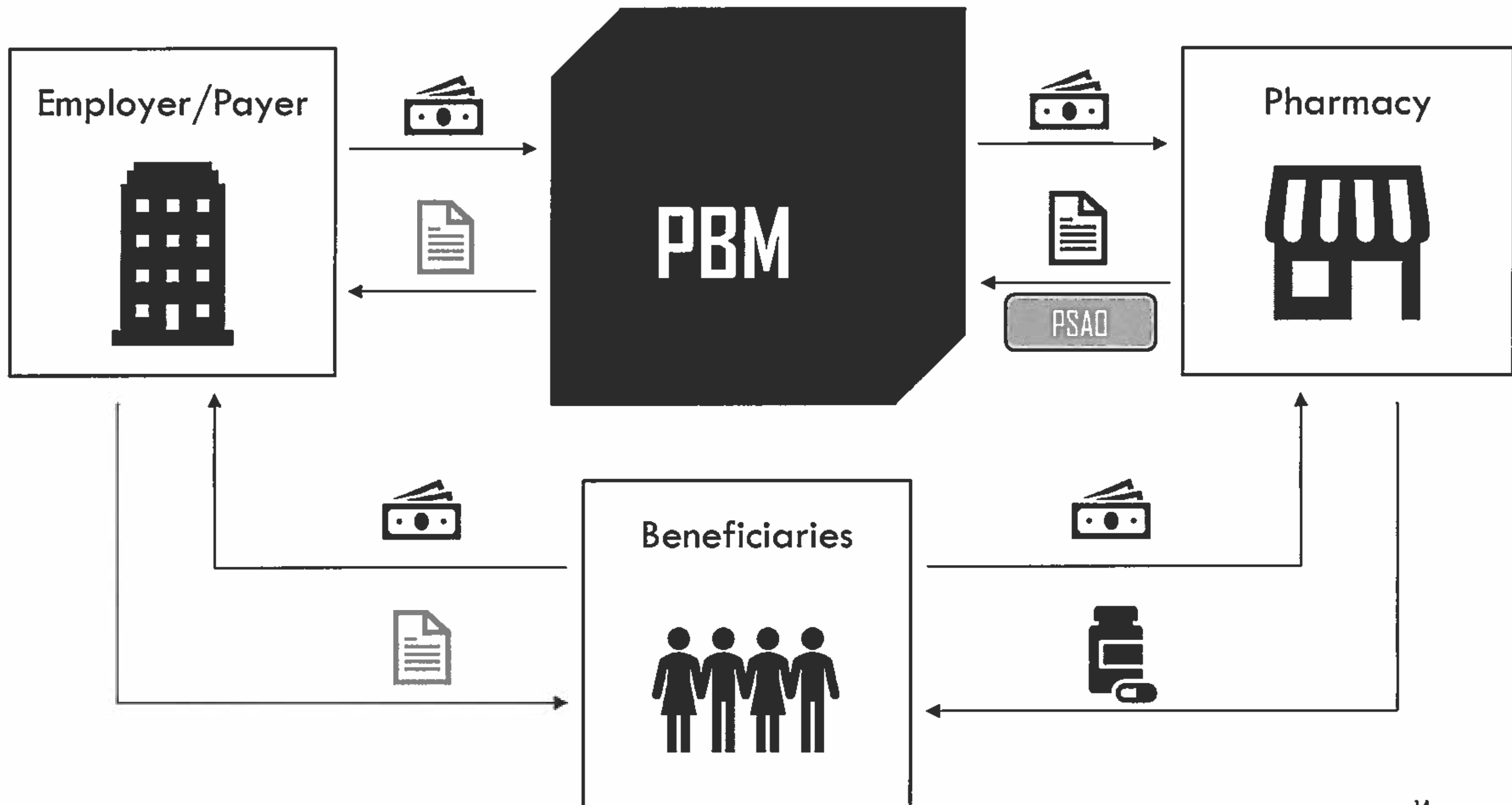
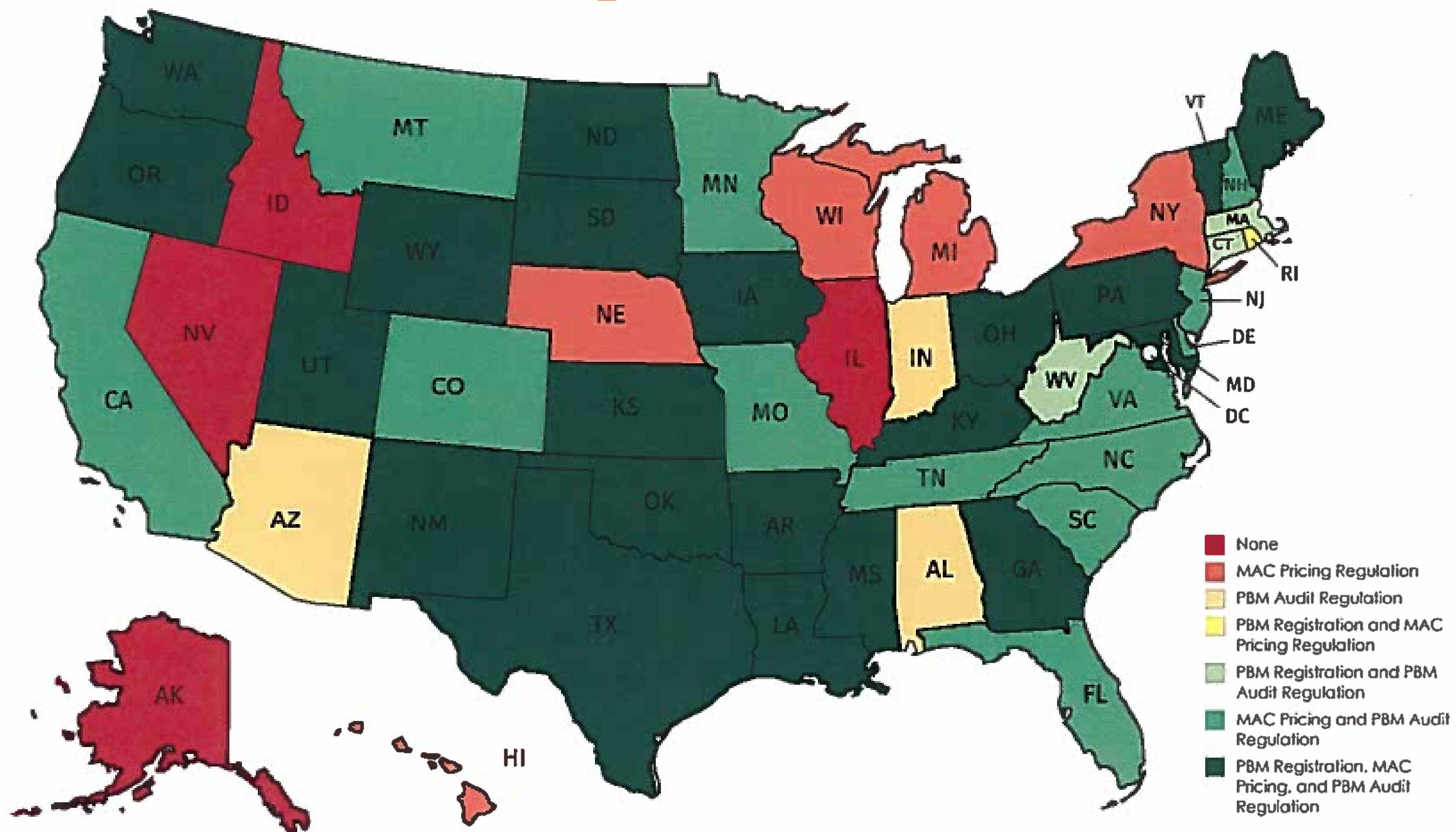
PBM 101

GENERIC DRUGS



A Patchwork of Modest PBM Regulation



NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Updated February 2018

NAVIGANT

PHARMACY SAVINGS REPORT

February 25, 2019

WEST VIRGINIA MEDICAID

Actuarial Assessment of the SFY18 Impact of Carving out Prescription Drugs from Managed Care for West Virginia's Medicaid Program

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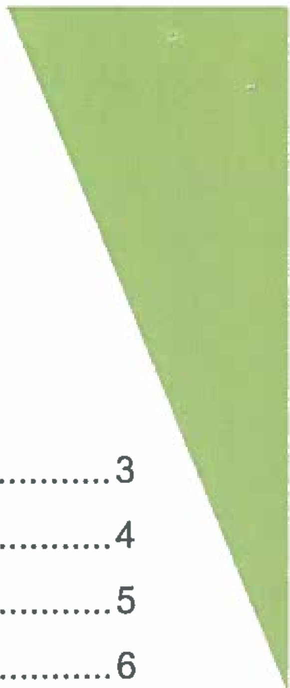

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Overview & Intended Use

The West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS) requested that Navigant Consulting, as a subcontractor to The Lewin Group, assess the potential savings that have been achieved during SFY18 (July 1, 2017 – June 30, 2018) due to the carve-out of prescription drug services from West Virginia's Medicaid managed care program.

The information contained in this document was prepared to estimate the cost savings to the State of West Virginia and may not be appropriate for any other purpose. Any user of the information should possess a familiarity with West Virginia's Medicaid program, and a certain level of expertise in pharmacy claim costs, actuarial science, and healthcare modeling is required to avoid misinterpretation of the data presented.

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Caveats

The figures presented rely heavily on data received from DXC and are only appropriate insofar as the base data is credible. Additionally, note that about 10% of claims in either the SFY17 or the SFY18 periods were unable to be priced under the NADAC repricing step. For those claims, the unit cost was assumed to be the same under both a FFS/MCO scenario and NADAC. These figures represent Navigant's best estimate of cost savings to the State at the time of this report.

Furthermore, additional considerations could be made such as risk adjusting different periods to ensure the same level of acuity. This would be a practical method to ensure equivalence between populations of different time periods, with respect to the underlying risk that is changing between those time periods. At the time of this analysis, a risk adjustment model was not able to be run on the data due to the time needed to consider such an adjustment, so this was excluded from the modeling of savings.

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Executive Summary

BMS requested that Navigant Consulting, as a subcontractor to The Lewin Group, assess the potential savings that have been achieved during SFY18 (July 1, 2017 – June 30, 2018) due to the carve-out of prescription drug services from West Virginia's Medicaid managed care program.

Navigant took a prescribed approach by repricing both SFY18 and SFY17 pharmacy claims to the unit cost rates from the National Average Drug Acquisition Cost (NADAC) fee schedule to appropriately compare the two years of data. Navigant also adjusted the SFY18 fee-for-service (FFS) experience to reflect how claims would be reimbursed under managed care. A comprehensive review of pricing in SFY18 along with managed care experience prior to SFY17 suggests that the current FFS arrangement is more cost effective than the prior managed care arrangement, even though actual FFS costs in SFY18 were significantly higher than managed care experience in SFY17 even after accounting for trend and membership differences. Additionally, it is our understanding that the drastically higher dispensing fees present in SFY2018 are a result of mandated CMS rule and not necessarily a byproduct of carving pharmacy benefits out of managed care. More detail on this conclusion is provided in this report.

Additionally, administrative expenses must be factored into savings estimates. Due to significant MCO administrative burden and taxes and fees, such as the Health Insurance Provider Fee (HIF), the State ended up saving money on pharmacy due to the carve-out. In total, our actuarial estimate suggests savings of $54,450,000 in SFY18 to the West Virginia Medicaid program. As 74.34% of West Virginia's Medicaid costs are paid by Federal funds due to Federal Medical Assistance Percentage (FMAP), this means that the State saved approximately $13,970,000.

Additional details on how these savings are determined can be found below. Note that these savings were also determined by examining the claims and administrative expenses and repricing the claims. Actual pharmacy claim costs increased significantly from SFY17 to SFY18, with much of this being attributable to significantly higher dispensing fees as well as greater volume of claims. However, it is important to note that year-to-year pharmacy costs under managed care varied significantly in the years leading up to the carve out in SFY18. For instance, the use of SFY15 base data to project manage care expenses that would have occurred in SFY18 results in higher projected managed care claim costs than FFS in SFY18. Therefore, it is important for the State to recognize that experience will vary year-to-year and that proper utilization controls, especially for new pipeline drugs, will be necessary to manage and maintain savings.

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Overview of Methodology

As of July 1, 2017, pharmacy services were shifted from managed care to a FFS reimbursement structure. This memo describes how Navigant determined the SFY18 fiscal impact of implementing the carve-out pharmacy services to West Virginia's Medicaid program and summarizes the savings and important considerations for the State.

Navigant took the following steps to calculate these savings:

1. Reprice both SFY17 managed care and SFY18 FFS experience to NADAC rates to establish baseline comparison of costs, adjust for dispensing fees, and calculate difference in expected claim costs as of SFY18.
2. Analyze differences in administrative costs covered by the State under both managed care and FFS reimbursement arrangements.
3. Forecast SFY18 managed care claim costs, as if managed care was still in place, using actual SFY17 experience as the base data.
4. Ensure all base expenses and projections have appropriate exclusions for drugs that were not covered by MCOs in SFY17 or FFS in SFY18.

Step 1

Navigant reviewed the State's drug costs in SFY18 and compared the effective rates to NADAC rates for individual drugs to determine the percentage of NADAC the State was paying for prescription drugs. A similar exercise was done for the MCOs' SFY17 experience, even though they were not originally indexed to NADAC. Then, total claim costs in SFY18 were repriced to model SFY18 experience under managed care. To do this, Navigant removed the dispensing fees and repriced the FFS claims to the average MCO reimbursement using NADAC as the index. The MCO dispensing fee pricing was then added back to show the SFY18 amount under MCO pricing. This total repricing difference is shown below in Table 1.

Step 2

Navigant examined administrative expense fees under managed care (capitation admin amount and HIF) compared to FFS (DXC, State, and additional vendor fees). This can be found at the bottom of both Tables 1 and 2. This administrative cost difference combined with the repricing difference results in a total likely savings shown in Table 3.

Step 3

Separately from the calculations made above, managed care claim costs from SFY17 were projected forward using trends by therapeutic class, as sourced from Express Scripts. These claim costs, projected into SFY18, were used for comparison to the implied savings from the repricing exercise.

Step 4

Drugs not covered by MCOs in SFY17 or FFS in SFY18 were excluded from this analysis. This includes Hepatitis-C and hemophiliac drugs, as well as Spinraza.

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Summary Analysis

As described in the methodology, managed care costs for SFY17 were compared to SFY18 both for claims and administrative expenses.

Analyzing Claims

The steps described in the methodology for repricing FFS SFY18 experience to what it would have been under managed care comprises the claims component of our comparison, shown below in Table 1. From this, it can be observed that repricing to managed care shows that FFS costs are slightly higher (about $2.5m) than managed care for just the claims component.

Table 1

CLAIM COST DIFFERENCES		
SFY18 FFS Rx Claim Cost for MCO members	(a)	$569,774,383
Dispensing fees	(b)	$122,511,975
SFY18 Claim Cost w/o dispensing fees	(c) = (a) - (b)	$447,262,407
MCO as % of FFS compared to NADAC	(d)	125.14%
SFY18 FFS Rx Claim Cost for MCO members adj. for NADAC	(e) = (c) * (d)	$559,722,448
MCO Dispensing Fees % of Base Claims	(f)	1.4%
SFY18 Rx Claim Cost (w/MCO pricing)	(g) = (e) * [1 + (f)]	$567,288,359
Claim cost difference due to repricing	**(h) = (a) - (g)**	**$2,486,024**

Analyzing Administrative Expenses

Administrative expenses differ significantly between managed care and FFS. Under managed care, the administrative expenses paid to the MCOs exceeded 10% of the pharmacy costs in aggregate. In addition, we note taxes and fees (such as the HIF) do not need to be paid under the FFS arrangement. The figures from SFY17 were grossed up to SFY18 to account for both change in membership as well as pharmacy utilization and unit cost changes. This results in $66.8m paid in MCO admin expenses compared to $9.9m paid in State admin expenses under FFS. This can be shown below in Table 2.

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Table 2

ADMINISTRATIVE COST DIFFERENCES		
SFY17 MCO Rx Admin	(i)	$49,995,426
Annual HIF Amount	(j)	$11,362,597
Annual Rx Trend Factor	(k)	1.089
Grosses up for SFY18 (Total Trend)	(l) = [(i) + (j)] * (k)	$66,829,253
SFY18 DXC Rx admin expense for MCO members	(m)	$8,943,624
BMS extra staffing and vendor costs	(n)	$950,739
SFY18 FFS Rx admin for MCO members	(o) = (m) + (n)	$9,894,363
Administrative cost difference	**(p) = (o) - (l)**	**($56,934,890)**

Total Difference

The difference between the FFS experience, repriced as if it were managed care pricing, leads to the following table. This includes cost differentials both for claim cost repricing as well as administrative expenses for the State.

Table 3

Carve-out Net Cost/(Savings) Impact		
Claim cost difference due to repricing	(h)	$2,468,024
Admin cost difference	(p)	($56,934,890)
Total	(q) = (h) + (p)	**($54,448,866)**

Observations & Considerations

This analysis indicates that the bulk of the savings are due to administrative costs. Appropriate control of utilization will continue to be required over time to maintain achieved savings.

Merely projecting SFY17 MCO experience to SFY18 shows a potential claim cost differential of $54.4m, which would remove much of the potential savings as shown above in Table 3. However, when Navigant examined past data periods, it appears that MCO experience in SFY17 may have been suppressed and therefore lower than expected. Navigant compared the SFY17 and SFY18 data SFY15 data summaries from the State, which showed a similar level of experience, after adjusting for excluded drugs and despite being two years older. As shown in

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Table 4, forecasting with older data in SFY15 shows that projected SFY18 managed care spend is closer to actual SFY18 FFS spend. In this case, it is in the best interest of the actuary to look at multiple base periods to have a more reasonable projection of future experience. Note that SFY16 experience is not referenced only because a validated data set, either from an actuarial rate certification or MCO attestation, was not readily available at the time of the analysis.

Table 4

Pharmacy Claim Expenses for Populations Impacted by Carve-out	
SFY15 Experience (used in base data for SFY17 rates)	$474,124,543
SFY17 Experience (from overall MCO financials collected for SFY20 rate development)	$475,724,437
Projected SFY18 (from SFY17)	$518,144,282
Projected SFY18 (from SFY15)	$560,616,509
Projected SFY18 (average SFY15/17)	$539,360,489
Actual SFY18 (FFS)	$569,774,383

As seen in Table 4, differences in claim expenses vary from $9.2m (Projection from SFY15 data) to $51.6m (Projection from SFY17), independent of NADAC-based repricing. In both cases, the State of West Virginia appears to be saving money in large part due to the differences in administrative expenses. It is critical that multiple years of data be considered for a projection rather than just relying on the most recent year of managed care experience (SFY17). This brings greater credibility to the projection rather and smooths out year-to-year volatility in experience.

Additional considerations include rebates, changes in the State's preferred drug list (PDL), and pharmacy benefit changes:

Rebates

Rebates do not play a factor in the savings. These are received by the State directly from manufacturers. Excluding physician-administered drugs (which are still part of the managed care claims), total rebates invoiced for all members increased from $417.6m in SFY17 to $423.2m in SFY18.

Preferred Drug List (PDL)

While numerous changes have been made to the State's PDL, Navigant recognizes that these would be savings the State has achieved independent of the shift from managed care to FFS. These changed have not been fully calculated but the drugs covered by these PDL changes are likely a small fraction of overall expenses.

Exclusions from Analysis

BMS has overseen several other benefit changes. These have included carve-outs of hemophiliac and Hepatitis-C drugs. These drugs have been appropriately excluded from

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this analysis.

Point-of-Sale vs. Outpatient Setting

Over the past couple years, there has been a nationwide trend with greater utilization of high cost outpatient drugs. This analysis only examines drugs covered by the prescription drug benefit (point-of-sale drugs) and does not include outpatient administered drugs that would still be covered by the MCOs through a hospital setting.

Additional statistical observations of the data can be found in Appendix A. Note that breakouts by category of aid do not show material differences in impacts on utilization and savings.

Sincerely,

Colby Schaeffer
ASA, MAAA

Sterling Felsted
ASA, MAAA

CC: Russ Ackerman
ASA, MAAA

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Appendix A – Statistical Observations

Navigant made the following observations regarding the data received from the State for both managed care experience in SFY17 and FFS experience in SFY18.

The average dispensing fee in SFY17 under managed care (through the PMCs the MCOs used) was $0.59 per script. In SFY18 under FFS this was increased to $10.49 per script, resulting in total dispensing fees of $122.5m in SFY18. In the FFS model, dispensing fees are based on the actual costs of a pharmacy to dispense a prescription. Dispensing fees increased for one primary reason: In February 2016, CMS required states to submit state plan amendments for reimbursement changes to outpatient pharmacies in the Covered Outpatient Drug final rule. CMS required reimbursement to pharmacies at aggregate actual acquisition cost with a cost-based dispensing fee. West Virginia was able to utilize the cost-to dispense study conducted by the state of Ohio, and the resulting $10.49 dispensing fee and other reimbursement was approved by CMS and implemented before the July 1, 2017 carve-out. The National Average Drug Acquisition Cost (NADAC) survey was chosen as the actual drug cost used to reimburse pharmacies.

A table for the top five therapeutic classes, in terms of dispensing fee percentage of drug cost, is shown as follows.

Table 5

Rank	Therapeutic Class	Dispensing Fee as % of Rx Class Costs	Dispensing Fee Expense
1	Pain	66.0%	$4,317,155
2	Depression	54.7%	$10,008,232
3	High Blood Pressure/Heart Disease	43.7%	$15,282,524
4	Ulcer Disease	40.5%	$5,093,266
5	Flu	38.0%	$192,533

Additionally, there are insights that can be gained by examining percentage of total spend by therapeutic class. Because savings calculations either involve older summary data that is not broken down by class or rely on NADAC repricing where about 10% of drugs are not allocated, savings estimates cannot be allocated at this level. Total pharmacy costs from claims for managed care members by therapeutic class for both FFS (SFY18) and managed care (SFY17) is found on the next page in Table 6.

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Table 6

Therapeutic Class	FFS % of Spend (SFY18)	MCO % of Spend (SFY17)	Change in Distribution
Asthma	10.0%	10.1%	-0.1%
Attention Disorders	6.0%	7.3%	-1.3%
Chemical Dependence	8.1%	7.4%	0.7%
Contraceptives	1.3%	1.0%	0.3%
Cystic Fibrosis	0.5%	0.4%	0.1%
Depression	2.1%	2.1%	0.0%
Diabetes	11.9%	12.5%	-0.7%
EpiPen (split out as own class)	0.3%	0.7%	-0.4%
Flu	0.1%	0.0%	0.0%
Growth Deficiency	1.0%	1.0%	0.0%
Hereditary Angioedema	0.4%	0.5%	-0.1%
High Blood Cholesterol	1.5%	1.7%	-0.2%
High Blood Pressure/Heart Disease	3.9%	3.6%	0.3%
HIV	2.0%	2.0%	0.0%
Infections	5.3%	4.9%	0.3%
Inflammatory Conditions	6.5%	6.3%	0.3%
Mental/Neurological Disorders	4.5%	5.6%	-1.1%
Miscellaneous Specialty Conditions	0.0%	0.0%	0.0%
Multiple Sclerosis	2.3%	2.8%	-0.5%
Oncology	2.1%	2.1%	-0.1%
Other (Mental Health Related)	0.9%	0.9%	0.0%
Other (Not Mental Health Related)	19.3%	18.5%	0.8%
Pain	0.7%	0.6%	0.2%
Progestational Agents	0.0%	0.0%	0.0%
Pulmonary Arterial Hypertension	0.3%	0.2%	0.1%
Seizures	4.6%	4.2%	0.5%
Transplant	0.1%	0.1%	0.0%
Ulcer Disease	1.5%	1.3%	0.1%
Unclassified	2.5%	1.9%	0.6%
Therapy Class not found	0.3%	0.0%	0.3%

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COMMONWEALTH *of* VIRGINIA

Department of Medical Assistance Services

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December 1, 2017

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.,
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones

SUBJECT: Report on Managed Care Pharmacy Benefit Manager (PBM) Transparency

Item 310 V of the 2017 Appropriations Act states the Director, the Department of Medical Assistance Services, shall include language in all managed care contracts, for all department programming, requiring the plan sponsor to report quarterly, for all quarters through the one ending June 30, 2019, to the department for all pharmacy claims; the amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. In the event there is a difference between these amounts, the plan sponsor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data and information provided by the plan sponsor shall be kept secure; and notwithstanding any other provision of law, the department shall maintain the confidentiality of the proprietary information and not share or disclose the proprietary information contained in the report or data collected with persons outside the department. Only those department employees involved in collecting, securing and analyzing the data for the purpose of preparing the report shall have access to the proprietary data. The department shall provide a report using aggregated data only to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of this initiative and its impact on program expenditures by December 1, 2017. Nothing in the report to the Chairmen of the House Appropriations and Senate Finance Committees shall contain confidential or proprietary information.

Should you have any questions or need additional information about this report, please feel free to contact me at (804) 786-8099.

CBJ/
Enc.

pc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

Managed Care Pharmacy Benefit Manager (PBM) Transparency Report

A Report to the Virginia General Assembly — *December 1, 2017*

Report Mandate:

Item 310 V of the 2017 Appropriations Act states the Director, the Department of Medical Assistance Services, shall include language in all managed care contracts, for all department programming, requiring the plan sponsor to report quarterly, for all quarters through the one ending June 30, 2019, to the department for all pharmacy claims; the amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. In the event there is a difference between these amounts, the plan sponsor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data and information provided by the plan sponsor shall be kept secure; and notwithstanding any other provision of law, the department shall maintain the confidentiality of the proprietary information and not share or disclose the proprietary information contained in the report or data collected with persons outside the department. Only those department employees involved in collecting, securing and analyzing the data for the purpose of preparing the report shall have access to the proprietary data. The department shall provide a report using aggregated data only to the Chairmen of the House Appropriations and Senate Finance Committees on the implementation of this initiative and its impact on program expenditures by December 1, 2017. Nothing in the report to the Chairmen of the House Appropriations and Senate Finance Committees shall contain confidential or proprietary information.

Background

Enhanced pharmaceutical price transparency regarding provider payments, administrative fees, negotiated discounts, and rebates will provide the Virginia Department of Medical Assistance Services (DMAS) with the information and tools required to better evaluate pricing models utilized by the DMAS-contracted Medicaid managed care organizations (MCOs).

MCOs contract with pharmacy benefit managers (PBMs) to perform tasks related to pharmacy claim processing and benefit administration. The functions and services provided by the PBM may include, but are not limited to, prescription claim adjudication and pricing, provider network management, formulary and benefit management, and supplemental rebate negotiations.

To increase the transparency of the relationships between MCOs and PBMs, DMAS amended its contract with the MCOs to now require disclosure of the

About DMAS and Medicaid

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high quality and cost effective health care.

Medicaid plays a critical role in the lives of over a million Virginians, providing health care for those most in need. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

contract terms that the MCOs have with their contracted PBMs. Broadly speaking, contract arrangements follow one of two pricing models: pass-through pricing or spread pricing. Pricing variance in these models center around the amount paid to the pharmacy providing the medication and the amount that an MCO reports to the department as their amount paid to the PBM for the prescription. A pass-through pricing model means that there is no expected difference in the PBM to pharmacy and MCO to PBM reported payment amounts. In a spread model, the PBM may leverage pharmacy network reimbursement rates negotiated on the PMB's full volume of prescriptions to pay pharmacies at a much larger discount from a published price. The resulting final prescription price paid to the pharmacy is calculated using the PBM's discounted rate while the PBM charges a reimbursement rate to the MCO that does not utilize the negotiated deep discount. This results in a difference or spread between the full discount amount paid to the pharmacy provider and the higher amount charged to the MCO. This difference between those two prices is referred to as the spread and results in a higher payment amount to the PBM by the MCO. Variations of these models exist in the public and private sector, and each offers different limitations and advantages. DMAS strives to review and identify the relative issues and merits of the pricing models deployed in the Virginia Medicaid Managed Care program and the fiscal impact on the Commonwealth and will do so when sufficient data permits the Agency to make informed decisions.

The mandate from the General Assembly requires the collection of additional price elements present in claim response transactions between the PBM and the submitting pharmacy, which DMAS obtained as components of the MCO encounter submission process. This additional claim-level detail provides the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the MCO for the transaction. Comparing actual reimbursement to pharmacy providers also provides DMAS the opportunity to ensure that PBM reimbursement rates to pharmacies do not fall below the acquisition prices which could place pharmacy providers in a negative fiscal position and could result in pharmacies deciding not to participate or accept Medicaid prescriptions.

To ensure the security of reported data, the data elements representing actual pharmacy payment details were removed from inbound encounter claims through an automated process and placed in a secure, password-protected Oracle data table. Access to the data is restricted to DMAS employees engaged in data analysis for this report. As an additional security measure, the final claim identifier and the MCO are excluded from the pricing data in the Oracle table. Another distinct process must then be executed in order to compare the actual pharmacy payment to the MCO-reported payment to the PBM for the prescription. The resulting data set is protected by a second unique password created by and known only to the data analyst.

The report detail below consists of aggregated data from available MCO prescriptions (referred to as encounters) and contains no proprietary or confidential details regarding plans, products, or pricing algorithms.

Observations and Analysis of Reported MCO Prescription Data

A total of 2,833,613 prescription encounter records were submitted to DMAS between July 1, 2017 and September 30, 2017. Each transaction was evaluated for the presence of necessary data elements to complete the review. The following encounters were excluded from the analysis for the reasons noted below:

- 259,309 encounter records did not include the required data element Ingredient Cost Paid to Pharmacy.
- 371,910 encounter records did not include the MCO Payment Amount reported to DMAS.
- 125,882 encounter records were reversals of claims processed prior to the required reporting of detailed payment amounts.

The removal of those records resulted in 73.28 percent of records, or 2,076,512 encounters, eligible for evaluation. DMAS staff who works with managed care plans to ensure claim accuracy will contact the plans to discuss encounter transactions that were submitted without the required data elements. These staff will handle only non-financial claim information.

Several anomalies were discovered when reported payment amounts were compared. Encounter records that require further research, including contact with the submitting plans, include the following:

- A single encounter claim with an MCO-reported payment amount more than $186,000 above the reported payment to the pharmacy provider. This encounter was excluded from the total reported below.
- Encounters reporting a "patient paid amount" though no member copays are allowed in managed care plans. This appears to be a PBM or MCO attempting to report other health insurance payments, but the encounters must be investigated and verified.
- Encounter transactions for which the amount reported to DMAS as paid by the MCO was less than the amount reported as paid to the pharmacy provider (see table below). These encounters will require further investigation because DMAS would not expect the PBMs and MCOs to be losing money on a pharmacy transaction.

Prescription Encounter Claims with Negative Variance
(reported MCO payment less than reported payment to pharmacy)

Date Span	Claim Count	Dollar Variance	Avg./Claim	Minimum	Maximum
< 07/01/2017	651	-$8,528.44	-$13.10	-$0.01	-$444.80
07/01/2017-07/31/2017	118,349	-$703,011.17	-$5.94	-$0.01	-$2,367.39
08/01/2017-08/31/2017	128,255	-$951,038.44	-$7.42	-$0.01	-$4,106.85
09/01/2017-09/21/2017	101,186	-$853,566.41	-$8.44	-$0.01	-$4,106.85

After correcting for the above anomalies, a total of 1,575,821, or 75.89 percent of the 2,076,512 eligible claims, were available for analysis.

The reported MCO payment was greater than the amount paid to the pharmacy for 152,250, or 7.33 percent, of the 2,076,512 claims analyzed. The average difference per claim was approximately $22.72. Extrapolating from a single quarter of data, this results in an estimated annual total of $13,834,118 in reported MCO payment amounts to the PBMs in excess of payments to pharmacies. As noted in the limitations section below, extrapolating an annual total from the first quarter of data that has identified opportunities for feedback, corrections, and data quality improvements on the part of the submitting MCOs may introduce a level of variance in the projected 4 quarter total. The projected total likely underestimates the annual impact because 26.72 percent of the total submitted encounters were missing required data elements and could not be included in this analysis.

The following table presents the aggregated view of encounter transactions by MCO reported month, and includes the total cost variance, average cost variance per claim, and maximum variance by month.

Prescription Encounter Claims with Positive Variance
(reported MCO payment greater than reported payment to pharmacy)

Date Span	Claim Count	Dollar Variance	Avg./Claim	Minimum	Maximum
< 07/01/2017	1,788	$19,026.87	$10.64	$0.01	$465.78
07/01/2017-07/31/2017	69,150	$1,350,559.36	$19.53	$0.01	$2,555.06
08/01/2017-08/31/2017	50,869	$1,204,285.19	$23.67	$0.01	$3,371.27
09/01/2017-09/21/2017	30,443	$884,658.10	$29.06	$0.01	$4,931.94

Further encounter detail analysis will be required in subsequent quarters because no distinct pattern of differences in reported payment amounts was identified in the small sample available for this PBM Transparency Report. DMAS is currently developing a template for the MCOs to use when providing the itemization of all fees, processing charges, or other administrative pricing elements that comprise the dollar variance between the amount the MCO paid to their PBM and the amount that the PBM paid to the pharmacy for the prescription. This template will be reviewed with the pharmacy directors of the various MCOs for their input and comments. DMAS will deliver the template along with the requested claims to the MCOs for additional reporting. The final versions of the additional detail requested of the MCOs will be due to the department as of May 1, 2018. DMAS will review, summarize, and report on the additional information provided in fall of 2018.

Limitations

Only one quarter of encounter claim data was available for analysis in the production of this report. The volume of data collected in a single quarter is not sufficient to make accurate conclusions about the relative impact of various pricing models.

DMAS will continue to work with the submitting plans to improve the data integrity and data quality of their submitted prescription encounters. DMAS is working to eliminate or minimize the volume of claims that must be removed from the data review and analysis of payment details as noted in the anomalies above with the ultimate goal of providing a meaningful, accurate, and comprehensive review that fulfills the mandate from the General Assembly.

Future Opportunities

Data collected over a full year of prescription encounter claims will produce a more robust and complete representation of the various managed care and PBM contract models present in the Virginia Medicaid program. With higher data integrity and quality in the MCO encounter submissions and MCO reported additional price detail, the relative merits of each model can be evaluated for impact on the prescription drug spending required to meet the needs of Virginia Medicaid members.

This required reporting process can inform continued efforts to increase the integrity and quality of the MCO encounter data submitted to DMAS. These efforts include a new encounter data scorecard developed as a component of the Enterprise Data Warehouse to measure the accuracy, reliability, and timeliness of encounter data. In addition, language in the CCC Plus and Medallion 4.0 contracts strengthens the penalties for submission of poor quality data. These actions address recommendations regarding the improvement of data collection for better oversight of MCO spending in the 2016 JLARC report *Managing Spending in Virginia's Medicaid Program*.

Summary

- The total number of claims in the first quarter of FY 2018 for which the reported MCO payment was greater than the amount paid to the pharmacy was 152,250, or 7.33 percent of all claims analyzed. The average difference per claim was approximately $22.72.
- Extrapolating from a single quarter of data, this results in an estimated annual total of $13,834,118 in reported MCO payment amounts to PBMs in excess of payments to pharmacies.
- DMAS will work toward the development of a pharmacy claims data quality scorecard that will ensure that all data elements required by the General Assembly mandate are submitted by the PBMs and MCOs and can be analyzed in a future report.

OHIO'S MEDICAID MANAGED CARE PHARMACY SERVICES

AUDITOR OF STATE REPORT

AUGUST 16, 2018

Dave Yost • Auditor of State

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EXECUTIVE SUMMARY

Overview of Pharmacy Benefit Managers

The Ohio Department of Medicaid (Department) requires Managed Care Plans (Plans) to offer prescription drug benefits. However, these Plans contract third party service organizations, known as Pharmacy Benefit Managers (PBMs), to manage prescription drug benefits on their behalf. PBMs offer a variety of services, including but not limited to: claim adjudications; customer service or call centers; clinical services such as prior authorizations; drug utilization reviews; and mail-order and specialty pharmacies. While Plans outsource these services to PBMs, the Plans remain responsible for the compliance and accuracy of the services a PBM performs pursuant to the Plans' agreements with the Department.

PBMs provide cost-cutting measures to the insurance plans by establishing pharmacy networks. These networks give PBMs purchasing power, allowing them to negotiate deeply-discounted prescription coverage for the insurance plans and their customers. PBMs can also negotiate manufacturer rebates directly with the pharmaceutical company to further reduce prescription drug costs. These services allow PBMs to generate revenue through administration and service fees charged to insurance plan sponsors for processing prescriptions; through operation of their own mail-order and specialty pharmacies; and on the margin between the amount charged to insurance plan sponsors and the amount paid out to pharmacies for a prescription (also referred to as "spread pricing").

PBMs were originally designed to reduce administrative costs in administering a prescription drug benefit program. However, PBMs have grown and now have substantial profitmaking ability through price spreading and rebates, which are payments negotiated directly with pharmaceutical manufacturers. Also, many pharmacy owners maintain that PBMs have a conflict of interest since they can require customers to obtain prescriptions only from mail-order and specialty pharmacies they own.

Amid growing concerns about declining reimbursements to independent community pharmacies, members of the Ohio General Assembly asked the Auditor of State to independently analyze the following issues:

1) Lack of transparent data on pharmacy services;

2) Disconnect between pharmacy reimbursement and overall costs to the Medicaid program (spread pricing);

3) Potential conflict of interest related to a retail pharmacy chain that is affiliated with one of the Medicaid PBMs and reported reductions in pharmacy reimbursements; and

4) Impact of reductions in pharmacy reimbursement on access to care, particularly in rural communities.

In response to this request, the Auditor's office reviewed pharmacy payment data related to the State's Medicaid managed care program and performed analyses of price spreading, the reimbursements to pharmacies and the amounts paid to PBMs.

Data Transparency

While the Department requires Plans to adhere to the terms and conditions of the Medicaid program, it is difficult for the Department and the Plans to oversee compliance with prescription benefit programs outsourced to PBMs in part because they are not subject to industry-wide regulation. Exact terms of the financial arrangements for pharmacy services are hidden in part by the sheer number of entities involved in every transaction including managed care plans, PBMs, pharmacies, wholesalers, and manufacturers –

and by the contract provisions that keep nearly all of the details of these transactions confidential. These issues result in a lack of transparency in expenditure of Ohio's Medicaid dollars. Conversely, PBMs maintain that disclosure and transparency in their industry will lead to increased prescription drug prices because of reduced competition and increased overhead costs.

Disconnect Between Pharmacy Reimbursement and Medicaid Program Costs

The Plans reimburse PBMs on a pricing model that is based on a publically available price (the average wholesale price). PBMs reimburse pharmacies using different pricing models based on applicable contracts. As result, the amount reimbursed to a pharmacy by a PBM does not correlate to the amount paid to the PBM by the managed care plan for the same transaction. In other words, pharmacy reimbursements, and any increase or decrease to those reimbursements, has no impact on the overall Medicaid program's costs as those are based only on the payment from the Plans to the PBMs.

PBMs provide a range of administrative functions on behalf of Plans and, in lieu of being paid a set fee for these functions; the PBM retains the difference between the Plan's payment and the amount paid to the pharmacy – the spread. The Auditor's office obtained and analyzed the difference between the payment from the Plan to the PBM and the PBM's payment to the pharmacy (the price spread data). Below is a summary of our analysis and illustrates the price spread significance and profitmaking potential for PBMs.

Average Spread by Quarter and by Drug Type from April 1, 2017 through March 31, 2018

	Average Spread			
Quarter	**Brand**	**Generic**	**Specialty**	**Total Average Spread for All Claims**
4/1/2017-6/30/2017	$2.11	$5.39	$30.12	$5.09
7/1/2017-9/30/2017	$2.03	$5.71	$31.91	$5.35
10/1/2017-12/31/2017	$1.57	$7.10	$31.24	$6.47
1/1/2018-3/31/2018	$1.62	$6.48	$46.04	$6.01
Yearly Total	**$1.85**	**$6.14**	**$33.49**	**$5.71**
	Brand	**Generic**	**Specialty**	**Totals**
Number of Prescriptions	**5,268,144**	**33,913,042**	**197,408**	**39,378,594**
Percentage of Claims	**13.4%**	**86.1%**	**0.50%**	**100%**
Amount Paid by Plans (millions)	**$1,246.1**	**$662.7**	**$617.6**	**$2,526.5**
Total Spread (millions)	**$9.8**	**$208.4**	**$6.6**	**$224.8**
Spread Relative to Total Paid Amount by Drug Type	**0.8%**	**31.4%**	**1.1%**	**8.9%**

Potential Conflict of Interest

We further compared the spread resulting from payments from CaremarkPCS Health, L.L.C. (CVS Caremark) and OptumRx to CVS pharmacies and independent community pharmacies due to allegations of preferential treatment for CVS pharmacies. For this analysis, we grouped pharmacies into regions.

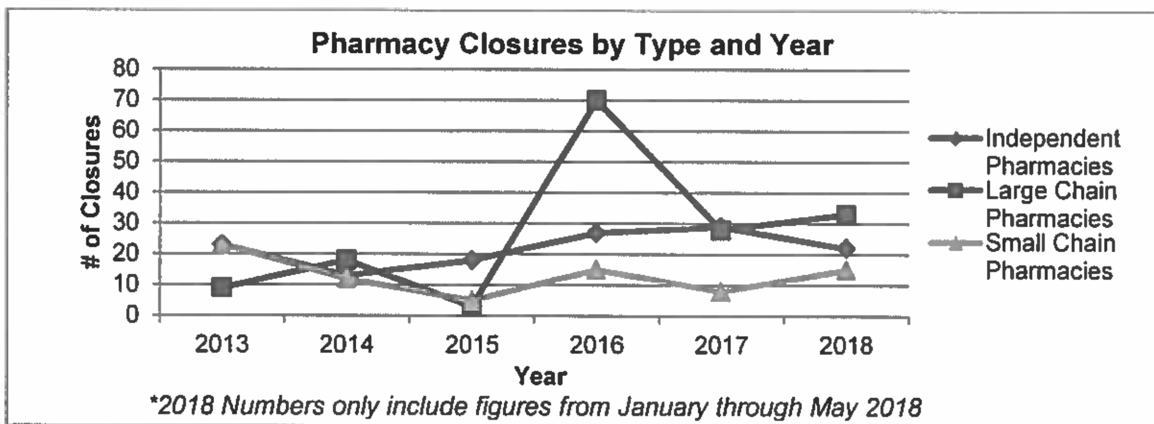
Spread Analysis by Region and Pharmacy Type

	CVS Pharmacies			Independent Pharmacies		
Region	**Brand**	**Generic**	**Specialty**	**Brand**	**Generic**	**Specialty**
Metro	$2.04	$5.49	$57.02	$1.67	$5.50	$43.67
Central	$1.60	$5.83	$66.58	$1.80	$5.11	$24.21
Northeast	$2.51	$5.60	$50.68	$3.55	$6.71	$39.14
Northwest	$4.85	$7.13	$43.50	$3.71	$6.69	$25.32
Southeast	$1.91	$5.58	$62.92	$1.88	$4.90	$43.28
Southwest	$2.06	$5.57	$50.19	$1.77	$5.27	$31.32
Overall Average Without Metro	**$2.37**	**$5.74**	**$53.42**	**$2.57**	**$5.80**	**$35.19**
Overall Average All	**$2.22**	**$5.63**	**$55.09**	**$2.10**	**$5.66**	**$39.08**

Based on this data, the difference between the Plan's payment to the PBM and the amount paid to the pharmacy (the spread) is similar for brand and generic drugs between CVS pharmacies and independent pharmacies. In comparison the spread is greater with CVS pharmacies for specialty drugs; however, caution should be used with this analysis as it does not reflect all transactions that occur between a pharmacy and a PBM. For example, the spread analysis does not include the direct and indirect remuneration (DIR) fee[1] paid by the pharmacy to the PBM or other contractual arrangements that could impact final payments. According to the PBMs, the unit cost reimbursement is not driven by region, and the maximum allowable cost reimbursement is the same for all independents by drug across all regions.

Impact of Reductions in Pharmacy Reimbursement on Access to Care

According to data maintained by the Ohio Board of Pharmacy[2], 132 independent community pharmacies, 78 small chain pharmacies and 161 large chain pharmacies have closed in Ohio since 2013.



**2018 Numbers only include figures from January through May 2018*

[1] DIR fee is the terminology used to categorize certain pharmacy network participation fees and the reconciliation of certain contractual terms with actual reimbursement.

[2] The Board considers an independent community pharmacy as one outlet, a small chain pharmacy as having two to 11 outlets and a large chain pharmacy as having 12 or more outlets. The Pharmacy Board licenses other terminal distributers of dangerous drugs such as veterinary clinics, hospitals, physician (prescriber) offices, and nursing homes. This data in this report did not include these other types of terminal distributers.

Conclusions

- The Auditor of State's office obtained data on Plans' payments to the PBMs and the PBMs' payments to pharmacies and determined that the data was sufficiently reliable for the calculation of spread pricing. The overall average spread of $5.71 is consistent with the average reported by the Department; however, the Auditor of State's analysis noted that the spread was higher ($6.14) for generic drugs which constituted over 86 percent of prescriptions. The Department recently contracted with an independent vendor to analyze the Medicaid pharmacy spread. Based on this vendor's market intelligence, the costs for the administrative fees covered by the spread would be from $0.95 to $1.90[3] per prescription, which is one-third of the pharmacy spread passed down in Ohio's Medicaid managed care program. According to the Plans, these administrative fees may vary based on other pricing considerations. Although this figure may not include all of services performed by a PBM, it suggests Ohio's current spread may be excessive and warrants the State taking further action to mitigate the impact on the Medicaid program.

- Data on pharmacy closures coincides with concerns expressed by pharmacists regarding reductions in reimbursements. However, this data does not show causality and does not include data on pharmacy openings. Further research is needed to determine the factors that led to these closures. While the Auditor of State's analysis shows differences in the spread by region, the spread analysis completed for this report was for a limited time frame. Representatives from the Plans indicated no access issues at this time.

- While much attention has been focused on the spread, it does not provide a complete picture of pharmacy costs and PBM compensation. There are a number of additional factors that impact PBM revenues and pharmacy reimbursements that were outside of the scope of this report, such as rebates, additional Plan fees, and pharmacy fees. The Ohio Legislature should take steps to mandate the reporting of additional statistical and financial data that would provide a more complete understanding.

- Additional concerns regarding pharmacy services were expressed by stakeholders or identified in industry publications which included rebates and rebate audits, automatic refills and impact of spread contracting on the medical loss ratio requirement for managed care organizations. In addition, the Auditor of State noted that the PBM contracts do not include any provision prohibiting the sale of de-identified data by a PBM to a third party. In addition, various practices were identified as indications of potential conflicts of interest that could impact pharmacy services in the Medicaid program and other publically funded health care. These concerns were outside of the scope of this review and are noted as issues for further study.

Recommendations

The Auditor of State offers the following recommendations for the Ohio Legislature. Additional recommendations for the Ohio Department of Medicaid can be found on page 18.

1. **ADDITIONAL AUDIT REQUIREMENT** - The State should require that the Department engage an independent audit entity to perform periodic compliance audits of each PBM that contracts with a managed care plan. The Department should establish the scope of the compliance examinations. The compliance audits should provide greater assurance about the PBMs' compliance with State requirements. The Department should develop, document, and implement a monitoring process to ensure that the Plans correct any findings from those audits.

2. **ADDITIONAL STATISTICAL AND FINANCIAL REPORTING REQUIREMENTS** - The State should go beyond monitoring the spread and obtain statistics and financial information that include transactions that occur outside of claims adjudication. This would give a more accurate picture of actual reimbursement to pharmacies for services rendered. We recommend that the Department require the Plans to report financial terms and payment arrangements they have with its PBM and

[3] This estimate of fees has not been independently verified by the Auditor of State.

prescription drug manufacturers, or labelers, including formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and all other fees. The Department should also include language ensuring that it has the right to audit this data at any time. The confidentiality of the information disclosed by the Plans should be maintained, to the extent that the information is protected under state or federal law.

3. **ANALYSIS OF ALTERNATE CONTRACT MODEL** - The State should perform an analysis to identify the costs and benefits of requiring pass through contracting for its pharmacy services and report on those results including a detail of the methodology used for the analysis. In pass through contracting, the PBM charges the Plan a flat administrative fee per claim or per member and then passes the exact price paid to the pharmacy through to the Plan. In the interim, the Department should work with its Plans and the PBMs to ensure that reimbursement methodologies reflect reasonable costs associated with providing the service.

   In addition, the State should engage an independent third party to conduct a complete analysis of the impact of moving pharmacy services to a fee-for-service model similar to the change implemented in West Virginia. The HealthPlan Data Solutions (HDS) executive summary contains a fee-for-service comparison; however, notes that the comparison is incomplete and recommends a follow-up analysis that incorporates the impact of rebates. The Auditor of State requested a copy of the full report developed by HDS but the full report is not yet available. Without the detailed methodology of the analysis performed by HDS, the Auditor of State cannot comment on or evaluate its fee-for-service pricing comparison.