F I S C A L I M P A C T R E P O R T

SPONSOR Ortiz y Pino **ORIGINAL DATE** 2/4/19 **LAST UPDATED** **HB**

SHORT TITLE Medicaid Managed Care Pharmaceutical Benefits **SB** 184

ANALYST Esquibel

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY19	FY20	FY21		
	($13,800.0)	($13,800.0)	Recurring	Insurance Premium Taxes/General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
FFS Rx Program	$0.0	$8,800.0	$8,800.0	$26,400.0	Recurring	General Fund
FFS Rx Program	$0.0	$42,200.0	$42,200.0	$126,600.0	Recurring	Federal Medicaid Funds
MCO Rx rates		($2,000.0-$6,000.0)	($2,000.0-$6,000.0)	($6,000.0-$18,000.0)	Recurring	General Fund
MCO Rx rates		($8,000.0-$24,000.0)	($8,000.0-$24,000.0)	($24,000.0-$72,000.0)	Recurring	Federal Medicaid Funds
NMMIP/HIX assessments		($1,800.0)	($1,800.0)	($5,400.0)	Recurring	General Fund
Administrative 20 FTE	$0.0	$850.0	$850.0	$2,550.0	Recurring	General Fund
Administrative 20 FTE	$0.0	$1,450.0	$1,450.0	$4,350.0	Recurring	Federal Medicaid Funds
Total	$0.0	$69,500.0	$69,500.0	$208,500.0	Recurring	General Fund, Federal Medicaid Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
UNM Health Sciences Center (UNMHSC)
Regulation and Licensing Department (RLD)

SUMMARY

Synopsis of Bill

Senate Bill 184 (SB184) proposes the Human Services Department (HSD) exclude, or "carve out," pharmacy benefits and services from the Medicaid managed care program.

FISCAL IMPLICATIONS

HSD reports under the provisions of the bill, HSD's payment of assessments would be reduced for the New Mexico Medical Insurance Pool (NMMIP) and Health Insurance Exchange (HIX). However, HSD reports a pharmacy carve-out could increase costs to the Medicaid program while also reducing revenue to the state based on the current situation where HSD pays higher pharmaceutical dispensing fees within the Medicaid fee-for-service (FFS) program compared to Medicaid managed care. In addition, a pharmacy carve-out could result in an overall loss of revenue to the state from reduction in collections of insurance premium taxes.

HSD notes based on FY18 pharmacy expenditure data, the difference between Medicaid managed care and fee-for-service (FFS) dispensing fees is approximately $8.63 per script with FFS being more costly. Medicaid managed care covered 5.9 million scripts in FY18. A carve-out, assuming application of the current FFS dispensing fees and approximately 5.9 million scripts, would result in an estimated increased cost of approximately $51 million total, and $8.8 million from the general fund. HSD did not provide data on the reduced cost of Medicaid capitated rates for pharmaceutical costs under the provisions of the bill, but an estimate of general fund savings ranges from $2 million to $6 million annually, and an estimate of federal matching funds could range from $8 million to $24 million annually.

Under SB184, HSD could also reduce costs in the Medicaid managed care capitation rates for the assessments for NMMIP and HIX . HSD estimates that based on CY19 rates, these reductions would be approximately $1.8 million in general fund. However, HSD notes it would forego the federal financial participation (FFP) currently received for these assessments, and the full cost could shift to non-Medicaid payers totaling approximately $8.9 million.

Additionally, a pharmacy carve-out would reduce the Medicaid managed care capitation rates, resulting in reduced insurance premium tax collection. Based on CY19, HSD estimates the impact would be a reduction to the state of approximately $16.8 million in total, and after removing the impact of the general fund contribution, the net reduction in insurance premium tax collection would lead to an estimated revenue losee of $13.8 million to the general fund.

Additionally, HSD indicates SB184 would result in new costs to the Medicaid program. To effectively implement a pharmacy carve-out, HSD estimates it would need 20 additional full-time equivalent (FTE) positions. These new positions would include clinical/medical expertise, pharmacists, staff managers, and pharmacy technicians. The cost of these additional positions

would total approximately $2.3 million per year including federal matching funds, with an $850 thousand general fund impact.

SIGNIFICANT ISSUES

HSD reports the state has implemented cost-controlling strategies for the Medicaid pharmacy benefit over the past several years, such as use of preferred drug lists (PDLs), generic substitution, pharmacy benefit management, prior authorization, ingredient reimbursement strategies, and supplemental rebates. Current utilization of generic prescription drugs in the Medicaid managed care program exceeds 85 percent.

HSD reports it manages and measures total per member per month (PMPM) spending on pharmacy. For example, despite an over $40 million increase in Hepatitis C drug expenditures in CY17, the Medicaid managed care organizations (MCOs) contained the overall pharmacy expenditures resulting in lower PMPM pharmacy expenses. This is due in part to the MCOs' access to pharmacy benefit managers (PBMs) with millions of national members (see chart below), which creates negotiating power with pharmaceutical companies. Additionally, some of the Medicaid MCOs are able to leverage further discounts through the federal 340B Drug Discount Program.

MCO	Pharmacy Benefit Manager	Number of Lives Covered in NM	Number of Lives Covered Nationally
BCBS	Prime	680,000	27 million
PHP	OptumRx	516,000	65 million
Western Sky	Envolve Pharmacy Solutions	65,700	9 million

HSD indicates the bill transfers the cost risk of changes in pharmacy expenditures from the MCOs to the Medicaid program, making health care cost projections less stable.

PERFORMANCE IMPLICATIONS

The interim evaluation of the Medicaid Centennial Care 1115 Waiver Program for CY17 showed that despite an increase in enrollment, the Medicaid managed care program demonstrated improvements in total program expenditures, costs per member, and costs per user for five out of six Medicaid eligibility groups. There were also positive shifts for pharmacy utilization, where use of generic drugs is more prevalent than brand drugs.

HSD reports these positive trends are the result of the Medicaid managed care delivery model, with an integrated physical, behavioral and long-term care program with MCO oversight of services, , medicine management, and care coordination for members with complex health care needs. Members with complex needs and/or multiple medications, benefit from integrated services and care coordination.

PERFORMANCE IMPLICATIONS

HSD notes federal regulations have substantial control over how fee-for-service dispensing fees are established limiting states' flexibility.

ADMINISTRATIVE IMPLICATIONS

SB184 would require HSD to implement, oversee and administer a carved-out Medicaid prescription drug benefit. As noted in the Fiscal Implications section, HSD would require additional staff and expertise in pharmacy benefit management, credentialing and contracting, prior authorization functions, medical/clinical oversight, and customer service operations.

There would also be IT system impacts related to duplicating pharmacy benefits management services and other work related to coordinating data with the MCOs and HSD's claims processing system. SB184 would likely have an impact on the Medicaid Management Information System (MMIS). Automated functions that now are administered by the Medicaid MCO pharmacy benefit managers would have to be brought in house and require substantial system customization.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

SB108 relates to SB131, Interagency Pharmacy Purchasing Council.

OTHER SUBSTANTIVE ISSUES

In its December 29, 201 Health Update newsletter, Manatt reported there are ongoing debates over whether Medicaid pharmaceutical carve-ins or carve-outs offer greater cost savings. Most of the literature supports the argument that greater savings are associated with carving in the prescription drug benefit—but it depends on the state and how well it manages its fee-for-service (FFS) program. There has been a rise in unified formularies, requiring MCOs to use the state's preferred drug list (PDL) to minimize variances across the state. Manatt also noted states have begun to carve out specific drug classes and treat those separately from the overall managed care contracts. https://www.manatt.com/Insights/Newsletters/Health-Update/Evolving-Pharmaceutical-Benefit-Trends-and-Medicai?utm_campaign=Health%20Update%201.23.19&utm_medium=email&utm_source=Eloqua&utm_campaign=Health%20Update%2012.18.18&utm_medium=email&utm_source=Eloqua&elqTrackId=92b8b660319f4deaa345adc71a53f8ef&elq=57ceae4a5fca4cfd8dd1d65da09dea9a&elqaid=6592&elqat=1&elqCampaignId=4202)

ALTERNATIVES

The bill does not specify what means are contemplated to cover prescriptions outside of the Medicaid managed care system. Presumably the bill would provide opportunities for some sort of purchasing pool or other cost-saving mechanism cheaper than making drug-purchasing a part of the Medicaid managed care plans. A structure would need to be built to support an alternative mechamism.

HSD suggests convening an Interagency Pharmacy Purchasing Council, as proposed in Senate Bill 131. Through the Council, HSD could explore additional options for leveraging bulk purchasing, negotiating prices with drug manufacturers, and other ways to achieve prescription drug savings and collaboration across the system.

RAE/gb