Medicaid Pharmacy Comprehensive Plan

Report Prepared in Response to Act 263 of the 2019 Regular Session

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Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

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1 Executive Summary

In accordance with Act 263 of 2019 Regular Session of the Legislature, the Louisiana Department of Health (LDH) is submitting information in regards to Act 263. Act 263 provides that LDH shall develop a comprehensive plan to administer the Medicaid prescription drug program and at a minimum the plan shall include the following:

(1) Best practices and clinical and cost outcomes from other states that have removed pharmacy services from Medicaid managed care organization contracts and assumed direct administrative responsibility.
(2) Managed care organization portal access to ensure coordination of patient care if pharmacy services are removed from Medicaid managed care organization contracts.
(3) Maximum rebate utilization through participation in the most effective bulk purchasing multi-state buying pool.
(4) Medicaid managed care organization (MCO) use of a pharmacy benefit manager (PBM) for Medicaid prescription drug benefit program administration if the pharmacy benefit manager is part of a larger company that also owns retail pharmacies.

1.1 Carve Out Options

LDH engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop a comprehensive plan in response to number (1), (2) and (4) above. See Appendix A for details. It is important to note that Mercer explored outcomes of two possible models:

1. Pharmacy benefit carve-out from managed care to fee-for-service (FFS)
2. Single PBM contracted by LDH designated as a Prepaid Ambulatory Health Plan (PAHP)

In the **FFS carve-out model**, pharmacy benefits administration for the entire Medicaid program is performed by FFS. The main advantage of this model is consistent and transparent pharmacy reimbursement.

In the **single PBM model** the state contracts with a single PBM to administer the pharmacy benefit. Consistency and transparency of pharmacy reimbursement will still be enhanced, though not to the same degree as the FFS carve-out, while maintaining the current managed care flexibility in pharmacy networks and contracting. The main disadvantage this approach is needing a waiver from the Centers for Medicare and Medicaid Services to operate as a Prepaid Ambulatory Health Plan (PAHP).

For savings, both models reduce administrative expenses by simplifying the pharmacy program from five MCOs, each with a subcontracted PBM, to one PBM for the entire program. In addition, there is a projected increase in federal and state supplemental rebate collections due to increased processing efficiency. For FFS carve-out only, there is an additional savings on drugs purchased through the 340B Drug Pricing Program, although this savings is difficult to quantify currently.

For costs, a common driver to both models is a decrease in MCO premium tax revenue, resulting in an increased need for state share funding. For the FFS carve-out model, there is an additional cost due to reimbursement of pharmacies using the FFS payment methodology, which, compared with MCO reimbursement, can be higher both for ingredient cost and dispensing fee.

While the anticipated savings from either model is substantial, it is offset by loss of MCO premium tax revenue which is used as state share funding. Therefore, both models result in cost shifting from federal to state funds.

The total budget impact of the FFS carve-out model is estimated to be an expenditure increase of $30,750,000. However, the total budget impact of the PAHP model is estimated to be an overall savings of $17,400,000. A breakout of the impact of these two models by means of financing is outlined below.

	State	Federal	Total Net Impact
FFS Carve Out	$66,960,000	($36,200,000)	**$30,750,000**
PAHP	$56,000,000	($73,400,000)	**($17,400,000)**

The main difference between these two models, in terms of budget impact, is the requirement that the FFS carve-out model use the same reimbursement methodology for all pharmacies. However, this is the feature of the FFS carve-out model that gives it high levels of consistency and transparency. Further, this increase in expenditures translates into increased revenue for pharmacies.

A detailed description of all anticipated savings and costs for Louisiana is provided in the attached Mercer report. While Louisiana can learn best practices from other states, direct comparisons of budget projections such as these are not possible due to different starting conditions in both FFS and managed care as well as different program financing structures across states as all state Medicaid programs differ.

To ensure care coordination, the need for a comprehensive and robust data sharing agreement was identified. Potential disruption to care management activities is mitigated by the fact that all MCOs currently have a subcontracted PBM and so are accustomed to exchanging data with another entity.

For MCO use of a PBM where the PBM and MCO are part of the same company, LDH identified several quantitative and qualitative metrics to evaluate for inappropriate activity.

The full report provides a detailed description of the above, including a fiscal impact analysis.

1.2 Single PBM Contracted through MCOs

A third option would consist of LDH identifying a PBM, either through a Request for Information or utilizing an Office of Group Benefits PBM, that all MCOs would be contractually mandated to utilize for pharmacy services. LDH would not have a contract with the PBM, but would strengthen MCO contract language for minimum requirements to improve standardization of benefits and transparency. Presumably, this option could result in administrative savings while retaining the MCO premium tax, which is essential for the Medicaid budget and financing structure.

Advantages and Challenges of a Single PBM contracted through the MCOs

	Advantages	Challenges
Financial	• Some flexibility in pharmacy provider reimbursements, similar to current arrangement • Potential for increased transparency • Retain MCO provider tax revenue	• Potential perceived conflict of interest if PBM selected is affiliated/owned by one of the contracted MCOs • May result in significantly less administrative savings than a carve-out model
Operational	• Potential for increased efficiency, if the MCOs share staffing resources • Potential for increased consistency for providers, if a single claims processing system is used	• Pharmacy provider community may prefer a carve-out model • LDH oversight and control is limited to the MCO contract • Would hold all MCOs accountable if PBM is not in compliance • Best practices are unclear as, to the best of our knowledge, there is no other state with this model

1.3 Multi-State Bulk Purchasing Pool (3)

Act 263 provides that LDH shall develop a plan to administer the Medicaid prescription drug benefit program in accordance with "…3) Maximum rebate utilization through participation in the most effective bulk purchasing multi-state buying pool….."

LDH, Bureau of Health Services Financing (Medicaid), issued a Request for Proposals (RFP) to engage a contractor to negotiate maximum supplemental rebates for Louisiana Medicaid and the contract was awarded to Magellan Medicaid Administration. Based on the RFP issued, the written proposals submitted to LDH and the guidance from the Office of State Procurement (OSP), it was determined that Magellan's TOP$ (The Optimal PDL $olution) pool, is the most effective Medicaid bulk purchasing multi-state pool initiative for Louisiana. TOP$ currently consists of Louisiana and six (6) other states including Connecticut, Idaho, Maryland, Nebraska, Washington and Wisconsin.

Magellan will assist the Department in obtaining the desired outcomes. Magellan will provide technical support for the State Supplemental Rebate Program and preferred drug list (PDL) management services and supplies, including but not limited to research into the relative safety, clinical efficacy and cost of products within defined therapeutic drug classes. It will also provide support in performing the federal and supplemental drug rebate processing for the LDH Medicaid program with invoicing, reconciliation, and dispute resolution for all of LDH's Medicaid drug rebate programs.

Further efforts to enhance cost avoidance through supplemental rebates were enacted as a result of the single PDL implementation with the current managed care organizations. Act 263 of the 2019 Regular Legislative Session supports and mandates a single PDL that includes all therapeutic drug classes that are subject to prior authorization. The first single PDL, issued and managed by LDH Medicaid, was implemented in May 2019. Previously, the MCOs were allowed to have individual PDLs for their respective organizations and retain the corresponding supplemental rebates. Act 483 of the 2018 Regular Session as well as Act 263 of the 2019 Regular Session prohibit MCO PBMs from retaining drug rebates and spread pricing. These changes allow LDH the opportunity to accrue additional supplemental rebates for the State and also alleviate the confusion of multiple PDLs for Medicaid recipients and providers. LDH decided to

restrict the supplemental rebates available by limiting the number of preferred brand name drugs with generics available. This limitation was in response to pharmacy provider concerns about inventory costs as well as increased MCO capitation rates.

2 Conclusion

The LDH Pharmacy Program continues to administer the Medicaid prescription drug program in the most clinically effective and cost efficient manner possible. The information presented in this report in response to Act 263 provides insight into the pros and cons of the options and the fiscal impact to LDH. Comparisons of other states point out the uniqueness of the Louisiana not found in other states.

LDH will utilize the information presented to move forward with administering the Medicaid Pharmacy Program. Strides have been made and will continue, such as the implementation of a Single PDL in May 2019, which will enhance provider and recipient administrative simplification and other strategies that improve the Department's ability to contain costs in the Pharmacy Program through supplemental rebates.

Appendix A

Mercer Louisiana Department of Health Pharmacy Comprehensive Plan

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HEALTH WEALTH CAREER

LOUISIANA DEPARTMENT OF HEALTH

PHARMACY COMPREHENSIVE PLAN

JANUARY 31, 2020

CONFIDENTIAL AND PROPRIETARY

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1
EXECUTIVE SUMMARY

The Louisiana Department of Health (LDH) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to support development of a pharmacy comprehensive plan (Plan) in response to Act 263, legislation passed in the 2019 Louisiana legislative session. The Plan evaluates two new models for LDH to administer the pharmacy benefit. The models are:

1. Pharmacy Benefit Carve-out to Fee-for-Service (FFS) (FFS Carve-out): In this model; all pharmacy services would be carved out from LDH Medicaid managed care organizations (MCOs) to LDH FFS. All pharmacy services would be processed by LDH's contracted pharmacy benefit administrator.

2. Single Pharmacy Benefit Manager (PBM): In this model, LDH would lead efforts to contract with one PBM, and all LDH Medicaid pharmacy benefits would be administered through the LDH-selected PBM. LDH would seek Centers for Medicare & Medicaid Services (CMS) approval to designate the PBM as a Prepaid Ambulatory Health Plan (PAHP).

The Plan also presents best practices for LDH to exchange pharmacy claims information with the MCOs in a FFS carve-out environment and best practices for overseeing a PBM that owns pharmacies.

OBJECTIVE

The objective of this project is to provide LDH with the pharmacy comprehensive plan required by Act 263. The four items required by the Act are:

1. Perform an environmental scan to identify other states that have removed pharmacy services from Medicaid MCO contracts and assumed direct administrative responsibility.

    A. Complete a comprehensive policy review for each pharmacy program design model.

    B. Perform an environmental scan to identify other state experiences with each pharmacy program design model. Identify best practices and any available clinical and cost outcomes resulting from the transition.

C. Identify the potential operational and financial impacts of each pharmacy program design model in terms of LDH's functional responsibilities, oversight activities and staffing requirements.

D. Evaluate the advantages and potential challenges LDH and the provider and member communities may experience with each model.

2. Provide best practice recommendations for pharmacy claims information to ensure coordination of patient care if pharmacy services are removed from Medicaid managed care organization contracts.

3. Evaluate the most effective bulk purchasing multi-state buying pool (this item will be completed by LDH).

4. Provide best practice recommendations for oversight of a PBM that also owns pharmacies.

APPROACH

To accomplish these objectives for the Plan, Mercer performed the following steps:

1. Performed an environmental scan of other state Medicaid programs using FFS carve-out and single PBM pharmacy program design models.

2. Identified the advantages and challenges experienced by other state programs using FFS carve-out and single PBM pharmacy program design models.

3. Performed a fiscal impact analysis for each of the selected pharmacy program design models.

4. Researched best practices observed in the pharmacy industry for exchange of claims information and oversight of PBMs.

RESULTS

Mercer summarized the results of the actuarial analysis of the two models in Tables 1a and 1b. The fiscal impacts are separated by state and federal funding sources.

Table 1a: Summary — FFS Carve Out Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
FFS Carve Out Fiscal Impact			
Total Capitation Rate Impact	($372,930,000)	($1,072,550,000)	($1,445,480,000)
MCO Provider Tax Revenue Impact	$79,500,000	$0	$79,500,000

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
FFS Carve Out Fiscal Impact			
Total FFS Program Impact	$360,390,000	$1,036,350,000	$1,396,730,000
Total Estimated $ Impact (Savings)/Cost	**$66,960,000**	**$(36,200,000)**	**$30,750,000**
Total Estimated % Impact	**22.8%**	**-3.4%**	**2.3%**

Table 1b: Summary — Single PBM as a PAHP Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
Single PBM as a PAHP Fiscal Impact			
Total Capitation Rate Impact	($372,930,000)	($1,072,550,000)	($1,445,480,000)
MCO Provider Tax Revenue Impact	$79,500,000	$0	$79,500,000
Total PAHP Impact	$349,430,000	$999,150,000	$1,348,580,000
Total Estimated $ Impact (Savings)/Cost	**$56,000,000**	**$(73,400,000)**	**$(17,400,000)**
Total Estimated % Impact	**19.1%**	**-6.8%**	**-1.3%**

Mercer identified and summarized the advantages and challenges of the two pharmacy program design models:

- Both FFS carve-out and single PBM models present a number of advantages over the managed care model, including but not limited to:
  - Consistency of benefit administration for prescribers and pharmacy providers.
  - Streamlined administration of the pharmacy benefit, leading to more efficient and accurate reporting, rebate invoicing and preferred drug list (PDL) coordination.
  - Consistency and predictability in pharmacy claims reimbursement to pharmacy providers.
- Potential challenges of FFS carve-out and single PBM pharmacy program design models include:
  - Decrease in budget predictability offered by the capitated payment managed care model.

  - Loss of the MCO provider tax revenue due to the reduced capitation payments made to the MCOs.

  - Coordination of member care if pharmacy utilization data is not promptly available to the MCOs via a mechanism similar to what is employed by the MCOs and their subcontracted PBMs today. The challenge can be mitigated by creation of a robust data exchange between the State's pharmacy claims processor and the MCOs, as described in Section 5 of this report.

  - Increase in reimbursement to non-local pharmacy providers in a FFS carve-out model due to the requirement that all pharmacies are paid using the FFS methodology.

- The primary additional advantage of a single PBM as a PAHP model is:

  - The potential to avoid an increase in reimbursement to non-local pharmacy providers if the PBM is designated as a PAHP.

- The disadvantages of the single PBM as a PAHP model include:

  - Requirement for CMS waiver authority to designate the PBM as a PAHP.

  - As a PAHP, the PBM would be subject to the Managed Care Rule requirements.

CONCLUSION

Based on this analysis, implementation of either a FFS carve-out or a single PBM structured as a PAHP model would result in additional costs to the state of Louisiana. While development of best practice data coordination structures between LDH and the MCOs would carry a cost, the financial impact of the data coordination is minimal compared to the increase in pharmacy provider payments in a FFS carve-out and a loss of MCO Provider Tax revenue in both the FFS carve-out and the single PBM structured as a PAHP model. LDH could consider the implementation of programmatic changes to offset the financial impact of changing to either pharmacy program design model.

If LDH elects to maintain the current pharmacy carve-in model, Mercer has identified best practice data analysis and oversight safeguards to monitor the activity of PBMs that also own pharmacies.

2
BACKGROUND

CURRENT LDH PHARMACY BENEFIT DESIGN STRUCTURE

As of December 2019, the LDH program covered approximately 1,675,000 lives monthly under Medicaid and the Children's Health Insurance Program (CHIP)[1]. Members are enrolled in one of five different MCOs: AmeriHealth Caritas of Louisiana, Aetna Better Health of Louisiana, Healthy Blue, Louisiana Healthcare Connection, and UnitedHealthcare of Louisiana. Nearly 100% of the State's traditional and expansion Medicaid members are enrolled with an MCO. The managed care plans each subcontract with a PBM that is responsible for processing pharmacy claims and performing other pharmacy benefit functions. Four of the five MCOs either own or are owned by the subcontracted PBM.

Table 2 identifies the current LDH MCOs, MCO-subcontracted PBMs, and the ownership or contractual relationship between the MCO and the MCO-subcontracted PBM.

Table 2

MCO	PBM	OWNERSHIP RELATIONSHIPS
AmeriHealth Caritas of Louisiana	PerformRx	AmeriHealth Caritas is the parent company of PerformRx.
Aetna Better Health of Louisiana	CVS Health	CVS Health is the parent company of Aetna.
Healthy Blue	IngenioRx	Healthy Blue is a joint venture between Anthem and Blue Cross Blue Shield Louisiana. Anthem is the parent company of IngenioRx, which is a joint venture with CVS.
Louisiana Healthcare Connections (LHCC)	Envolve Pharmacy Solutions on CVS platform	Centene is the parent company of Envolve and LHCC.
UnitedHealthcare of Louisiana	OptumRx	UnitedHealth Group is the parent company of OptumRx.

[1] LDH monthly Medicaid enrollment report provided to Mercer

LDH has heard significant concerns from pharmacy providers regarding the current MCO and PBM structure. Stakeholders, especially independent (local) pharmacies, have historically been concerned with low reimbursement, spread pricing arrangements administered by PBMs, and MCOs/PBMs with pharmacy ownership interest steering members to the owned pharmacies. In addition, prescribers have expressed concerns regarding operational and patient challenges associated with navigating the pharmacy benefit across five MCOs and their subcontracted PBMs. Direct management of the pharmacy benefit by LDH has been proposed as a potential solution to provider concerns.

CURRENT ADMINISTRATIVE AND OVERSIGHT STRUCTURE

Under the current program design structure, LDH pharmacy staff, pharmacy staff at the University of Louisiana—Monroe (ULM), and outside vendors, Magellan and DXC, provide pharmacy administrative services to the fee-for-service program.

Additionally, LDH pharmacy staff are tasked with MCO oversight functions, which ensure enrolled members have access to pharmacy services and that the MCOs are in compliance with contract requirements.

Current administrative and oversight functions and the primary owner are listed and described in Table 3 below.

Table 3

FUNCTION	DESCRIPTION	RESPONSIBLE PARTY
Single PDL Maintenance	Drug marketplace research, recommendations and cost sheets for P&T, negotiate rebates	Magellan
PDL Oversight and MCO Coordination	Oversee Magellan PDL activities, coordinate with MCOs	LDH
MCO Encounter Data	Validate proper file creation	LDH and DXC
MCO Compliance	Track compliance issues, issue resolution, formalize findings and enforcement of fines	LDH
Capitation Rate Setting	Develop, oversee and approve analyses and rates	Mercer and LDH
FFS Utilization Management	Process FFS prior authorization (PA) requests; develop drug utilization review (DUR) criteria, tasks, and reports	ULM and DXC
Data Analytics	Ad hoc reporting and analysis	ULM

FUNCTION	DESCRIPTION	RESPONSIBLE PARTY
FFS Pharmacy Claims Processing	Point-of-sale pharmacy claim processing, including implementation of hard and soft claims edits	DXC, using LDH specifications

LDH CURRENT PHARMACY DEPARTMENT STAFFING

The LDH pharmacy program is managed by eight full time employees (FTEs). Staff includes:

- Pharmacy Director
- Five Pharmacists (two employed, three contracted)
- Program Manager (non-pharmacist)
- Program Monitor (non-pharmacist)

ULM staff supporting LDH includes pharmacists and data analytics staff. In a future FFS carve-out pharmacy program model, LDH still anticipates that ULM would be retained for assistance for all current pharmacy-related duties, with the possible exception of PA processing.

3
PHARMACY PROGRAM DESIGN OPTIONS

Mercer's research into pharmacy benefit program design is focused on two options: a FFS carve-out option, wherein LDH directly administers the pharmacy benefit using the current FFS structure, and a single PBM option, where LDH procures a single PBM to administer the LDH pharmacy benefit across both the FFS and managed care populations. Mercer identified the advantages and challenges presented by each option for LDH to consider.

PHARMACY CARVE-OUT TO FFS

Background

Carve-out Model Description

In a pharmacy carve-out to FFS model, all pharmacy services would be administered directly by LDH and its contracted claims processing vendor, with clinical support from ULM. In a FFS carve-out model, the State has the flexibility to decide which components of pharmacy management would be performed internally by LDH staff and which would be outsourced to vendors with additional expertise.

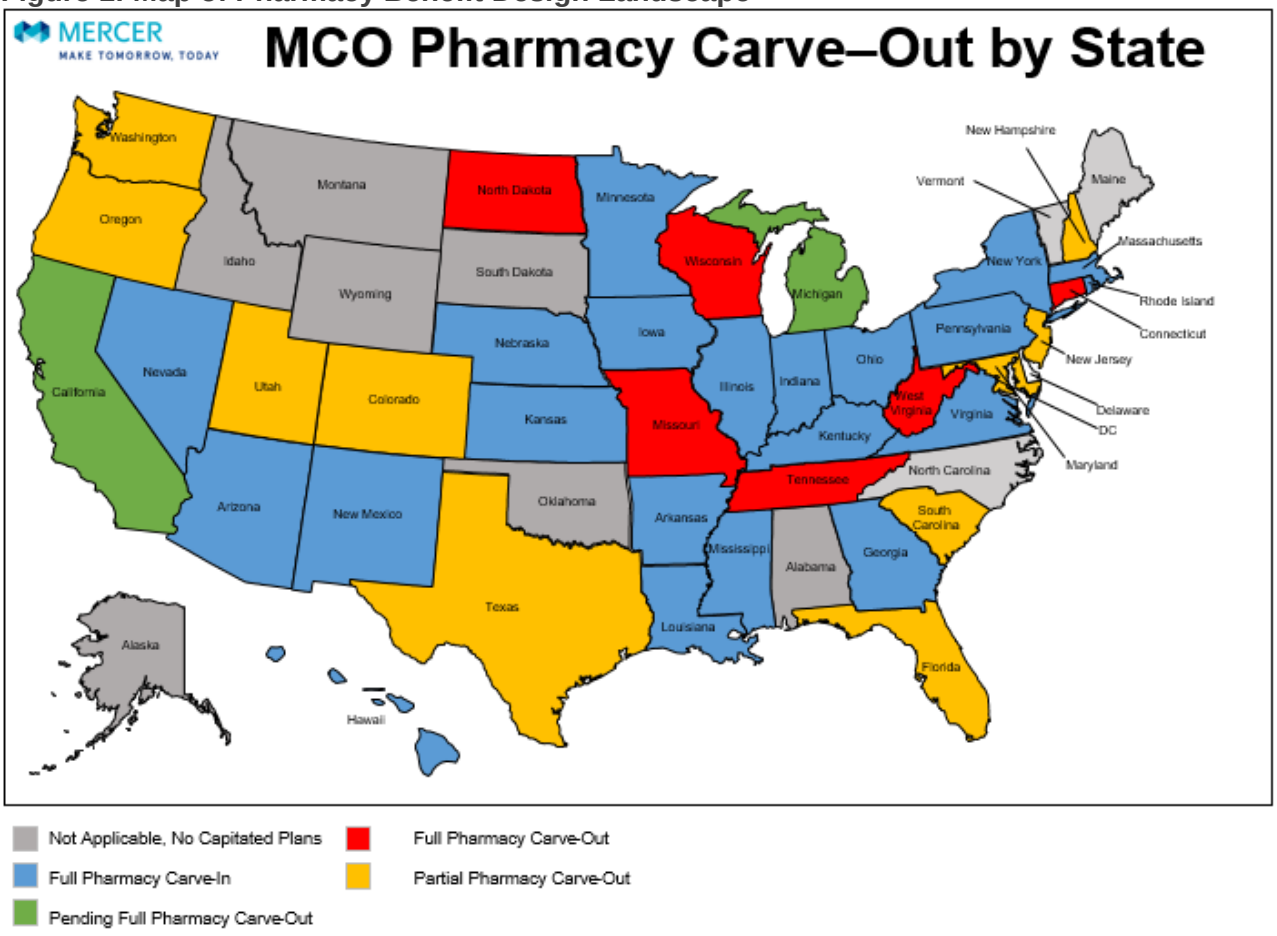
State Medicaid Environmental Scan

Mercer performed a market assessment and environmental scan to identify which state Medicaid pharmacy programs currently utilize a FFS carve-out model for the pharmacy benefit. The map below highlights which state pharmacy programs have a full managed care carve-in, full carve-out (including single PBM), partial pharmacy carve-out or another alternative.

Six states, or approximately 12% of state Medicaid programs[2], including most recently North Dakota, have a full pharmacy FFS carve-out. Twelve more states and the District of Columbia (DC) partially carve pharmacy out of managed care plans. Two other states, Michigan and California, have recently publicly expressed an intention to migrate to a full FFS carve-out model within the next two years.

[2] Kaiser Family Foundation and National Association of Medicaid Directors. "States Focus on Quality and Outcomes Amid Waiver Changes," accessible at 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

Figure 1: Map of Pharmacy Benefit Design Landscape



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. The State moved forward with this carve-out option with reliance on an actuarial study which forecasted a $30 million savings. In March 2019, a report released by Navigant showed calculated actual savings of $54.4 million to the State Medicaid Program for the first state fiscal year (SFY 2018) of carve-out. 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 fee-for-service methodology. Prior to the carve-out, it was estimated that the West Virginia MCOs were paying pharmacies an average dispensing fee of $0.59 per prescription.

The majority of the calculated savings achieved through West Virginia's 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 89.3% of West Virginia's Medicaid prescription drug costs for this analysis are paid by federal funds due to the 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: LDH 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 carve-out to FFS program. Operationalizing this plan will take significant planning and resources to ensure every facet of the pharmacy program is considered and included.

Table 4 provides a summary of the potential FFS carve-out operational impacts.

Table 4: Potential LDH Operational Impacts

OPERATIONAL IMPACT CATEGORY	PHARMACY BENEFIT CARVE-OUT TO FFS MODEL IMPACT
Utilization Management Coordination	• Increased volume of claims and exception requests
DUR Program	• Simplification of DUR reporting to CMS
Rebate Processing	• Increased efficiency of rebate 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 (Medicaid Management Information System [MMIS]) Impact	• Integration of historic encounter claims necessary • Mechanism for delivery of FFS pharmacy claims to MCO system needed
LDH Care Coordination	• Pharmacy and member notification of changes necessary • Additional service authorizations or grandfathering process required for formulary exceptions in transition period
Pharmacy Provider Impact	• Potential for disruption at implementation • LDH communication and staffing plan required to meet pharmacy provider needs • Increased dispensing fee revenue for non-local pharmacy providers
Member Impact	• Potential for disruption at implementation, particularly for prescriptions requiring authorization
LDH Staffing Impact	• Up to one additional staff member • Additional staff members may be needed if pharmacy benefit administration is in-house rather than vendor-managed

LDH Anticipated Staffing Changes

The infrastructure and processes for a FFS pharmacy environment already exist within LDH and, by extension, at ULM. Interviews with LDH staff indicate that between LDH and ULM, staff generally is adequate to operationalize and oversee the expansion of the existing claims processing contract or a newly-procured claims processing vendor, but there is a likely a need for additional staff at ULM to handle the increase in PA requests. Some current LDH staff may need to be trained in order to successfully transition to updated or different duties, but much of the oversight in place for the MCOs would still be applicable to overseeing the pharmacy claims processor and continued oversight of the ULM contract.

LDH would need additional staff support if it implements the pharmacy benefit FFS carve-out model using state staff in place of ULM staff. Additionally, LDH staffing needs could be increased if additional clinical programs are to be implemented by LDH to replace any current management programs performed by an MCO's PBM. Examples of MCO currently-administered programs may include medication therapy management, specialty drug case management, or adherence monitoring programs. The FFS program administered by LDH already operates robust clinical programs, some of which already include MCO members and would continue under a pharmacy FFS carve-out.

Pharmacy Benefit Carve-out: Qualitative Considerations

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

Table 5 below summarizes some of the identified advantages and challenges of a pharmacy benefit FFS carve-out model; some of these are further explained below.

Table 5: Advantages and Challenges of Pharmacy Benefit Carve-out to FFS Model

	ADVANTAGES	CHALLENGES
Financial	• Transparency • Statewide consistency in provider payment and utilization management • Potential for rebate processing efficiency • Potential savings on 340B claims	• Decrease in pharmacy budget predictability compared to managed care capitation • Change in federal administrative funding • Loss of MCO provider tax revenue • Potential conflict of interest if contracted pharmacy claims processor is aligned with one of LDH's contracted MCOs

	ADVANTAGES	CHALLENGES
Operational	• Pharmacy provider community acceptance • Efficiency in LDH decision making • Consistency with pharmacy network management	• Different parties at risk for retail and clinician-administered drugs • Data coordination for continuity of care and case management • Transition care planning • Less opportunity for decentralized innovation

Advantages

- **Statewide consistency in provider payment and utilization management:** Provider administrative burden, both at the physician and pharmacy level, may be reduced with the implementation of a single FFS vendor rather than to the current design which requires providers to operate under multiple PBM administrative processes. Pharmacy providers will also experience more consistent reimbursement levels as all pharmacies will be reimbursed using the FFS payment methodology. Currently, only local pharmacies are reimbursed at the FFS methodology in managed care. FFS Medicaid has a higher dispensing fee than is typically paid by a MCO-subcontracted PBM to chain pharmacies. While the higher dispensing fee payment may add to the overall program costs, it may help ensure continuity of a robust pharmacy network and patient access.

- **Potential savings on 340B claims:** The FFS carve-out program design may provide savings on the cost of prescriptions procured through the 340B program. The CMS Covered Outpatient Drug rule requires 340B claims to be paid at no more than the Health Resources & Services Administration (HRSA) ceiling price plus a professional dispensing fee, which is generally lower than the amount paid to 340B providers by the MCO-subcontracted PBMs. While the additional 340B savings may provide a benefit to LDH, it may present a financial challenge for 340B provider groups.

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

Challenges

- **Decrease in pharmacy budget predictability:** In a managed care model, the state pays the MCOs a capitated rate, and the MCOs are at risk for utilization that exceeds the state payment. Once the capitated rate is finalized, the state knows how much LDH will pay for prescription drugs, regardless of developments in the marketplace that may cause unexpected price fluctuations. In a FFS carve-out environment, the state will be required to pay the costs of all prescription drug utilization, whether the total is lower or higher than expected. While LDH is

already subject to pharmacy-related budget volatility due to fluctuations in federal drug rebate revenue, a FFS carve-out would somewhat increase the level of budget volatility within each fiscal year for the managed care enrolled population as prescription drug spend would no longer be included in the predictable capitation rate. However, the size of the managed care enrolled population and the volume of pharmacy claims in each year will generally support LDH's ability to forecast pharmacy expenditures in FFS.

- **Change in federal administrative funding:** In the current managed care model, LDH receives federal matching dollars at the FMAP on the capitation rate per rate cell, which includes expenditures for administrative activities and direct pharmacy services. In a FFS carve-out model, administrative activities performed by LDH or a contracted vendor would be matched at the standard 50% administrative rate. Some services may be eligible for an enhanced medical services match, and LDH could secure a 90% enhanced match for implementation of the claims processing vendor by tying these services to MMIS modularity, with a 75% match for maintenance and operations

- **Loss of MCO tax revenue associated with pharmacy portion of the capitation rate:** If pharmacy is carved out of the managed care contract and thus the managed care premiums, pharmacy costs can no longer be included in the calculation of the MCO tax. It is important to recognize that there are cash flow considerations with respect to the loss of MCO tax revenue. Specifically, the MCO tax is collected during the fiscal year that ends in June after the calendar year in which it is incurred. Therefore, there would be a lag between the implementation of a FFS carve-out and a reduction in tax revenue collected by the State of Louisiana.

- **Different parties at risk for retail and clinician-administered drugs:** 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, the MCO capitation rate will be set to include clinician-administered drugs but exclude prescriptions dispensed by the outpatient pharmacy channel. LDH needs to establish clear expectations related to whether or when the MCO is responsible for clinician-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:** In the current model, all MCOs are currently subcontracting with PBMs and have access to outpatient prescription data. In a FFS carve-out model, the need for frequent and ongoing data flow between the MCOs, LDH and any contracted pharmacy vendor may create potential operational challenges. 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 case management and other care coordination services.

SINGLE PBM

Background

Single PBM Model Description

Under a single PBM model, the state contracts with a PBM that manages the pharmacy benefits for participants enrolled in each of the contracted health plans as well as the population remaining in the FFS program. The pharmacy benefit is carved out of the health plans, but instead of the drug benefit being managed directly by the FFS program, it is managed by a PBM selected by the state.

While it is possible that a single PBM model could be accomplished by requiring all health plans to contract with a selected PBM, no states are currently exercising this option. However, Puerto Rico, a US Territory, employs this type of single PBM model. In Puerto Rico, the Territory contracts with both a PBM and a pharmacy program administrator (PPA); in tandem, these entities administer the full range of pharmacy services for the Medicaid population. The PBM is under contract with the Territory and is paid by the Territory for administrative functions such as claims processing and utilization management. The MCOs are responsible for the cost of the prescriptions paid for by the PBM, but are not responsible for the PBM's administrative expenditures. In other words, the MCOs in Puerto Rico are fully at-risk for the medical portion of pharmacy expenditures, despite the PBM and PPA being chosen by, contracted with, and paid by the Territory.

Mercer believes that Puerto Rico's circumstances are unique for multiple reasons, including its status as a Territory and its contracts with Territory-based MCOs and PBM. If the model of requiring a health plan to take on the risk of pharmacy expenditures managed by a state-selected PBM were attempted in Louisiana or another state, it would generate significant operational and political opposition from the health plans:

- Most health plans contract with one PBM for both their Medicaid business and commercial exchange or Medicare business lines. If the state selects a single PBM, it could create a scenario where some plans would have to contract with different PBMs for their different lines of business, which could create operational inefficiency and duplication of efforts for clinical initiatives, such as prospective DUR efforts.

- Health plans would oppose having to split up their book of business across multiple PBMs, thus losing negotiating leverage and potentially preferred pricing with their selected PBM.

- There is also potential for a real or perceived conflict of interest arising if a state Medicaid program were to select a single PBM that is financially aligned with one of the state-contracted MCOs either through ownership structure or contracted arrangement.

However, if LDH were able to secure contracts with the MCOs which required them to contract with a state-selected PBM while leaving pharmacy expenditures included in the capitation rate, the tax revenues associated with the pharmacy portion of the existing MCO provider tax would be

maintained. LDH could explore using a risk corridor to share the risk of pharmacy utilization and cost with the MCOs in a single PBM arrangement.

TennCare, the State of Tennessee's Medicaid program, is an example of a Medicaid pharmacy program operating under a single PBM model. TennCare operates the PBM arrangement as a PAHP under an 1115 waiver, but a single PBM model could also be managed under a Section 1915(b) waiver. Tennessee has operationalized its PBM model utilizing MCOs in a unique manner. The single PBM manages the pharmacy benefit and reimburses pharmacy providers directly, however the MCOs receive funding directly from the State to reimburse the PBM. Neither the single PBM nor the MCOs are at risk for the cost of prescriptions, although the single PBM does have the opportunity for gain sharing in rebate contracting.

The TennCare single PBM structured as a PAHP model offers many of the same advantages and challenges as those noted above in the section covering the FFS carve-out model. Additional advantages and challenges unique to the single PBM structured as a PAHP model are outlined in the table and narrative below.

Table 6: Additional Advantages and Challenges of a Single PBM PAHP Model

	ADVANTAGES	CHALLENGES
Financial	• Flexibility in pharmacy provider network and reimbursements, and potentially no requirement to follow the FFS reimbursement methodology	• Potential real or perceived conflict of interest if PBM aligned with one of the contracted MCOs • Loss of tax revenue • Change in federal administrative funding
Operational	• Similar to FFS carve-out	• Need waiver authority from CMS to structure as a PAHP • Structuring as a PAHP subjects the PBM to the requirements of the federal Medicaid Managed Care rule

Advantages

- **Flexibility in pharmacy provider reimbursements:** A potential advantage of a single PBM structure compared to a carve-out to FFS is the ability to utilize a flexible pharmacy reimbursement structure. Since a PAHP is considered managed care, Mercer believes the single PBM could continue to pay non-local pharmacies at an efficient contracted rate that is sufficient to maintain access but not necessarily the same as the FFS reimbursement methodology. TennCare, in their PAHP model, requires the single PBM to follow the FFS reimbursement methodology, and the PAHP is reimbursed on a non-risk basis.

  - The regulation governing non-risk contracts at 42 CFR 447.362 limits Medicaid payments to the contractor to the State plan fee schedule plus the net savings of administrative costs the State realizes through the contract by not purchasing the services on a FFS basis. Note this technically means that the FFS fee schedule is the upper limit for provider reimbursement, but it would be possible for the MCOs to continue to pay the chain pharmacies less than the FFS reimbursement rate.

Challenges

- **Real or perceived conflicts of interest:** If the selected PBM is also part of the ownership structure of one or more of the MCOs participating in the LDH program, there are conflict of interest concerns for both LDH and the MCOs to consider. For example, LDH and its contractors would need to ensure that adequate firewalls are in place to ensure that the PBM is unable to share other MCOs' member or utilization information with its parent company. One potential way to mitigate this risk would be to limit eligible vendors to those PBMs without any ownership relationship or alignment with any of the contracted MCOs. However, such an eligibility limitation would reduce the pool of potential vendors that LDH could contract with, which might have the effect of reducing competition and increasing the cost of the services provided. In the past, TennCare has used MagellanRx, which is not affiliated with any of the contracted MCOs. However, TennCare has recently contracted with OptumRx as the single PBM even though UnitedHealthcare is one of the contracted MCOs.

- **Waiver authority:** The single PBM as a PAHP model would require waiver authority from CMS. The process for establishing waiver authority requires significant effort from the state, and CMS approval is not guaranteed. The typical time it takes to draft an application and secure approval from CMS is 12 to 24 months.

- **Change in federal administrative funding:** Per 42 CFR 438.812, the administrative costs for the non-risk PAHP are matched at 50% and direct service costs are matched at the FMAP rate. Under a risk-based PAHP arrangement, the PAHP would not be tied to the FFS rate for provider reimbursement, and the capitation rates paid to the PAHP would be matched in the same manner as capitation paid to MCOs. No state has yet implemented a PBM structured as a risk-based PAHP model. A risk-based PBM structured as a PAHP would be permissible under a 1915(b) waiver or section 1115 demonstration (e.g., Louisiana's Dental Benefit Program authorized via 1915(b) waiver authority), although Mercer is not aware of any PBMs currently operating in a capitated risk-based arrangement.

- **Managed care rule requirements:** The single PBM structured as a PAHP model by definition structures the PBM contract as a managed care plan, and thus the PBM is subject to the Managed Care Rule requirements. Some smaller PBMs and PBMs not affiliated with an MCO might not have familiarity with or the ability to meet these requirements. A PBM would not qualify as a PAHP if its only function was to process pharmacy claims. Examples of Managed Care Rule requirements which would apply to the pharmacy PAHP include:

  - Network adequacy, network development and provider credentialing
  - Member information requirements (including but not limited to member handbook, provider directory and notices)
  - Member appeals and grievances
  - Quality requirements, including encounter quality review (EQR)
  - Program integrity
  - Federal approval of the contract and actuarial rate certification
  - Medical loss ratio requirements

- **Tax revenue:** In order for LDH to retain some or all of the MCO premium tax revenue currently collected on managed care pharmacy services, pharmacy services would need to be taxed directly as their own class of service. CMS identifies in regulation the classes of provider services that can be taxed including MCO services and outpatient drugs. However, PBMs generally do not qualify as MCOs and are not currently recognized as a class of services which can be taxed. While it may be possible to structure a PBM tax in Louisiana or to tax pharmacy services directly, that strategy may present challenges as federal requirements would require that all pharmacy services (Medicaid and non-Medicaid) be subject to such a provider tax. In addition, the recently released CMS Medicaid Fiscal Accountability Proposed Rule introduces increased scrutiny to health care related taxes moving forward. As is the case in a FFS carve-out, there would be a lag between the implementation of a single PBM structured as a PAHP and a reduction in in the tax revenue collected.

4
FINANCIAL IMPACTS

Mercer calculated the estimated financial impacts of a pharmacy benefit carve-out to FFS and a single PBM structured as a PAHP model as outlined below:

- Managed Care Program Budget Impact
- FFS Pharmacy Program Budget Impact
- Total Estimated Fiscal Impact

The fiscal estimates represent the overall budget impact to Louisiana's Medicaid program during calendar year (CY) 2019 and are separated by state and federal funding sources.

In order to determine the fiscal impact of each of the pharmacy program design models, Mercer considered how the transition from the managed care to the FFS or single PBM environment would impact ingredient cost reimbursement, dispensing fees, rebate collection, administrative costs, and other components of the capitation rate-setting process. To evaluate these elements, Mercer reviewed historical MCO final reports from first and second quarter CY 2019. Mercer applied adjustments to the data as necessary to estimate the overall fiscal impact of each program design model.

FINANCIAL IMPACT ADJUSTMENT CONSIDERATIONS

Table 7 below lists each adjustment category, the financial implication of each category and a brief description to explain how Mercer applied the adjustment.

Table 7: Summary of Adjustments Used for Estimated Financial Impact of a Pharmacy Benefit Carve-out

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Estimated Pharmacy Base Dollars	Savings	• The base pharmacy dollars for CY 2019 were estimated to be $1.4 billion. These expenditures would be removed from the capitation rates and paid through the FFS program.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Estimated Pharmacy Efficiency Adjustments	Cost	• In the managed care rate setting process, Mercer makes adjustments for inappropriate utilization or reimbursement levels identified during the base period using a customized series of clinical-based pharmacy utilization management edits and reimbursement reviews. • The pharmacy efficiency adjustments serve as an offset to the base data and would no longer apply in a FFS carve-out or a single PBM structured as a PAHP model. • Mercer assumed a 2.5% pharmacy efficiency adjustment.
Rebates — MCO Market Share Rebate	Cost	• In managed care rate setting, capitation rates are reduced by an estimated amount of market share rebates believed to be attainable through efficient contracting. • In a pharmacy benefit FFS carve-out or a single PBM structured as a PAHP, the market share rebate reduction would no longer be applied and the MCO capitation rates would increase by this amount. • Because LDH currently employs a comprehensive Uniform PDL, Mercer assumes that the MCOs are unable to collect any MCO market share rebates on prescription drugs. However, the MCOs do currently collect rebates on diabetic testing supplies. Mercer assumes that rebates for diabetic supplies would no longer be available in a FFS carve-out or single PBM program design.
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 2.25% for administration expenses.
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 assumed a 1.5% underwriting gain.
MCO Provider Tax Reduction	Savings	• The State recoups a specified portion of the capitation payments from the MCOs as the MCO Provider Tax. Carving the pharmacy benefit out of managed care would reduce the capitation rates and the associated tax.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
MCO Provider Tax Revenue	Cost	• The MCOs are subject to a 5.5% provider tax. Upon removal of the pharmacy component of the capitation rate, the tax revenue will decrease correspondingly. • Impact of the reduced tax is recognized on an accrual basis although there would be a lag in reduction of cash flow associated with MCO tax.
Estimated Pharmacy Base Dollars	Cost	• The base pharmacy dollars for CY 2019 were approximately $1.4 billion. These expenditures would be removed from the capitation rates and paid through the FFS program instead.
Estimated Change to Non-Local Pharmacy Reimbursement	Cost	• CMS requires state Medicaid FFS programs to reimburse providers at their average acquisition cost plus a professional dispensing fee (PDF). This is a different reimbursement model than MCOs currently utilize for non-local pharmacies. • Overall, reimbursement to non-local pharmacies would be expected to increase in a FFS carve-out model. • 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. • In the PBM structured as a PAHP model, the PBM is considered managed care and thus may not be required to follow the state plan reimbursement rates, pursuant to CMS approval of the waiver and contract.
Estimated Change to 340B Pharmacy Reimbursement	Savings, but unable to quantify	• In a FFS carve-out, 340B claims would be paid at AAC plus a professional dispensing fee, likely representing a savings compared to what is currently paid by MCOs. • Mercer was unable to quantify the impact of the 340B savings using the available data. The financial reports submitted by the MCOs indicated that 340B represented 1% of total pharmacy claims and 2% of pharmacy claim dollars. • In a single PBM structured as a PAHP model, the PBM would not be required to pay 340B providers using the FFS methodology. Any 340B savings would be an optional policy decision and could also be achieved in the current managed care structure.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
Member Utilization Management	No impact	• LDH 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 FFS 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. LDH 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, LDH will have to continue to rely on MCO encounter data to continue to invoice and collect for rebates on clinician-administered drugs.
Rebates — State Supplemental	Savings	• LDH currently receives supplemental rebates on MCO utilization drugs subject to the Uniform PDL. • LDH currently allows the MCOs to collect rebates on diabetic testing supplies. In a FFS carve-out or single PBM model, Mercer assumes that MCOs will no longer be allowed to collect rebates and LDH will instead collect rebates from diabetic supply manufacturers.
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 $0.05 per member per month (PMPM) in additional fees for transmitting data files and offering the MCOs and LDH access to web portal for care management services.

ADJUSTMENTS	FINANCIAL IMPLICATION	DESCRIPTION
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 $2 million to the current pharmacy claims processing vendor contract. • Mercer estimates the cost of a single PBM contract to cover both FFS and managed care lives to be approximately $5 million to $7 million annually, not including the costs paid to the pharmacy providers for prescriptions dispensed. This estimate is for a standard approach, generally adhering to the following parameters: – Does not include extensive staffing requirements such as on-site call centers and/or provider education representatives deployed across the state – Allows the vendor to manage the program out of state, with one to two local account representatives – Does not include excessive penalties and service level agreements – Does not require heavy customization that would require software development – Does not include implementation fees or customization fees, which would result in an increased cost to the State
Clinical Vendor (ULM) Cost	Cost	• Mercer estimated that the additional claims and member volume would require an increase to the number of staff needed at ULM to support the LDH pharmacy program. An increase of $500,000 was anticipated to reflect the additional membership and claims for the FFS carve-out model • In the single PBM structured as a PAHP model, Mercer assumed no additional cost for the ULM contract as additional utilization management functions would likely be included in the single PBM contract
Staffing	Cost	• Mercer estimated the cost of one additional staff member based on the average Pharmacy Department salary provided by LDH.

- At this time, states using FFS carve-out and single PBM programs are at risk for the pharmacy benefit expenditures. While this structure may benefit the state in some years, particularly if environmental forces drive down drug prices more than anticipated, it also has the potential to create budgeting challenges in years when market forces create unexpected prescription drug cost and utilization increases. LDH currently experiences budget volatility for prescription drug costs in the FFS population. The current managed care population generally experiences more predictable medical needs compared to FFS; therefore, while an increase in volatility is likely with a FFS carve-out, the proportional magnitude may be small compared to what is already experienced in FFS. The potential financial implications of budget volatility resulting from a pharmacy FFS carve-out of managed care could not be quantified.

- In previous analyses, Mercer has acknowledged uncertainty regarding the Health Insurance Provider Fee (HIPF) and whether the fee would create financial implications in a FFS carve-out. Recently, however, Section 502 of the Further Consolidated Appropriations Act of 2020 removed Section 9010 of the Affordable Care Act effective for calendar years after December 31, 2020. This removal means that MCOs will no longer have to pay the HIPF starting in CY 2021. The removal of this fee removes the potential cost to LDH of reimbursing the MCOs for this fee moving forward, regardless of pharmacy FFS carve-out.

Tables 8a–12 below provide Mercer's financial estimates of each budget impact category, broken down by each program type and component. Estimates do not account for the increased base dollar and administrative expenditures associated with implementation of the Hepatitis C Subscription model. Tax calculations use blended general and expansion match rates and do not account for the enhanced CHIP match rate. The FFS carve out estimate assumes additional payments to the current vendor; the PAHP estimate assumes procurement of a full service PBM.

Tables 8a and 8b, also shown in the Executive Summary as Tables 1a and 1b, present the summary level fiscal impact of a FFS carve-out and a single PBM as a PAHP, respectively:

Table 8a: Summary — FFS Carve Out Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
FFS Carve Out Fiscal Impact			
Total Capitation Rate Impact	($372,930,000)	($1,072,550,000)	($1,445,480,000)
MCO Provider Tax Revenue	$79,500,000	$0	$79,500,000
Total FFS Program Impact	$360,390,000	$1,036,350,000	$1,396,730,000
Total Estimated $ Impact (Savings)/Cost	**$66,960,000**	**$(36,200,000)**	**$30,750,000**
Total Estimated % Impact	**22.8%**	**-3.4%**	**2.3%**

Table 8b: Summary — Single PBM as a PAHP Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
Single PBM as a PAHP Fiscal Impact			
Total Capitation Rate Impact	($372,930,000)	($1,072,550,000)	($1,445,480,000)
MCO Provider Tax Revenue	$79,500,000	$0	$79,500,000
Total PAHP Impact	$349,430,000	$999,150,000	$1,348,580,000
Total Estimated $ Impact (Savings)/Cost	**$56,000,000**	**$(73,400,000)**	**$(17,400,000)**
Total Estimated % Impact	**19.1%**	**-6.8%**	**-1.3%**

Table 9 provides the detailed breakdown of the reduction in the capitation rates paid to the MCOs in both the FFS carve-out and a single PBM as a PAHP models:

Table 9: Managed Care Program Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
Managed Care Program Fiscal Impact			
Estimated Pharmacy Base Dollars (from Financial Reporting Requirements [FRRs])	($349,540,000)	($1,005,250,000)	($1,354,790,000)
Estimated Efficiency Adjustments	$8,740,000	$25,130,000	$33,870,000
Rebates — MCO Market Share Rebate	$1,600,000	$4,600,000	$6,200,000
MCO Administration Expense	($7,630,000)	($21,950,000)	($29,580,000)
Underwriting Gain	($5,590,000)	($16,090,000)	($21,680,000)
MCO Provider Tax Reduction	($20,510,000)	($58,990,000)	($79,500,000)
Total Capitation Rate Impact	**($372,930,000)**	**($1,072,550,000)**	**($1,445,580,000)**

Table 10 provides the provider tax revenue reduction to the State in both the FFS carve-out and a single PBM as a PAHP models:

Table 10: MCO Provider Tax Estimated Revenue Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
MCO Provider Tax Revenue Impact			
MCO Provider Tax Revenue	**$79,500,000**	**$0**	**$79,500,000**

Tables 11 and 12 provide a detailed breakdown of the impacts to the FFS program for each model. Table 11 provides detail for the FFS carve-out and table 12 the single PBM structured as a PAHP:

Table 11: FFS Carve-out Program Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
FFS Carve Out Program Fiscal Impact			
Estimated Pharmacy Base Dollars (from FRRs)	$349,540,000	$1,005,250,000	$1,354,790,000
Estimated Change to Pharmacy Reimbursement	$13,330,000	$38,320,000	$51,650,000
Member Utilization Management	No Impact	No Impact	No Impact
Rebates — Federal	($1,700,000)	($5,070,000)	($6,770,000)
Rebates — State Supplemental	($1,680,000)	($4,820,000)	($6,500,000)
Data Coordination with MCOs	$230,000	$680,000	$910,000
Claims Processing Vendor Cost	$500,000	$1,500,000	$2,000,000
Clinical Vendor (ULM) Cost	$130,000	$380,000	$500,000
Staffing	$40,000	$110,000	$150,000
Total FFS Program Impact	**$360,390,000**	**$1,036,350,000**	**$1,396,730,000**

Table 12: Single PBM as a PAHP Program Estimated Fiscal Impact

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
Single PBM as a PAHP Program Fiscal Impact			
Estimated Pharmacy Base Dollars (from FRRs)	$349,540,000	$1,005,250,000	$1,354,790,000
Estimated Change to Pharmacy Reimbursement	$0	$0	$0
Member Utilization Management	No Impact	No Impact	No Impact
Rebates — Federal	($1,700,000)	($5,070,000)	($6,770,000)

Fiscal Impact Adjustments	STATE IMPACT (A)	FEDERAL IMPACT (B)	TOTAL ESTIMATED FISCAL IMPACT (C = A + B)
Single PBM as a PAHP Program Fiscal Impact			
Rebates — State Supplemental	($1,680,000)	($4,820,000)	($6,500,000)
Data Coordination with MCOs	$230,000	$680,000	$910,000
Claims Processing Vendor Cost	$3,000,000	$3,000,000	$6,000,000
Clinical Vendor (ULM) Cost	$0	$0	$0
Staffing	$40,000	$110,000	$150,000
Total PAHP Program Impact	**$349,430,000**	**$999,150,000**	**$1,348,580,000**

Key Fiscal Analysis Observations

As presented in the tables, removing the pharmacy benefit from the MCOs and operating under FFS would present a total program cost of $30.8 million, which consists of a Federal savings of $36.2 million and a cost to LDH of approximately $67.0 million, or a 22.8% increase to LDH based on calendar year (CY) 2019 estimates. The two main factors driving the cost are the loss of MCO provider tax revenue, which is estimated to be $79.5 million, and the changes in reimbursement methodology for prescription claims paid to non-local pharmacies, estimated to be $51.7 million, $13.3 million of which is state share.

If LDH were to structure the program as a single PBM operating as a PAHP, there is potential opportunity to maintain the current reimbursement rates for chain pharmacies. Avoiding increased costs due to a change in reimbursement rates results in a total program savings of $17.4 million, which consists of a Federal savings of $73.4 million and a cost to LDH of approximately $56.0 million, or 19.1%.

In either model, LDH could consider the implementation of programmatic changes to offset the financial impact of a program design change.

In addition to the financial impacts, moving pharmacy benefits to a FFS carve-out or a single PBM structure requires careful planning, communication and rigorous oversight for a successful implementation. However, once implemented, a FFS carve-out of managed care to FFS can provide a uniform member and provider experience across the program. A single PBM can offer the State additional flexibility in reimbursement and provider enrollment while simultaneously giving the State additional control and transparency similar to that offered by a FFS carve-out model. Mercer recommends completion of a request for information, as well as a detailed operational assessment before any decision is made to move forward with a FFS carve-out or a single PBM.

5

DATA EXCHANGE IN A CARVE-OUT ENVIRONMENT

Coordination of member care is vital for improved member outcomes. Moving the administration of pharmacy benefits from the MCOs to the State, while the MCOs are still responsible for the members' overall care and payment of non-pharmacy claims, can create challenges for the MCOs and the state. In the current environment, pharmacy claims data is regularly transmitted from the MCO's subcontracted PBM to the MCO. In order to effectively manage members, MCOs will continue to need a full picture of each member's care, including their prescription claims. Fortunately, with modern-day technology, there are mechanisms to facilitate the exchange of member pharmacy claims at a suitable frequency, or even in real time.

Mercer recommends that LDH inserts specific and direct language into the MCO contracts and into a future request for proposals (RFP) to procure a FFS carve-out claims processor or single PBM. Examples of language used in other recent procurements are listed below:

- Provide web-based services to support communication and tools for the Department of Health.
- The Contractor shall provide real-time data access, daily data feeds, and support for State staff, MCOs, and other contracted partners. This includes individual access to the Contractor's point of sale claims system, prior authorization system, and all other information systems as necessary.
- Work with the Department of Health and other contracted partners regarding continuity of care.
- To ensure that managed care plans are able to continue to meet their contractual obligations relating to beneficiary care coordination, medication adherence and other related responsibilities, the Department of Health will work directly with the Contractor to ensure that it meets all State requirements related to data feeds and real-time access into an electronic portal/environment, as well as dedicated Contractor staff to assist with and resolve all pharmacy-related issues.

6

OVERSIGHT OF A PBM THAT ALSO OWNS PHARMACIES

Mercer believes LDH is uniquely positioned to create an oversight and auditing model to be emulated in other states. As MCOs, PBMs, pharmacies and other healthcare entities continue their emphasis on vertical integration through acquisition of each other, it will become more important than ever for states to understand these companies' structures and ensure that the proper firewalls exist to ensure the most effective and efficient use of the State's Medicaid funds.

Mercer recommends that LDH determine their expectations and draft specific language to be used in an RFP for a single PBM or to be included in MCO PBM subcontracts. Items to consider include:

- Member access to pharmacies: As required by the recently enacted Act 263, all subcontracted PBMs are required to allow any willing pharmacy meeting participation requirements into the network. Despite the any willing provider requirement, Mercer acknowledges that there is potential for PBMs that own pharmacies to steer members to their owned pharmacies, allow those owned pharmacies greater power to grant exceptions to standard claim edits and/or PDL requirements, and pay higher rates to pharmacies under the PBM's ownership. Avoiding ongoing conflicts of interest requires specific contract language and regular oversight.
- Monitoring provider notices sent by the PBM to ensure that language is consistent with LDH policy.
- Data analysis, potentially through a partnership with ULM or an alternative data analytics vendor, could provide several metrics to monitor for inappropriate steering, payment and claims processing, including:
  - Percentage of claims filled at owned pharmacies compared to baseline.
  - Prescriptions with initial fills at non-owned pharmacies that are transferred to owned pharmacies for refills.
  - Percentage of high-margin/high-cost medications filled at owned pharmacies compared to baseline.
  - PDL-compliance calculation of owned pharmacies compared to non-owned pharmacies (number of on-PDL claims divided by total claims), controlled by prescriber.

  - Comparison of the number and frequency of overrides of common claim rejections, such as refill-too-soon and generic available, between owned and non-owned pharmacies.
  - Comparison of claim approval and denial rates between owned and non-owned pharmacies.
  - Comparison of days' supply per claim between owned and non-owned pharmacies.
  - Comparison of average price paid per prescription for common prescriptions between owned and non-owned pharmacies.
    - Comparison of per prescription dispensing fees paid to owned pharmacies and non-owned pharmacies.
    - Comparison of the average wholesale price (AWP), wholesale acquisition cost (WAC) or National Average Drug Acquisition Cost (NADAC) paid for generic, brand and specialty drugs to owned and non-owned pharmacies.

- Additional metrics to monitor include member service calls and complaints, and provider services calls to LDH from pharmacies that feel business is being steered away from their pharmacy by the PBM.
- Payment rates: It is likely that LDH will require the FFS claims processor to pay LDH FFS payment rates to all pharmacies, whether the entity owns the pharmacy or not. While LDH may elect to give a single PBM structured as a PAHP flexibility to pay different rates to different pharmacies based on marketplace factors, LDH may want to consider a contract provision prohibiting differential payment, in aggregate, between owned and non-owned pharmacies. Mercer recommends monitoring payments for compliance with contract requirements relating to reimbursement rates, and also monitoring the prevalence of usual and customary (U&C) claims to ensure that owned pharmacies are not inflating billed amounts to avoid a U&C payment.
- Utilization management: If the FFS claims processor or the single PBM are responsible for processing PA requests, Mercer recommends that LDH and ULM compare the vendor's PA approval and denial rates for prescriptions that are filled (or attempted to be filled) at owned pharmacies vs. non-owned pharmacies. ULM is also uniquely positioned to review PA documentation and evaluate if the criteria are being applied consistently with how ULM has historically applied them.

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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.

APPENDIX A

METHODOLOGY

Mercer's fiscal analysis is based on pharmacy expenditures reported to Mercer by each of the MCOs participating in the LDH program. These expenditures were reported through the standard quarterly FRR submissions. Mercer used the base pharmacy amounts from Schedule X of the Q2 2019 FRRs, which summarized pharmacy spend for January–June 2019. Using these base dollars, Mercer made the following adjustments and assumptions:

- Mercer annualized the data, applying a 2% seasonality increase to complete for the second half of 2019.
- Mercer assumed that 30% of claims and paid amount are currently processed at local pharmacies, and thus the reimbursement on those claims would not change; the other 70% of claims are processed by non-local pharmacies and would be subject to future reimbursement changes.
- Mercer compared the discounts off of AWP paid by each plan for brand, generic, and specialty drugs reported on the FRRs to the NADAC equivalency metrics reported by CMS analyses performed by Mercer. We then used this comparison by plan and by drug type to determine how much more (or less) the discount would be in a NADAC pricing model.
  - Mercer assumes that the FFS NADAC ingredient cost methodology is equivalent to a generic ingredient reimbursement of AWP - 88.5%.
  - Mercer assumes that the FFS NADAC ingredient cost methodology is equivalent to a brand ingredient reimbursement of AWP - 20.4%.
  - Mercer assumes that the FFS WAC ingredient cost methodology is equivalent to a specialty drug ingredient reimbursement of AWP - 16.67%.
- Mercer multiplied the claim count difference between the MCOs' existing dispensing fee and the FFS dispensing fee of $10.99 to determine the increase in dispensing fee payments in a NADAC pricing model.
- Mercer excluded estimated U&C and third party liability (TPL) claims and dollars from budget impact totals.
  - Approximately 1.7% of the total paid amount was assumed to be U&C.

  - Approximately 0.4% of the total paid amount was assumed to be associated with TPL claims.

- Mercer reviewed the totals identified as 340B on the FRR submissions and identified that 340B claims were already being paid by the MCOs at a discount based on the average cost per claim. Mercer was not able to determine how much additional discount might be available if the 340B claims were paid at AAC.

  - Current MCO financial reporting shows 340B accounts for 2% of the total paid amount of $1.354 billion, or $27.1 million.

  - If 340B savings of 20% to 40% could be achieved on that 2% of paid amount, this would equate to a total impact of $5 million to $10 million.

- Mercer assumed a blended federal matching rate (FMAP) of 74.2% in determining the split between federal and state funding sources for most adjustments, with these exceptions:

  - Mercer assumed a blended federal matching rate (FMAP) of 74.95% to reflect the impact of the unit rebate offset amount (UROA) for the savings in federal rebate estimate.

  - Mercer assumed a 50% federal matching rate for the administrative components of a single PBM structured as a no-risk PAHP.

  - Mercer assumed a 75% matching rate for clinical staff support, maintenance of a FFS claims processing system, and data coordination.

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