TEXAS MEDICAID:

THE IMPACT OF MANAGED CARE ON MEDICAID RECIPIENTS INDEPENDENT PHARMACIES

A white paper evaluating the transition of the Prescription Drug Benefit into Medicaid Managed Care.
Executive Summary

Further changes are needed to transform the model of care and reimbursement for the Medicaid prescription drug benefit. Transparency is needed in the current system to provide Texas Legislators with meaningful insight in making such decisions. To achieve this, the state needs to understand and benchmark the impact thus far on state budgets, pharmacies and constituents. Without a proper benchmark, there is no economic accountability or a succinct way to measure economic efficiency. Moving the prescription benefit to managed care has created nominal state tax savings at best, while pharmacy providers have seen significant reductions in reimbursements. The biggest economic benefit to the state is the collection of additional state premium tax revenues, which is paid by the federal government through federal matching tax dollars.

Federal taxes are driving up the cost of managed care models to the tune of $1 billion in Texas Medicaid. With the advent of the Affordable Care Act ("ObamaCare"), new federal taxes in the form of the Health Insurance Fee are placed on Medicaid managed care payments. The state now faces increased managed care premium payments to pay this federal tax.

Pharmacies — more so Independent/Small Business Pharmacies, which makeup roughly 2,000 businesses across the state — are continuing to experience significant reductions in reimbursement per prescription while the state pays more per prescription. The question is where are the state dollars going and to whom?

Pharmacy Benefit Managers (PBMs) are profit centers for managed care organizations (MCOs) with no transparency and lack network adequacy standards to ensure patient access to needed medications. Anecdotal evidence suggests pharmacies are not able to stock specific medications because reimbursement payments are not sufficient to cover the costs associated with providing patients access to needed medications. The soundest way to ensure patient access in any healthcare system is to provide a reimbursement methodology to health providers that bear a relationship to the provider’s true and reasonable cost associated with providing the service or product. The recent Myers and Stauffers (M&S) report quantifies the true cost for pharmacy providers filling Medicaid enrollee’s prescriptions. There are payment models available that could ensure state and federal savings while remunerating providers with appropriate levels of compensation to ensure access.

This paper recommends the Legislature protect taxpayers from a run-away Medicaid prescription drug budget with efficiencies and oversight to ensure pharmacies are compensated to deliver viable prescription benefits to Medicaid recipients, while finding the best pay-per-performance model to lower costs for the state and improve quality for patients.
Background

In 2011, the 82nd Texas Legislature with the passage of House Bill (HB) 1 directed the equalization of the prescription drug benefit, which was supposed to achieve savings by expanding the three drug-limit statewide. However, in the summer of 2011 during 1115 Waiver negotiations between the Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services (CMS), the Texas cost containment initiative was revoked by HHSC and CMS and an unlimited prescription drug benefit took effect statewide for managed care enrollees. By the end of 2015, close to 90 percent of all eligible enrollees will be in a managed care plan.

HB 1 also:
- directed increase of Over-the-Counter medications;
- instructed HHSC to pursue more competitive drug ingredient pricing;
- sought to improve the generic utilization rate when generics would be a less expensive alternative — net of the Preferred Drug List (PDL) and rebates applied for PDL utilization;
- reduced the dispensing fee of all prescription drugs; and
- directed Texas Medicaid to carve-in the Prescription Drug Benefit into the Managed Care Organizations (MCO) model of care on March 1, 2012. This was expected to allow MCOs to better manage patient drug utilization, increase premium tax funds collected by Texas through matching federal tax dollars, and maintain the management of the PDL within the Vendor Drug Program (VDP), thus retaining rebate revenues for the state.

Altogether these changes were projected to save Texas Medicaid more than $115 million General Revenue (GR), or approximately $300 million total, in the SFY 2012 – 2013 Biennium.

In 2013, the 83rd Texas Legislature with the passage of Senate Bill (SB) 1 directed HHSC to find further efficiencies in the Vendor Drug Program (VDP). Strategies to achieve this included a more competitive ingredient cost; increased rebate revenues, reduced narcotic drug utilization, elimination of barbiturates and benzodiazepines and other Preferred Drug List (PDL) cost savings. Through SB 7, the Legislature also directed a population carve-in to managed care, which transitioned in 134,000 elderly and/or disabled individuals on September 1, 2014, and directed the carve-in of more than 50,000 nursing facility patients. These changes are estimated to result in 90 percent of the Medicaid population receiving services through Managed Care.

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### Exhibit 1: HB 1-Rider 61 Projected Savings

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>General Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 12</td>
<td>Three Prescription Drug Limit</td>
<td>$46.3</td>
</tr>
<tr>
<td>Item 10</td>
<td>Increase Over-the-Counter Medications</td>
<td>$ 4.5</td>
</tr>
<tr>
<td>Item 14</td>
<td>More Competitive Drug Ingredient Pricing</td>
<td>$28.3</td>
</tr>
<tr>
<td>Item 15</td>
<td>Increase Generic Drug Utilization</td>
<td>$ 7.4</td>
</tr>
</tbody>
</table>

**Additional Cost Reductions**
- Reduction in the Dispensing Fee $28.8
- Carve In the Drug Benefit to Managed Care/PBMs $ 0.7

**Total Anticipated Savings 2012 - 2013** $115.3

*in millions*
Anecdotal evidence suggests that more than 13 pharmacies have closed with the conglomeration of cost savings initiatives from the state. Many others have had to tap lines of credit, reduce store hours, reduce advertising, marketing and charitable giving, or discontinue patient services such as home delivery. These pharmacies have typically served a high percentage of Medicaid patients and have been located in the Valley, Central Texas and the Panhandle. Small businesses with fixed costs find it difficult to cost shift when more and more Medicaid and commercial clients are all tied to a PBM, which negotiates spreads on one end from the payor and limits payments to pharmacies on the other end. Independent Pharmacies have responded and deployed new business strategies, but the result continues to be that store-fronts are subsidizing the Medicaid program to the benefit of MCOs and Prescription Benefit Managers (PBMs)—not the taxpayers.

**Managed Care Savings**

Managed care can be an effective way for states to save money, especially in the first year of a transition. Exhibit 2 demonstrates how a discount is assumed in the first year, and then a lower cost can be projected over time. In this illustration, the baseline is traditional Fee-For-Service (FFS). At the time of conversion, the state may apply actuarially sound discounts, or negative pressure, to the FFS trend which drops the forecast, generating “savings.” This would mean instead of paying more than the $2,300 in 2016, which is the projected FFS cost, the state would pay less than $2,300 as noted by the Managed Care Forecast. Therefore, 2016 would have savings based on the difference.

In this illustration, it is important to note that cost growth may continue, but it is from a lower base. Additionally, if the trend line grows at a congruent or lower slope than the baseline forecast, then there are added savings each year to the state. Furthermore, various issues arise in the evaluation of savings with managed care including actuarially sound principles, premium taxes paid to the state, expanded benefits for clients and experience rebates. Additionally, the health insurer fee, which is an “ObamaCare” directive, is a new fee to help fund the federal and state exchanges. It will likely wipeout cost savings for states who operate managed care.

...the result continues to be that store-fronts are subsidizing the Medicaid program to the benefit of MCOs and Prescription Benefit Managers (PBMs)—not the taxpayers.
Increase in State and Federal Insurance Taxes

Medicaid MCOs are subject to the State Premium Tax. Therefore, increased Medicaid MCO payments increase state premium tax revenues through matching federal tax dollars paying the state tax. This rate is applied to the premiums charged by the health insurer. When benefits are added to managed care like the pharmacy benefit was in 2012, or carved-in, the premiums go up as the state MCO premium goes up. Additionally, the state is no longer paying a pharmacist. The state is paying an MCO, who is paying a PBM, who is paying a pharmacist. As a result, the premium taxes paid to GR go up. In 2012, the taxes spiked 51 percent to almost $160 million and in 2013 10 percent to more than $175 million for CHIP and Medicaid related premiums.\(^5\) We estimate that 13 percent or $22 million is related to the prescription drug benefit.\(^6\)

A portion of the funding for “ObamaCare” works much the same way. According to a 2013 Milliman Research Report, this fee is an excise tax that will be assessed annually by the federal government beginning in 2014. This fee starts at $8 billion for 2014 and grows.\(^7\) HHSC has recently indicated that the Health Insurer Fee for Texas Medicaid might be nearing $1 billion.\(^8\) Even though Texas has opted out of Medicaid expansion, the 84th Legislature will be faced with a bill to pay to the federal government on behalf of the Medicaid managed care plans.

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Medicaid Prescription Drug Program

The Texas Medicaid Vendor Drug Program has managed the prescription drug benefit frugally with a two part equation – fixed and variable components. The equation was changed on September 1, 2010 (SFY 2011) in order to implement a 1 percent decrease, which was decreased again on February 1, 2011 (SFY 2011) in order to implement a second 1 percent decrease. And on September 1, 2011 (SFY 2012), a third change reduced the dispensing fee by 85 cents. The $1 dispensing fee reduction equated to more than a 13 percent cut to pharmacies on top of all the other initiatives. These significant reductions were all implemented prior to the prescription drug benefit transition to MCOs and/or their subcontracted PBM. Under managed care, which took effect March 2012 (SFY 2012), HHSC forecasted overall reductions to chain pharmacies of around .3 percent and overall reductions to independent pharmacies of around 6 percent.\(^9\) Independent pharmacies saw reductions, however, of between 10 percent and 18 percent.\(^10\)

With the carve-in of the prescription drug benefit, the state pays MCOs a capped and full risk premium per member per month for providing all medically necessary prescription drugs to their enrolled members. MCOs contract with PBMs to negotiate and to manage contracts with pharmacies.

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**Exhibit 4. Medicaid Prescription Drug Forecast (in millions)**

<table>
<thead>
<tr>
<th></th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>2,764</td>
<td>3,015</td>
<td>5,779</td>
</tr>
<tr>
<td>MC</td>
<td>2,755</td>
<td>3,004</td>
<td>5,760</td>
</tr>
<tr>
<td>Savings</td>
<td>(8.6)</td>
<td>(10.3)</td>
<td>(18)</td>
</tr>
</tbody>
</table>
According to data provided by HHSC in Exhibit 3, Medicaid Prescription Drug Costs over the last five years have grown year over year. HHSC modeled costs under a FFS and Managed Care model and estimated that savings would only be $8 million GR, $20 million total, or 0.3 percent savings (see Exhibit 4). Moreover, the premiums are steadily increasing as is the cost per recipient per month. Texas must begin asking the question, “At what expense to the state do we continue with a traditional managed care model?”

The savings estimate for the prescription drug benefit is less than 1 percent in the first year and reflects a 3 percent trend line in year over year growth in either model. This data signifies the need to benchmark the MCO plans and their work with PBMs to ensure savings are being generated as expected and network adequacy and – more importantly – access to needed medications is not compromised. Exhibit 5 shows the expected costs for either model: FFS or MC over FYs 2012 and 2013. There is no change, and no gap for savings, not even in the first year. The closeness of the lines highlights the efficiency already in the VDP management. During Legislative discussions regarding these changes, HHSC studied commercial pharmacy claim payments and found commercial plans and PBMs have higher administrative costs than the current administrative costs within VDP. Additionally, while carving in the benefit increases the premium tax revenue to the state there is an increased premium the state pays to each plan to administer this benefit.

Exhibits 5 and 6 demonstrate that in FY 12, FY 13 and FY 14 all had an increase. However, pharmacies—more so Independent/Small Business Pharmacies — are continuing to experience significant reductions in reimbursement per prescription while the state pays more per prescription. Therefore the question remains; where the state dollars are going and to whom?

Anecdotal evidence suggests pharmacies are not able to carry certain drugs because the reimbursement is not sufficient to cover the costs to provide patients access to needed medications.
Exhibit 6 shows the year over year increase in prescription drug premiums paid per member per month to MCOs. These are non-legislatively directed increases to MCOs and PBMs.

New efficiency measures appear to be on the horizon. The old measure, Average Cost Per Medicaid Prescription, has been transformed to Average Cost Per Medicaid Recipient Month for Prescription Drugs. This is a very important distinction as there is no public data at this point to do valid year over year comparisons of costs. Exhibits 5 and 6 demonstrate that in FY 12, FY 13 and FY 14 all had an increase. However, pharmacies —more so Independent/Small Business Pharmacies — are continuing to experience significant reductions in reimbursement per prescription, while the state pays more per prescription. Therefore the question remains; where are the state dollars are going and to whom?

In 2015, the cost per prescription is expected to accelerate under the FFS program with the large reduction to the denominator, or number of participants remaining in FFS. This acceleration may also be exacerbated by the FFS population being comprised of high acuity individuals who remain in the FFS program, versus the general community population recognized in measures developed by national quality groups. Therefore, in a true comparison year over year, congruent samples must be retained in the numerator and denominator.

The recipient month calculation allows for prescription cost stratification over the total enrolled number which gives a false sense of the cost per prescription and/or the cost per enrollee’s prescription. As seen in the FFS and commercial market, not all enrollees will utilize the prescription drug benefit every month the state pays the enrollee’s premium. Therefore, it is of utmost importance for the state to decide and set benchmarks congruently and continue the comparison across models and across Medicaid PBMs.

Conclusions

Texas implemented an innovative hybrid model when deciding to carve-in the Prescription Drug Benefit. However, as noted during Sunset Commission hearings in November 2014, VDP has only recently been able to begin management statewide of the PBM business practices. With this knowledge and experience, HHSC should take back the reigns, improve transparency and implement a progressive pay-for-performance system to administer the prescription drug benefit. Vendor Drug is the PBM for Texas Medicaid. Without more accountability and work with the pharmacies to ensure network adequacy and access to prescription drugs, the current system is not sustainable.

A major advantage to the state with managed care models is the ability to hold each contractor/PBM accountable for standards such as quality, access and beneficiary satisfaction; however, these tools are missing. We recommend network adequacy and access to care standards be developed for statewide impact, and include phone surveys to ensure pharmacies are carrying specific drugs. Anecdotal evidence suggests pharmacies are not able to carry certain drugs because the reimbursement is not sufficient to cover the costs to provide patients access to needed medications.
Data suggests that Texas Medicaid is spending a growing amount of funds per recipient per month to PBMs, even though dispensing fees have been significantly reduced and ingredient costs and rebates have been renegotiated at more competitive pricing. With this financing pattern, pharmacies, including a larger number of small business pharmacies, are now subsidizing the Medicaid prescription drug benefit.

Additionally budget writers should take into consideration the patient choices recognized by other states and evaluate a prescription co-pay in Medicaid. According to Kaiser Family Foundation (KFF), 43 states require a co-payment of some sort for prescription drugs in Medicaid. There are exclusions for certain populations, but for comparison we pulled California, Florida and New York. CMS allows for a Medicaid co-payment up to $3.90 for drugs or up to 20 percent of cost for individuals above 150 percent Federal Poverty Level (FPL).

We have found that even if the Legislature wanted to restore or mitigate the deep cuts which continue to close small business pharmacies, they cannot. There is no mechanism in place for transparency and accountability for the Legislature with PBMs. Most MCO contracts pay providers based on the Medicaid Fee Schedule. So that when HHSC adjusts the Medicaid Fee Schedule, such as with a legislatively directed rate increases, the provider is then paid a higher rate by the MCO. However, under VDP, there is no fee schedule governing the PBMs payment to the pharmacy. So under the current modeling, additional funds to the PBM through the per member per month doesn't yield a benefit to the pharmacy. Therefore, we urge the Legislature to provide a way to transparency and a way to ensure access to medications.

Recommendations

In adhering to the importance of transparency and accuracy, the VDP commissioned Myers and Stauffer (M&S) to make recommendations for competitive ingredient pricing and dispensing fees. HHSC or the Texas Legislature should utilize the Sunset recommendations to elevate a comprehensive data and fiscal management solution with sound and cohesive quality dashboarding for the prescription drug benefit. All VDP administered programs, Medicaid, CHIP, Children with Special Health Care Needs Services Program and the Kidney Health Care (KHC) program, should be included.

The M&S report published in 2014 set forth the statistical validation for ingredient pricing and dispensing costs that reflect the true economic costs associated with dispensing a prescription. The most sound way to ensure patient access to needed prescriptions is to adopt a methodology that resembles these findings. This pay-for-performance model will establish a streamlined framework that reduces program duplicities and expenditures while ensuring patient access through setting accountability standards for quality of care.
Footnotes:
1. Health and Human Services Consolidated Budget
2. 2014 Health and Human Services Consolidated Budget and Budget Documents
3. Sunset Commission’s Staff Report, October 2014
4. According to Rudd and Wisdom, “The premium rates also include an amount for premium tax (1.75 percent of premium), maintenance tax, and a risk margin (2.0 percent of premium).”
5. Texas Comptroller of Public Accounts
6. The calculation is Monthly Financial Reports to run Medicaid payments and then estimated the percent of VDP as a percent of Medicaid. This estimate does not take into consideration the percentage of VDP claims in managed care versus those in FFS.
8. HHSC’s LAR and LAR presentation specify a need of $89 million GR for 2015, plus the 2015 base in 2016 and 2017 plus $115.8 million GR. This would be approximately $383 million GR, $913 million All Funds.
9. TAC 12/23/2011
10. Legislative Testimony 83rd Texas Legislative Session.
12. See http://kff.org/medicaid/state-indicator/prescription-drugs