING	TOTAL PAID AMOUNT	CLAIM COUNT
0 Quantity Claims and 0 or negative paid claims	The MCOs did not pay anything for the claim so these were not re-priced.	($140)	204,800
TPL Claims	The pharmacy reimbursement for these claims were determined by another payer and would not be subject to the MCO or FFS reimbursement methodology.	$73,328,000	1,159,000

EXCLUSION TYPE	REASON FOR EXCLUSION FROM REPRICING	TOTAL PAID AMOUNT	CLAIM COUNT
Dual Eligible Claims	Mercer only evaluated the non-dual populations for this analysis.	$8,784,000	320,400
Compound Claims	Quantities dispensed on compound claims are often incomplete or inaccurate and cannot be re-priced.	$508,000	7,800
Supplies and Non-Drugs	Supplies and other non-drugs are reimbursed using different price schedules.	$4,534,000	170,300
Invalid NDC/No pricing Claims	There is no pricing available to reprice these claims.	$454,000	44,400
Total		**$87,607,000**	**1,906,800**

These exclusions represent 21% of total amount paid and 35% of claim counts of the base data used for the analyses.

Other Data Sources

Mercer relied on the following data sources to complete these analyses:

- DMAS CCF list as of July 2019.
- Mercer proprietary brand/generic algorithm.
- Mercer proprietary specialty product list.
- NADAC, Federal Upper Limit (FUL), and WAC from national compendia as of October 2019.

MODEL SPECIFIC METHODOLOGIES AND ASSUMPTIONS

Mandatory Pass-Through Pricing Model

For the mandatory pass-through pricing model, Mercer conducted the following steps:

1. Mercer summarized the historical encounter paid amount by MCO for July 2018 through December 2018.

2. Mercer calculated the estimated base administrative costs by multiplying the PBM reported administrative fee per claim and the total claim counts during July 2018 through December 2018.

3. From the questionnaire, Mercer summarized the reported PBM retained rebates.

4. Mercer identified the amount of spread for the traditional contracts based on information provided in DMAS' transparency report, and validated by Mercer's experience in other states and public reports.

5. Mercer assumed a 3% administrative expense of total drug spend for efficiently run PBM/MCO contracts. Mercer based this assumption on MCO reporting and Mercer's rate development experience with other states.

6. Mercer calculated the amount of administration expense above the assumed rate, adjusted it for underwriting gain, and extrapolated it for the Expansion population.

This final result is the estimated amount that could be potentially removed from the capitation rates as an administrative fee efficiency adjustment.

PHARMACY BENEFIT CARVE-OUT OF MANAGED CARE

For the pharmacy benefit carve-out of managed care pricing model, Mercer made the following calculations and adjustments:

Repricing Adjustment: Mercer evaluated the repricing impact of the pharmacy benefit carve-out of managed care model using the following process:

1. Shadow Pricing MCO Encounter Data: Mercer compared historical encounter paid amounts to WAC prices as of the date of service to determine an overall WAC effective rate of the encounter data by drug type (Table 30). Mercer applied this WAC effective rate to current WAC prices to estimate current MCO pharmacy costs.

2. Estimated Shadow Price for the Expansion population: Mercer reviewed the historical WAC effective discount rates for Comm Non-Dual >1 and the LIFC Adult rate cells and applied those results to the estimated Expansion population drug spend. The experience of these rate cells most closely resemble the Expansion populations.

TABLE 30: MCO HISTORICAL WAC EFFECTIVE RATES BY POPULATION

	CCC PLUS POPULATION	MEDALLION POPULATION	EXPANSION POPULATION
MCO Estimated WAC Effective Rate			
Overall	**-4.4%**	**-6.0%**	**-4.5%**

3. Repricing MCO Encounter Data: Mercer repriced the pharmacy encounter data using the current pricing indices as of October 2019 and the FFS reimbursement methodology listed below.

   A. FFS Reimbursement Methodology:

      i. DMAS FFS uses a PDF of $10.65 and incorporates a lesser of methodology as follows:

         a. Lesser of NADAC + PDF and FUL+ PDF or U&C.

         b. If no NADAC, then lesser of WAC + PDF, FUL + PDF or U&C.

   B. Adjustments to the FFS Reimbursement methodology.

      i. **U&C:** When the pharmacy benefit moves from managed care to FFS, many claims that were not reimbursed at U&C under the PBM's reimbursement methodology now will be. This is because of the comparatively higher PDF required in the FFS reimbursement methodology. A claim is paid at U&C when the amount the pharmacy provider bills is less than what is the payer's calculated allowed amount. The DMAS MCO encounter data does not include pharmacies' U&C billed charges. To estimate the amount of claims that would pay at U&C, Mercer performed an environmental scan of the percentage of claims that pay at U&C in other state Medicaid FFS programs. Based on this research, Mercer estimated that 16.5% of claims that move from managed care to FFS will be paid at the provider's U&C. Mercer reduced the FFS methodology repriced paid amount to account for U&C between 1.5% and 2.0% depending on the population for these lower cost claims.

      ii. **340B:** When the pharmacy benefit moves from managed care to FFS, pharmacies that dispense 340B drugs to Medicaid beneficiaries must be reimbursed no more than the 340B acquisition cost and a PDF as required by the Virginia Medicaid State Plan. Approximately 4% of the total paid amount were for 340B identified drugs. Mercer observed that over 90% of the paid amount were already paid at pricing levels consistent with 340B discounts. Therefore, Mercer did not reprice the ingredient costs of these claims but did add an additional amount for the differential between the MCOs dispensing fees (estimated at $1.25 per prescription) and the FFS PDF of $10.65, resulting in a $400,000 increase in the FFS re-priced paid amount. Mercer included only

340B claims that the MCOs paid the entire claim in this estimate. For example, Mercer did not reprice 340B claims with third party liability (TPL).

iii. **CCF:** The encounter data used in this analysis was from a time period when the CCF was not fully in effect. Mercer applied the CCF as of July 2019 to the data and repriced generic claims expected to be subject to the CCF as brand preferred claims.

   a. For drugs indicated as brand preferred on the CCF, Mercer re-priced these claims without including the FUL in the pricing logic.

   b. For generic products of preferred brand products, Mercer re-priced these claims as if they were the preferred brand using the NADAC or WAC unit price for the innovator drug.

4. Mercer compared the current MCO estimated costs (Steps 1 and 2) to the estimated re-priced FFS costs (Step 3) to determine a percentage impact by population.

5. The percentage impacts determined in Step 4 were applied to the portion of eligible base dollars for repricing to calculate the overall fiscal impact of the differences in payment to pharmacies for prescription.

Rebates – Federal: Mercer assumed there would be a slight increase (0.5% of paid amount) in federal rebates collected in the pharmacy benefit carve-out model due to efficiencies achieved by having all retail pharmacy claims under one program. This assumption was based on Mercer's review of DMAS historical rebates collected and compared to other pharmacy benefit carve-out programs.

Rebates – MCO Market Share Rebate: Mercer removed the adjustment to the capitation rates that account for market share rebates available to efficiently contracting MCOs. Mercer used the rebate assumptions applied in the most recent capitation rate development process to estimate the total cost to DMAS for the removal of the market share rebate reduction in the capitation rates. These adjustments ranged by population between 1.2% and 1.9%.

Rebates – State Supplemental: Mercer assumed an additional 1.0% of total drug spend for the collection of supplemental rebates for the CCF open classes. Mercer developed the supplemental rebate assumption by reviewing DMAS reported supplemental rebate collections and comparing them to the experience reported by other states that have similar PDLs.

MCO Administration Expense: Mercer reduced estimated costs for the removal of estimated administration expense for non-spread administration fees (1.25% of total drug spend) from the capitation rates.

Underwriting Gain: Mercer also calculated the impact to the underwriting gain included in the capitation rates as the result of carving out the pharmacy benefit into FFS.

Data Coordination: Mercer assumed a $0.05 PMPM fee for DMAS and MCO data coordination fees and access to a web portal to assist with MCO care coordination services. This assumption was based on Mercer market information of similar services provided in the PBM sector.

Vendor Cost: Mercer assumed a $3,700,000 increase for services provided by the current FFS pharmacy claims processor for an increase in claims volume. This assumption was based on information provided by DMAS and other publically available information.

Staffing: Mercer assumed DMAS would need two additional full time equivalent staff members to manage and oversee the pharmacy benefit carve-out. Mercer estimated an increase of staffing costs of approximately $250,000. This estimate is based off of information provided by DMAS for average pharmacy staff salary costs.

STATE MANDATED PHARMACY PROVIDER REIMBURSEMENT

For the state mandated pharmacy provider reimbursement pricing model, Mercer made the following calculations and adjustments:

Estimated Impact to Pharmacies: There were no additional repricing considerations for the state mandated pharmacy provider reimbursement model compared to the pharmacy benefit carve-out model. The results for the estimated impact to pharmacy providers remained the same.

Payments from MCOs to PBMs: In this model, Mercer assumes that MCOs are able to retain the same amount of revenue as they currently receive, either through administrative fees, PBM spread or some combination of the two.

Rebates – State Supplemental: Mercer modeled that the state would adopt a complete PDL if it moved to a state mandated pharmacy provider reimbursement model. Mercer assumed an additional 1.0% of total drug spend for the collection of supplemental rebates for the CCF open classes. Mercer developed the supplemental rebate assumption by reviewing DMAS reported supplemental rebate collections and comparing them to the experience reported by other states that have full PDLs.

Rebates – MCO Market Share: Mercer removed the adjustment to the capitation rates that account for market share rebates available to efficiently contracting MCOs. Mercer used the rebate assumptions applied in the most recent capitation rate development process to estimate the total cost to DMAS for the removal of the market share rebate reduction in the capitation rates. These assumptions ranged between 1.2% and 1.9% by population.

Underwriting Gain: Mercer also calculated the impact to the underwriting gain included in the capitation rates as the result of carving out the pharmacy benefit into FFS.

Staffing: Mercer assumed DMAS would need two additional full time equivalent staff members to manage and oversee the mandatory pharmacy reimbursement pricing model for an increase of staffing costs of approximately $250,000. This estimate is based off of information provided by DMAS for average pharmacy staff salary costs.

Limitations of Analysis

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

For our analysis, Mercer relied on data, information and other sources of data as described in this report. We have relied upon this data without an independent audit. Although we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent upon this assumption. If the data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

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