Department of Health

Medicaid Program: Cost of Pharmacy Services Under Managed Care

Report 2019-S-11 | September 2020

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health (Department) obtained Medicaid pharmacy services under managed care in an economical manner. The audit covered the period January 1, 2016 to December 31, 2019.

About the Program

The Department administers New York's Medicaid program, which covers prescription and non-prescription drugs for Medicaid enrollees. The Department uses two methods to pay health care providers for Medicaid pharmacy services: fee-for-service (FFS) and managed care. Under FFS, the Department pays pharmacy providers directly for each drug dispensed to a Medicaid recipient. Under managed care, the Department contracts with managed care organizations (MCOs), which arrange for the provision of pharmacy services for Medicaid recipients and payments to pharmacy providers.

Under FFS Medicaid, the Department has taken a number of actions to help ensure pharmacy services are provided in an efficient and economical manner. However, it has not established sufficient controls and oversight to ensure the most cost-effective delivery of pharmacy services under managed care. Rather, the Department has relied on MCOs and the MCOs' Pharmacy Benefit Managers to achieve the goal of effectively and efficiently managing drug costs for the Medicaid program.

Key Findings

- The Department missed opportunities to minimize costs on pharmacy services delivered through Medicaid managed care because Department officials did not take steps to ensure the use of the lowest net cost drugs to the Medicaid program. As a result, for the period January 1, 2016 through December 31, 2019, we estimated $605 million in unnecessary costs to the Medicaid program.
- The Department does not require MCOs to use the most cost-effective drugs to the Medicaid program, nor does it provide MCOs with information or assistance to determine the most cost-effective drugs.
- Medicaid-participating MCOs are required to regularly provide their drug formulary information, as well as information on costs and supplemental rebates (which MCOs did not always provide as required) for all drugs delivered under managed care, but the Department does not review this information to determine if MCO formulary preferences result in the use of the most cost-effective drugs.

Key Recommendation

- Conduct timely routine analyses to identify the most cost-effective drugs to the Medicaid program and ensure drug utilization is steered toward drugs with the lowest net cost when medically appropriate.

Office of the New York State Comptroller
Division of State Government Accountability

September 17, 2020

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
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Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Cost of Pharmacy Services Under Managed Care*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
BLTG Program	Brand Less Than Generic Program	*Key Term*
Department	Department of Health	*Auditee*
Federal Rebate Program	Federal Medicaid Drug Rebate Program	*Program*
FFS	Fee-for-Service	*Key Term*
Formulary	List of Drugs Covered by a Medicaid Managed Care Organization	*Key Term*
HARP	Health and Recovery Plan	*Key Term*
MCO	Managed Care Organization	*Key Term*
MRT II	Medicaid Redesign Team II	*Key Term*
PBM	Pharmacy Benefit Manager	*Key Term*
PDP	Preferred Drug Program	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to individuals who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5 percent.

The State's Medicaid program is administered by the Department of Health (Department). The New York State Medicaid program covers medically necessary U.S. Food and Drug Administration-approved prescription and non-prescription drugs for Medicaid enrollees. The Department uses two methods to pay health care providers for Medicaid services, including pharmacy services: fee-for-service (FFS) and managed care. Under FFS, the Department pays Medicaid-enrolled pharmacy providers directly for each drug dispensed to a Medicaid recipient. Under managed care, the Department pays managed care organizations (MCOs) a monthly premium for each Medicaid recipient enrolled in one of their plans, and the MCOs are then responsible for ensuring that enrollees have access to health care services, including pharmacy benefits, and that payments are made to pharmacy providers.

When health care providers are paid for services rendered to recipients enrolled in managed care, MCOs are required to submit encounter claims, which provide information about each medical service provided to their enrollees, to the Department. In addition, MCOs report their medical costs and administrative costs annually to the Department on Medicaid Managed Care Operating Reports. The Department uses this information to establish the managed care premium payment amounts.

The Department offers many different types of Medicaid managed care coverage depending upon individual eligibility. Most Medicaid recipients are enrolled in mainstream managed care, which provides comprehensive medical services ranging from hospital care and physician services to dental and pharmacy benefits. Health and Recovery Plans (HARPs) are another type of managed care program that provide specialized care, including pharmacy services, to Medicaid recipients age 21 or older with serious mental illness and/or substance use disorders.

In 1990, Congress created the Medicaid Drug Rebate Program (Federal Rebate Program) to reduce state and federal expenditures for Medicaid prescription drug costs. The program requires a drug manufacturer to enter into a federal rebate agreement in exchange for state Medicaid coverage of most of the manufacturer's drugs. Federal rebates help defray a significant portion of Medicaid prescription drug costs in New York. The Department and its rebate contractor administer the Federal Rebate Program for the State and, on a quarterly basis, submit rebate invoices to the manufacturers based on the utilization of drugs covered through FFS and managed care.

Cost savings can also be realized through agreements with drug manufacturers for supplemental rebates on specific drugs. The Department, through its rebate contractor, negotiates supplemental drug rebates in FFS, and MCOs use a Pharmacy Benefit Manager (PBM) to negotiate supplemental rebates for drugs provided under managed care.

The pharmacy benefit is one of the largest expenses an MCO has. For the period January 1, 2016 to December 31, 2019, MCOs reported spending approximately $23.8 billion on pharmacy encounters. During the same period, the Department spent about $2.9 billion on FFS pharmacy claims.

Audit Findings and Recommendations

The Department has not provided adequate oversight to ensure that the Medicaid program is providing managed care pharmacy services in the most economical manner. The Department missed opportunities to minimize costs on pharmacy services delivered through Medicaid managed care because it did not take steps to ensure the use of the lowest-cost drugs to the Medicaid program. As a result, for the period January 1, 2016 through December 31, 2019, we estimated $605 million in unnecessary costs to the Medicaid program.

Oversight of MCO Pharmacy Services

The Department is responsible for managing the Medicaid pharmacy benefit and has taken a number of actions to help ensure pharmacy services within FFS are provided in an efficient and economical manner, but has not exerted similar oversight and controls upon MCOs to ensure managed care pharmacy services are cost effective. Accordingly, the Department relies on MCOs, and the MCOs' contracted PBMs, to effectively and efficiently manage drug costs. The Department sees its oversight role as primarily ensuring that the MCOs' list of covered drugs (i.e., drug formularies) includes the range of drugs required to be available under the Medicaid program.

In FFS, the Department has taken steps to contain costs. For example, it has established the Preferred Drug Program (PDP) and the Brand Less Than Generic (BLTG) program to help steer prescription drug utilization toward less costly drugs that provide the greatest value to the Medicaid program.

The PDP promotes the use of less expensive, but equally effective, drugs when medically appropriate through a Preferred Drug List. The BLTG program promotes the use of certain brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent (for instance, after rebates). Furthermore, drugs in the PDP or the BLTG program can generally be dispensed with fewer or no restrictions, such as prior authorization requirements, compared with other drugs and are thus more attractive for prescribers. In choosing drug preferences within these initiatives, a significant factor in the Department's decision making is the net cost of drugs after federal and supplemental rebates.

The Department does not require MCOs to dispense the lowest net cost drug when medically appropriate, nor does it require adherence to the same rules it has implemented in FFS, such as PDP or BLTG. Furthermore, while MCOs are required to regularly provide their drug formulary information to the Department, as well as PBM reports on drug costs and supplemental rebates (which, we noted, were often incomplete or missing) for all drugs delivered under managed care, the Department does not review this information to determine if MCOs' formulary preferences result in use of the most cost-effective drugs. Additionally, federal drug rebates account for significant cost reductions to the Medicaid program, but MCOs cannot factor in the value of these savings when they identify cost-effective drugs for their formularies. Unlike the Department, MCOs do not have access to this information and the Department does not provide MCOs with other information or assistance to identify the most cost-effective drugs.

MCOs typically work with their PBMs to conduct their own clinical reviews to identify drugs that provide the greatest value to them and therefore should be placed on the drug formulary. Cost is an important factor when MCOs and PBMs conduct these reviews. When developing drug formularies, MCOs and PBMs must first consider effectiveness, clinical significance, and safety. As such, MCOs may choose certain drugs for their formularies due to their superior clinical and/or safety indication, but when there is no substantial clinical difference between two drugs, the net cost of a drug after supplemental rebates is the primary factor determining its inclusion on an MCO formulary.

However, a drug with the lowest cost to an MCO is not always the drug with the lowest cost to the Medicaid program. MCOs determine the net cost of a drug to them by calculating the amount they are required to pay for each drug claim, and then subtracting the amount of any additional discounts, such as supplemental rebates, that can be obtained by an MCO and PBM from the drug manufacturer. When determining formularies, however, MCOs cannot factor in federal rebates available through the Federal Rebate Program, which lower many drugs' net cost.

For the period January 1, 2016 to December 31, 2017, we reviewed the drug costs of the mainstream managed care plans and HARPs of 17 MCOs and identified instances where less expensive drugs were likely available. We found that the Department and MCOs missed opportunities to minimize costs on drugs delivered through managed care because existing oversight, control activities, and cost containment methodologies did not ensure the use of the lowest net cost drugs. We estimated as much as $297 million in unrealized cost savings for the two years reviewed – and an additional $308 million for the next two years of our audit period (January 1, 2018 to December 31, 2019), totaling $605 million over the four years.

The following table provides a hypothetical example of a cost comparison of two clinically equivalent drugs and illustrates how the federal rebate can significantly impact net cost. Based on the initial cost to the MCO for a given calendar quarter and the supplemental rebate available to the MCO from the manufacturer, Drug A was less expensive than Drug B ($9.50 vs. $15.00). In this scenario, the MCO would typically steer providers to prescribe Drug A by including it on its formulary with fewer or no restrictions compared with Drug B.

Drug Name	Drug A	Drug B
Price per unit	$10.00	$15.00
Supplemental rebate percentage	5%	0%
Net cost to MCO	$9.50	$15.00
Federal rebate percentage	35%	100%
Net cost to Medicaid	$6.00	$0.00

However, although Drug B has a higher initial price, it also has a federal rebate of 100 percent of cost. Had the federal rebate been applied when calculating net cost (as would occur under FFS), Drug B would have had zero cost. Drug A has a lower initial price, but has a federal rebate of 35 percent, therefore making this drug's net cost to the Medicaid program higher ($6.00 vs. $0). When MCOs chose Drug A as a "preferred drug" for their formularies, the Medicaid program was not functioning in a cost-effective manner.

During the audit, when asked about actions to ensure cost efficiency within the managed care pharmacy benefit, Department officials did not provide any specific information or any indication that the Department was reviewing this issue.

During our 2019 audit, we communicated with Department officials about our observations and in their written response to our preliminary report, in line with the audit findings, Department officials stated they were working in conjunction with the State's Medicaid Redesign Team II (MRT II) process to comprehensively evaluate other models for managing Medicaid prescription drug benefits, such as implementing a statewide formulary or fully carving the pharmacy benefit out of managed care. On March 19, 2020, the Department issued an Executive Summary of MRT II Proposals, in which it recommended removing the pharmacy benefit from managed care and covering it under FFS instead. The Fiscal Year 2021 enacted budget approved the Department's recommendation, and the removal of pharmacy services from managed care is scheduled to go into effect on or after April 1, 2021 and upon federal approval.

Recommendations

1. Conduct timely routine analyses to identify the most cost-effective drugs to the Medicaid program and ensure drug utilization is steered toward drugs with the lowest net cost when medically appropriate.
2. Should the decision to remove the pharmacy benefit from managed care change:
    - Continuously review drug costs to identify drug alternatives that offer the best cost efficiencies to the Medicaid program and that should be given preference on managed care formularies.
    - Coordinate with MCOs and monitor their formularies to ensure benefits are administered in a manner that generates the greatest cost efficiencies to the Medicaid program.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department obtained Medicaid pharmacy services under managed care in an economical manner. The audit covered the period from January 1, 2016 through December 31, 2019.

To accomplish our objective and assess related internal controls, we interviewed officials from the Department and MCOs and examined the Department's and MCOs' relevant policies, procedures, and contracts as well as applicable federal and State laws, rules, and regulations. We reviewed Medicaid Managed Care Operating Reports and PBM reports and the associated specifications, instruction manuals, and data dictionaries. We extracted managed care pharmacy encounter data for mainstream and HARP MCOs as well as FFS pharmacy claim data from the Medicaid Data Warehouse. We excluded managed care encounters and FFS claims with third-party insurance payments.

We identified various clinically equivalent drugs that were in the same drug grouping on the Department's FFS Preferred Drug List. We also identified potentially equivalent drugs that were within the same drug sub-class according to the Generic Product Identifier. We calculated average quarterly federal and MCO supplemental rebate amounts for each drug based on historical rebate amounts provided by the Department and MCOs. We calculated net costs (after federal and MCO supplemental rebates) for each drug under managed care for 17 MCOs with mainstream and HARP plans. Within a drug grouping or sub-class, we identified instances where a more expensive drug had higher utilization under managed care than in FFS and a less expensive drug had lower utilization under managed care than in FFS. We then estimated potential cost savings based on the difference in net cost of the two drugs and the potential change in utilization had the Department and MCOs taken steps to ensure that the least expensive drugs were utilized.

After we calculated waste per drug within the selected drug groupings or drug sub-classes for the period from January 1, 2016 to December 31, 2017, we estimated the waste for the period from January 1, 2018 to December 31, 2019. To accomplish this, we used the percentage of waste relative to the total pharmacy costs for 2016-17 and applied it to the total pharmacy costs for 2018-19.

We shared our methodology with the Department and the Office of the Medicaid Inspector General during the audit for their review.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this final report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with the audit recommendations. Our response to certain Department comments is included in our State Comptroller's Comment, which is embedded in the Department's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Agency Comments and State Comptroller's Comment

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

August 12, 2020

Ms. Andrea Inman, Audit Director
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Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report **2019-S-11** entitled, **"Medicaid Program: Cost of Pharmacy Services Under Managed Care."**

Thank you for the opportunity to comment.

Sincerely,

Lisa J. Pino, M.A., J.D.
Executive Deputy Commissioner

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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2019-S-11 entitled, "Medicaid Program: Cost of Pharmacy Services Under Managed Care"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2019-S-11 entitled, "Medicaid Program: Cost of Pharmacy Services Under Managed Care."

Recommendation #1:

Conduct timely routine analyses to identify the most cost-effective drugs to the Medicaid program and ensure drug utilization is steered toward drugs with the lowest net cost when medically appropriate.

Response #1:

Per the enacted 2020-2021 budget, the Department will move to a single statewide Preferred Drug Program which will transition the pharmacy benefit from managed care to the fee-for-service (FFS) system, effective 4/1/2021. This will promote the use of less expensive, equally effective prescription drugs when medically appropriate for all Medicaid members (managed care and FFS). The transition of the Medicaid pharmacy benefit to the FFS program requires a high risk and high-profile implementation with impacts on health plans, providers and consumers. Therefore, it is imperative that the Department's efforts and resources are laser focused on this initiative so that the transition occurs on time along with the $87.2M in State Medicaid savings realized.

Recommendation #2:

Should the decision to remove the pharmacy benefit from managed care change:

- Continuously review drug costs to identify drug alternatives that offer the best cost effectiveness to the Medicaid program and that should be given preference on managed care formularies.
- Coordinate with MCOs and monitor their formularies to ensure benefits are administered in a manner that generates the greatest cost efficiencies to the Medicaid program.

Response #2:

The Department does not anticipate that the decision to transition the pharmacy benefit from managed care will change. However, if this does change, the Department maintains that the approach suggested by OSC is flawed and inaccurate, as it disregards rate setting principles and associated costs built into capitated rates.

State Comptroller's Comment - We disagree with the Department's characterization of the audit conclusions as inaccurate. The audit identified significant inefficiencies in the Department's existing practices, and the correction of these inefficiencies lies with the Department to implement. The Department's decision to move Medicaid pharmacy services from managed care to fee-for-service only corroborates the conclusions that we reached in this audit.

Therefore, if there is a change in direction, the Department would continue to work with its contracted actuary to ensure the appropriate and cost-effective development of the capitated

rate and continue its oversight activities, which include monitoring of plan performance against the capitated rate and making adjustments as necessary. Additionally, the Department would conduct a comprehensive re-valuation of the various models available to manage the Medicaid pharmacy benefit to determine an alternative model that best leverages the State's volume and negotiating power and ensures full visibility into prescription drug costs.

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