STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

January 10, 2007

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
131 Lowe House Office Bldg.
Annapolis, MD 21401-1991

RE: 2006 Joint Chairmen's Report (P. 113) – Study on the Potential Savings from Carving-Out Prescription Drugs from HealthChoice

Dear Chairmen Currie and Conway:

In keeping with the requirements of the 2006 Joint Chairmen's Report, the Department is submitting the enclosed report on whether the State could achieve additional savings by carving-out prescription drugs services from the HealthChoice program. The report was due December 1.

If further information is required, please contact Tricia Roddy, Director of Planning, at (410) 767-5806.

Sincerely,

Signature on file

S. Anthony McCann
Secretary

Enclosures

cc: Anne Hubbard
Tricia Roddy
Jeff Gruel

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

INTRODUCTION

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

EVALUATION AND FINDINGS

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

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

Direct Costs

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

Description of Methodology

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

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

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

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

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

Results

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

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

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

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

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

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

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

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

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

Description of Methodology

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

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

Results

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

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

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

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

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

Description of Methodology

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

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

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

Results

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

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

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

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

Description of Methodology

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

Results

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

E) Comparison of the impact on administrative costs

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

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

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

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

Results

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

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

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

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

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

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

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

Indirect Costs

F) Other Issues to Consider

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

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

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

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

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

Additional Comments from the Managed Care Organizations

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

Recommendation

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

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

ATTACHMENT 1

October 23, 2006

Ms. Tricia Roddy
Director, Planning Administration
Department of Health & Mental Hygiene
201 W. Preston St.
Baltimore, MD 21201

Dear Ms. Roddy:

Thank you for the opportunity to comment on the Draft DHMH "Study on the Financial Implications of a Pharmacy Carve-out to the HealthChoice Program" ("Study"). For the reasons set forth below, we are concerned about the Study and the possibility that yet another benefit, in this case prescription drugs, would be carved out from the HealthChoice Program. In our view, it is likely this will not only fail to save money in the long-term, but it may add to administrative costs for MCOs and compromise the quality of care delivered to HealthChoice members.

1. <u>CURRENT EXPERIENCE WITH CARVED-OUT BENEFITS IS NOT OPTIMAL</u>

Medicaid managed care provides recipients with better outcomes through an integrated system of care to ensure that all necessary medical services, including pharmacy services, are provided in unison to deliver high quality cost-effective health care. We believe that a pharmacy carve-out will run counter to these objectives.

Currently, under the HealthChoice program ("Program"), the provision of specialty mental health services and psychiatric drugs are carved out of the Program. These services are provided by the State under separate contracts with other vendors. (However, the MCOs are responsible for the provision of primary mental health, substance abuse and all other medical and pharmacy services.) In many cases for our HealthChoice members, psychiatric symptoms are a barrier to compliance with medical treatment. As a result, the MCOs face challenges with respect to coordination of care to ensure the delivery of high-quality care to our members.

The challenges faced today with the mental health carve-out would only be exacerbated with a pharmacy carve-out and is contradictory to the purpose of managed care: to manage the healthcare needs of the whole person through coordination of care and disease management to deliver the highest quality outcome for the member. For example, under the existing pharmacy carve-out, providers and case managers must rely on a member to inform them:

- if specialty mental health services are being provided to the member;
- if psychiatric drugs have been prescribed for the member; and
- whether the member is compliant with the recommended course of treatment.

Introducing yet another vendor to this process creates, rather than removes, inefficiencies and creates barriers to coordinated care. As of today, there is no standard process requiring vendors in the mental health carve-out to collaborate with MCOs for sharing claims data in a real-time fashion. In addition, these members are forced to work with multiple vendors to obtain medically-necessary psychiatric treatment. As a result, HealthChoice members who either receive or require psychiatric drugs and therapy may not achieve the best possible medical outcome compared to a fully-integrated program.

The following illustrates the benefit of managing care for a member when AMERIGROUP is able to manage the pharmacy benefit:

- The successful treatment of asthma members is largely dependent upon their utilization of medicine. Scientific evidence shows that asthma members will reduce their frequency of asthma attacks if they take their medicine daily, however, only about 30% of the population is compliant with treatment. Because AMERIGROUP currently has the ability to monitor when members refill their medicine, AMERIGROUP is able to ensure that members are taking their medicines by reminding members to pick up medicines and seek timely refills. As a result, compliance is increased resulting in better health outcomes for the member and savings on emergency room visits and admissions.

- AMERIGROUP members who suffer from congestive heart failure ("CHF") are also better served by our ability to manage their pharmacy benefit. CHF members are among our most expensive members and are totally managed by taking the right combination of medications and watching salt intake. By looking at the drug profile of a member, AMERIGROUP can determine whether members in a CHF group are prescribed and are using the right medicines. In addition, we can request that pharmacists talk with a treating physician and/or send the member to a cardiologist if the medical regimen is not appropriate for a member.

2. <u>AMERIGROUP RESPECTFULLY QUESTIONS THE METHODOLOGY USED TO CALCULATE THE $20M IN POSSIBLE ESTIMATED SAVINGS FROM A CARVE-OUT</u>

A comparison of the fee-for-service dual eligible disabled population to the Medicaid only disabled population as relied on in the Study may not be a valid comparison for several reasons:

- The basic methodology assumes the usage patterns would be comparable for the dual eligible disabled members and the Medicaid only disabled members. However, the data should be properly mix adjusted so that the health status and other definable

risk categories are similar in both the fee-for-service managed care cohorts in the Study.It is stated that the members have "similar" diagnoses, but no information was presented to show that the data was similar, or what constitutes similar diagnosis.

- It is quite possible that MCOs have a significantly higher incidence of HIV/Aids and Sickle Cell members each of which can have a significant impact on utilization. These are very ill members who incur significant pharmacy costs during their lifetime.

- The MCO SSI population may not be as healthy as the fee-for-service dual eligibles. A dual eliglible, by definition, has access to certain benefits based on amount of time spent employed which would suggest they may be healthier than members who have never worked. As an example, we know that Sickle-Cell members have the disease their whole life and typically start incurring serious health issues in their 20s, preventing long-term employment.

In addition, a comparison of the dual eligible to the TANF (Family and Children) population would not be valid since these two populations have very different utilization patterns:

- Duals tend to use more drugs, many of which are for chronic conditions, and more costly brand names. As a result, the savings achieved in the disabled study would be significantly different than any savings achieved in TANF.

- Effective January 1, 2006 dual eligibles no longer received a Medicaid drug benefit therefore neither the state nor the MCOs would be responsible for those drug costs. Those costs are now covered under Medicare Part D.

Finally, we note that only a subgroup of total pharmacy dollars was considered in the DHMH analysis:

- The top 50 NDC drugs account for approximately 43% of the total adult dollars and 53% of the under 21 dollars. The top fifty drugs may or may not have a higher rebate amount than drugs associated with the non-top 50 drugs.

- The top 50 NDCs were submitted based on cost, therefore the data includes high cost injectible drugs and certain diabetic supplies that would not be included in a pharmacy carve-out and therefore should not be included in the rebate analysis.

- It is unclear as to whether the State used the same exact NDCs in their fee-for-service calculation as required to be used by the MCOs.

- 13% of the HealthChoice population has one quarter of their data used for the Study while 87% of the population has no data used in the Study.

3. A PHARMACY CARVE-OUT IS LIKELY TO INCREASE ADMINISTRATIVE AND MEDICAL COSTS.

The MCOs would continue to be responsible for monitoring the member's use of prescriptions and overall medical management of health care needs. However, administrative cost associated with these activities are likely to increase as additional resources would be needed to obtain necessary data from the State.

- The state would have to incur the cost of creating a system to provide pharmacy data to MCOs to assist MCOs with overall medical management.
- MCOs would need to create processes for acceptance and validation of the external data and build into some kind of usable format for medical management.
- MCOs would need to train clinical staff on a new system that provides real time access to data.

In addition to the impact of administrative costs, the Program may experience increases in medical costs through increased emergency room care and inpatient hospital admissions due to an MCOs inability to effectively case manage members with chronic disease.

- Carve-in allows MCO to monitor pharmacy profile for certain populations who collectively make up 70% of inpatient cost
- Effective disease management is dependent on access to drug utilization management for members with asthma, cellulites, CHF; or diabetes.
- The carve-out will reduce ability of MCOs to monitor and care for members recently discharged from a hospital to ensure member is obtaining and using medicine

4. THE LEWIN GROUP STUDY OF ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Arizona conducted a study, funded by the Center for Health Care Strategies and performed by the Lewin Group to analyze the effectiveness of providing the pharmacy benefit under Medicaid managed care versus a carve out from the Medicaid managed care program. The Lewin Group recommended against a pharmacy carve-out from the Medicaid managed care program for several reasons, including the following:

- Under a carve-out, it is not possible to instill the forceful incentives that the health plans are currently given to minimize pharmacy spending. Additionally, under the carve-out, the state (and its contractor) would not hold the type of leverage over the physicians that the health plans have, and the contractor would not even be affected by the physicians' prescribing patterns.

- There was no evidence that moving from a situation in which the pharmacy benefit is administered and paid for by capitated health plans to a pharmacy carve-out program was financially advantageous. The majority of states with capitated Medicaid managed care programs do not carve out pharmacy, and those that do were not motivated by cost concerns.

- The programmatic impacts of a carve-out would be detrimental to the highly integrated system of care that has existed in Arizona.

- Physicians would be likely to find the carve-out setting more administratively burdensome than the current system. Based on interviews conducted in connection with the study, there is real concern that any added administrative burden associated with a carve-out would result in a diminished provider network for Arizona Medicaid enrollees.

- A carve-out also would create additional complexities for enrollees who are accustomed to addressing all of their health care issues through the health plan. A carve-out would require that enrollees work with at least one additional entity for pharmacy issues.

- A carve-out would necessitate a broad range of new administrative activities for state staff, including an immediate, major procurement effort, revision of health plan contracts and enrollee materials, and oversight of the carve-out contractor(s) and collection of rebates.

- With prescription drugs taking on an ever increasing role in the delivery of health care, isolating this benefit would disrupt the ability to manage other aspects of health care. As in Maryland, the Arizona study found that health plans rely heavily on pharmacy data in the care coordination process. While it is technically possible that online pharmacy data could continue to be available to health plans under a carve-out, the experience of virtually all state-administered pharmacy carve-out programs at this time is that the health plans do not obtain pharmacy data as quickly and of the same quality as when they are at risk.

- A vendor that is responsible only for pharmacy costs under a carve-out will likely be motivated to control pharmacy costs only, even if at the expense of increasing costs in other health care categories.

In conclusion, we believe that the benefits provided to Medicaid beneficiaries by providing all health care services, including pharmacy services, through an MCO far outweigh any potential savings that may be achieved through a pharmacy carve-out. Clearly, studies of Maryland's own managed care program, as well as, studies of other state programs demonstrate that managed care Medicaid provides greater access to higher quality cost-

effective health care than a fee-for-service system. This is due, in large part, because of the coordination of care that is inherent to managed care. Furthermore, additional medical and administrative costs imposed on the Program as a result of a pharmacy carve-out may significantly reduce or eliminate any proposed savings to the Program. The current study does not consider what the overall impact may be to the delivery system with a pharmacy carve out. And, finally, the methodology used in the Study must be refined to ensure that an accurate account of the cost impact is captured.

Again, thank you for the opportunity to provide comments on the Study.

Sincerely,

Steven B. Larson, MA, JD
Chief Executive Officer

SBL:pm

cc: Vincent M. Ancona, COO

ATTACHMENT 2

October 23, 2006

Ms. Tricia Roddy
Director, Planning & Administration
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Ms. Roddy,

Thank you for the opportunity to provide comment concerning the Department of Health and Mental Hygiene's study on the Financial Implications of a Pharmacy Carve-Out to the Maryland HealthChoice Program. Jai Medical Systems has participated in the HealthChoice program since 1997. Prior to the HealthChoice program, our medical centers and physicians provided primary care to Medicaid recipients under the fee for service program for more than twenty years. We therefore believe that as an Historic Provider organization we may offer an unique perspective on the Pharmacy Carve out issue.

Essentially, Jai Medical Systems does not support a Pharmacy Carve-Out for the HealthChoice program. It is our concern that a Pharmacy Carve-Out will cost the state more money over time while creating program instability and reduced quality of care. There are many reasons for this position which are detailed below:

Rebates

According to the Department's study, the most significant cost differential is generated by the State's current ability to receive larger rebates on prescription drugs than the MCOs. This is due in large part to OBRA 90 which mandates that state medicaid programs receive the highest rebate available from pharmaceutical manufacturers. However, the larger rebate is also due to the more inclusive nature of the Department's Preferred Drug List (PDL) when compared to the formularies of the managed care organizations. This results in higher rebates, as it is a standard industry practice for pharmaceutical manufacturers to provide larger rebates when more drugs are covered within a class, formulary, or PDL.

Rebate savings are likely to dramatically reduce over time. There is no guarantee that the high rebates the State is currently enjoying will continue. The State is receiving very large rebates for certain medications, in some cases the rebates are in excess of eighty percent. If these specific rebates are reduced, or if the medications with these high rebates fall out of doctors prescribing patterns, the cost savings described in the Department's report would be lowered significantly. Additionally, if the State were to attempt to reduce the more inclusive nature of its PDL, in an

attempt to save money through the increased use of generic drugs, it is highly probable that the rebates will be lowered.

Currently, the MCOs are saving money by encouraging physicians to prescribe more generic medications. The Department's report shows the MCOs to be consistently using a higher mix (approximately 10% more) of lower cost generic medications. This use of generic medications in likely to decrease dramatically if the pharmacy component is carved out. According to the Center for Health Care Strategies, Inc. report entitled *Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System*, the current PDL managed by the state will become more permissive over time.

> "By all accounts, a state-administered pharmacy benefit will be a target for extensive tinkering by parties with vested interests, e.g., drug manufacturers, advocates, and legislators with specific agendas (views on infertility treatment, performance-enhancing products, etc.). We believe these activities will diminish the cost containment rigor of PDLs, prior authorization, and other cost containment features - as well as make the drug benefit a target for a variety of broader political issues."

It is reasonable to conclude that while the state may currently enjoy higher rebates this is not a guarantee of future savings. The current savings through rebates is achieved in exchange for a more permissive formulary, resulting in the risk of a much greater overall expense in the future.

Prescribing Patterns

If a Pharmacy Carve-Out were implemented, physician prescribing patterns would change. The most obvious change, as the Department's study supports, would be the percent of generic prescriptions written compared to the percent of brand name prescriptions written. However, other implications are not as obvious. According to the Center for Health Care Strategies, Inc. Report entitled *Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System*,

> "Some features of the health plans' efforts that have contributed to the extremely cost-effective performance of the existing pharmacy benefit cannot be replicated under a carve-out. Under the carve-out, it is not possible to instill the forceful incentives that the health plans are currently given to minimize pharmacy spending. Additionally, under the carve-out, the state (and its contractor) would not hold the type of leverage over the physicians that the health plans have, and the contractor would not even be affected by the physicians' prescribing patterns."

Essentially, if the state were to carve out the pharmacy benefit, the gross cost would escalate since the percent of lower cost generic prescriptions would drop and the state would not be in a position to influence the prescribing patterns of physicians. The loosening of the PDL and the broadening of prescribing patterns will reduce potential savings.

Pharmacy Co-payment

It is unclear how the Department's study accounts for pharmacy co-payments in its analysis. Currently, the Medicaid Fee for Service program mandates a $1.00 co-pay for generic drugs and a $3.00 co-pay for brand name drugs. If the co-payment requirement were maintained under a

pharmacy carve out scenario then current enrollees would experience a significant reduction in benefits since six of the seven MCOs participating in the HealthChoice program charge no co-payment for prescriptions. It should be noted that this benefit is something the MCOs are choosing to provide its members. This benefit does not cost the State, as the MCOs are paid based on a risk adjustment system that assumes the enrollee paid the co-pay. It is possible some enrollees may be discouraged from getting their medicine based on their inability to pay the co-pay. Losing this additional benefit will anger many enrollees and may reduce the quality of care received in the State of Maryland's Medicaid program. This may also increase hospitalizations, as it reduces preventative care, which in turn is very costly.

Report Comparison Problems

The 50 NDCs requested by the Department included NDCs for Glucose monitoring device test strips and Synagis. In both cases, MCOs and Medicaid have redundant suppliers outside of the typical pharmacy vendor for these items. For example, DME suppliers often supply Glucose monitoring strips to diabetic recipients. It is unclear how this issue is addressed in the study.

Quality of Care Reporting

The Department currently uses HEDIS reporting to assess the quality of care provided by MCOs. Many of the HEDIS measures reported by the MCOs require the use and analysis of pharmacy data. If the pharmacy benefit were carved out from MCOs, plans would be unable to, or have great difficulty, reporting the following HEDIS measures:

Comprehensive Diabetes Care
Use of Appropriate Medication for People with Asthma
Appropriate Treatment for Children with Upper Respiratory Infection
Appropriate Testing for Children with Pharyngitis

Jai Medical Systems Managed Care Organization, Inc. would encourage legislators to consider the impact on the citizens of Maryland, in addition to perceived cost savings, when considering whether a pharmacy carve-out would be beneficial. It is Jai Medical Systems' belief that such a carve-out would be detrimental to our members. It is also believed that the savings realized based on rebates will diminish over time.

Managing pharmacy utilization and costs is a major component of managed care. It should not be carved out of the MCOs. However, an additional option which our organization opposes, would be for the Department to implement an efficiency adjustment based on the report. Our rationale for opposing this option being that the report indicates that the main difference in cost is

the rebate differential and not MCO inefficiency. Based on current law, MCOs are not entitled to the same rebates that Medicaid receives and therefore MCOs are incapable of recouping any efficiency adjustment. Perhaps the best solution would be for legislators, the Department, and MCOs to work together in legislating rebate reciprocity for Medicaid MCOs from the pharmaceutical manufacturers.

Please contact me if you have any questions or concerns regarding this issue or if you require any additional information.

Sincerely,

Jai Seunarine
Chief Executive Officer

ATTACHMENT 3

October 20, 2006

Tricia Roddy
Director of Planning
Maryland Department of Health and Mental Hygiene
201 W. Preston St.
Room 224
Baltimore, MD 21201

Dear Ms. Roddy,

As requested, Priority Partners would like to convey our concerns over the results of the recent study on the financial implications of a Pharmacy Carve-out to the Maryland HealthChoice Program completed by the Department of Health and Mental Hygiene (DHMH). Outlined below, are the most significant issues from our perspective regarding the study as well as our concerns related to the potential impact on continuity and quality of care.

Study Issues

- Priority Partners believes that the estimated $20 million in rebate savings that could be achieved by the DHMH may be overstated based on the data presented in Tables 1 and 2 in the carve-out study. We have been under the impression that our discounts prior to rebates are greater than those achieved by the DHMH. Our ingredient cost prior to rebates is based off AWP minus 15%. We understand that the DHMH price prior to rebates is the lesser of AWP minus 12% or WAC plus 8%. If this is true, we do not understand how it is possible for the DHMH ingredient cost in Table 1 to be almost 10% lower than the MCO ingredient cost, and the DHMH ingredient cost prior to rebate in Table 2 is almost the same as the MCO price. If the DHMH ingredient cost prior to rebate in Table 1 and Table 2 were 3% more expensive than the MCO price, then the DHMH estimated rebate savings over the MCO price could decrease by as much as $10 million. Some of this could be driven by script quantities, which were not taken into account in this analysis. We believe this discrepancy is significant enough that the DHMH should research the issue and report back to the MCOs before filing the study with the legislature. It would not reflect well on the DHMH if the legislature decides to

carve out pharmacy based on this analysis only to find unachievable cost savings as a result of bad information.

- Based on our review of the data provided by the DHMH, it appears that a substantial portion of the $20 million savings is based on additional rebate dollars that DHMH may be able to collect from manufacturers; however, the calculation does not take into consideration a potential shift in generic-brand mix over the next two to three years. Published reports estimate that drugs with annual sales of about $22 billion in 2005 will loose their patent over the next 2 years. In fact, the MCOs use of generics is 9 percentage points higher than FFS. This accounts for $30 million in reduced costs. It only takes a shift of 6 percentage points in the FFS generic usage to eliminate the estimated $20 million in savings from the supplemental rebates. Based on the drugs used in this analysis that have already lost or are going to lose their patents, the potential $20 million in rebate savings may have already disappeared.

- Priority Partners generic utilization is currently very close to 74% and we expect this number to increase by about 10% over the next two years. Factoring in this potential shift in drug mix may also translate to a net cost advantage for the managed health plans, which have all been shown to have a higher generic mix.

- The report did not consider potential shifts in medication intensity that could arise as a result of less contractual leverage by the State to influence physicians' prescribing behavior.

Cost/Management Impact

- While the study focused mainly on drugs that are used for routine ailments, published reports indicate that specialty drugs that are used for management of severe disease states with annual drug cost of $10,000 - $250,000 will account for over 28% of total pharmacy expenditures within the next couple of years. Priority Partners has put in place a number of very effective utilization and cost-management programs to control these costs. Overall medical costs, including inpatient, outpatient and emergency room care which remain the responsibility of the MCO, could significantly increase if DHMH does not have comparable infrastructure in place to control and ensure appropriate utilization of specialty drug services.

- The Lewin Group in its 2003 report concluded that there is no evidence that moving pharmacy benefits from Managed health plans to a pharmacy carve-out program is financially advantageous.

- The Lewin Group also listed other reasons why a pharmacy carve out program may be detrimental the Medicaid program, including:

- Creating additional complexities for enrollees, who are accustomed to addressing all of their health care issue through the health plan.
- Disrupting the ability to manage other aspects of health care.
- The need for a broad range of new administrative activities for state staff to manage a pharmacy carve out.

Impact on Care

- Numerous studies have shown positive financial and clinical outcomes derived from disease management. As medication management is one of the core tenets of a good disease management program, it is essential for health plans to have access to real-time pharmacy information to effectively manage such problems.

- The MCO community has invested significant time and money to develop physician networks and relationships with these providers to help manage the member's medical expenses, which includes pharmacy costs. As a result, the MCO community is much better equipped to interact with providers and change behavior when it comes to prescribing patterns and overall management of care. By carving out the pharmacy benefit, the DHMH is reducing the effectiveness of managing the member's health. The DHMH would also duplicate administrative efforts.

We believe that this information makes for a very compelling argument for the maintaining the existing program structure. Please contact me at (410) 424-4691 if you have any questions or need additional information or clarification.

Sincerely,

Robert R. Neall
Chief Executive Officer

ATTACHMENT 4 October 25, 2006

To: Ms. Tricia Roddy, DHMH

From: Anthony J. Valdés, UnitedHealthcare

Re: Prescription drug carve out from the Maryland HealthChoice program

As requested, UnitedHealthcare has prepared the following document as a start to what we expect will be followed by much discussion and analysis of what the various implications would be to the members of the Maryland HealthChoice program if the pharmacy benefit was carved-out to fee-for-service.

While a strong doctor-patient relationship is, without question, the fundamental building block of quality health care, the availability of drugs to control chronic conditions and treat acute illnesses, is essential to an individual's ability to maintain or improve their health and functioning.

Yet, the availability of medications is only one component of health care, and without proper monitoring and coordination with an overall treatment plan, the medications themselves may not be sufficient to ensure the desired outcomes. That is where the state's plan to assume responsibility for the Medicaid drug benefit presents a risk, not only to the health of beneficiaries, but to various parts of the health care system itself.

Health plans now have real-time access to prescription information through their claims systems. If the state assumes responsibility for the drug benefit, it may be weeks before a health plan learns that one of its members has been prescribed a drug. By that time, a member may have had to be treated at an emergency room or admitted to a hospital. At best, his or her condition may have deteriorated unnecessarily, resulting in a loss of function and, certainly, a lessening of his or her quality of life. The result will be additional pressure on what is already a highly stressed segment of the health care system, to say nothing of needless suffering by the member and his or her family.

In addition, the state will lose the benefits of several important programs that UnitedHealthcare has implemented to hold the line on the cost of drugs. Among these initiatives are an aggressive generic drug program ensuring the most cost-effective, "A" rated medications are prescribed; detailed analysis of clinical practices including the monitoring of physician prescribing patterns protecting patients from over AND under-medicating; and intensive case management to help members stay compliant with their medication regimens.

HealthChoice was developed because it was acknowledged that the private sector had developed a better model for facilitating health care for Medicaid beneficiaries. One of the superior qualities in the health plan's repertoire is their ability to closely monitor the use of prescription medication. If we are serious about the need to control health care costs and want to see that taxpayer funds are used in the most effective manner, it would not make sense to fragment a system that has a demonstrated record of success. HealthChoice works well, continually demonstrates excellence and delivers outstanding value for the HealthChoice members and the Maryland taxpayers.

The Pharmacy Carve-Out Analysis

Without pulling together both UnitedHealthcare's pharmacy data and the state's FFS data, we cannot perform the necessary in depth analysis that is need to make a decision of this size and we are, therefore, left to point out discrepancies in the analysis. We would encourage a more encompassing analysis be performed prior to any decision to carve out pharmacy from HealthChoice.

Here are some top line issues/concerns that we have regarding the financial study that was completed for a pharmacy carve-out from the Maryland HealthChoice program:

1. Analysis of the top 50 drugs is not a valid mechanism for overall cost analysis. We cannot assume the experience of the Top 50 drugs can be applied to the total drug spend. On average, the top 50 NDCs made up less than half of the overall pharmacy dollars in this analysis.

2. Maryland FFS network discount rate [AWP-X% + disp. fee] is not as aggressive (competitive) as UnitedHealthcare's. Thus, the "ingredient cost/script" in Tables 1 and 2 do not accurately reflect relative cost of FFS versus MCOs.

3. With the patent expirations of the past year, the increase in the use of generics is the most cost-effective manner to manage pharmacy costs / trend. The effect / value of rebates will continue to diminish as more generics become available. Prior year's experience should not be applied to the future without a detailed analysis of the impact of projected increased use of generics over the next several years.

4. Table 5 reflects that the % of generics for MCOs has been relatively flat for the 3-year period. This is very inconsistent with our own experience. We have continued to significantly increase the utilization of generics during the period of this report. Thus, other MCOs may be performing sub-optimally in regards to generic utilization. A more effective and less disruptive method to achieve pharmacy cost savings is to define benchmarks of network discount, MAC rates and generic utilization. If all MCOs performed at or near optimal level, net savings to the state would be substantial.

5. The populations used in the analysis due not accurately match (not a direct comparison) the overall populations that we experience in the HealthChoice program.

6. Lastly, this analysis does not account for the fact that accurate and timely pharmacy data is a critical component to managing the health and well being of members in a multitude of ways. There are a wide range of activities that occur through the full spectrum of our medical management programs that require this data. These activities include:

- Identification of members with chronic medical conditions

- Identification of members with a history of substance abuse, and over utilization of narcotic drugs
- Identification of members lacking key medications that may control their disease or mitigate medical complications as dictated by evidence based medicine guidelines
- Use of pharmacy data to risk stratify members and target the highest risk members for case management intervention
- Use of pharmacy data to identify and alert physicians to drug-drug interactions
- Use of pharmacy data in provider profiling for quality initiatives

Anthony J. Valdés

ATTACHMENT 5

What is the cost of pharmacy fragmentation?

R. Burton, MD 2006

Fragmentation of pieces of health care, in order to save money for one specific cost area, may actually disrupt the entire continuum of care (Episode of Care, or EOC) enough to result in higher overall costs. *HealthNet*'s unpublished experience in the 1990s followed such a case, where pharmacy was fragmented off from overall care – in this case with Depression treatments. While they saved approximately $46 PMPY in drug costs, what they found was an actual all-care-included cost that went up $340 PMPY. Limiting pharmacy, purely on a cost basis, on the front end of a care cycle, and following only pharmacy costs looked very good, but the overall (Total Cost, TC) result actually cost more.

TC is the sum of all portions of costs within a therapy EOC. It includes visits to the physician's office, ER, admissions to the hospital, labs, and several other factors. To exclude consideration of all other pieces to control only one piece of the TC equation can, in many cases, be apparently good for that particular cost center, but can adversely impact the bigger picture.

Kathol (Kathol R et al. Epidemiologic trends and costs of fragmentation. Med Clin N Am. 90(4):549-72. 2006) showed that fragmentation can, in some cases, result in a doubling of the overall health care costs. Internal studies at Schaller Anderson have also shown that there may be areas in care that are dramatically inter-related. The cost of medical care with a comorbid behavioral disorder can result in costs that are 140% to 250% higher than without a behavioral diagnosis. Therefore, failure to recognize and treat the behavioral issue can lead to markedly higher overall costs. Considering that optimal treatment requires not only behavioral but also pharmacy linkages, any fragmentation of pharmacy can cause overall cost difficulties even while the pharmacy cost unit is looking better.

Richards (Richards T. Disease management in Europe. BMJ. 1998 August 15; 317(7156):426-427) has suggested that carveouts of pharmaceutical systems can damage overall effectiveness of Disease Management programs. "(There is a danger in) Medical 'carve outs' that entail patients being directed to certain specialists or pharmacy plans) for one disease risk fragmentation of care, especially for patients with multiple unrelated patholog(ies)." The issue here is that many patients do not have one isolated disorder, but often have significant comorbidities that impact each other. In running large group studies, Schaller Anderson has discovered that over 75% of people with CHF also have Hypertension; that over 40% of diabetics have lipid disorder and/or hypertension; that kidney patients have hypertension almost 65% of the time, and CHF over 50% of the time; that a large number of Coronary Disease members also have the linkages to hypertension and lipid disorders at equally high percentiles. By fragmenting off Pharmacy, a major tracking tool for Disease Management programs is pulled away from the armamentarium of tools used to help improve health and reduce overall costs.