Pharmacy Benefit Managers in the Medical Assistance Program

Sally A. Kozak, MHA, RN

Deputy Secretary

Office of Medical Assistance Programs

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Good morning Chairwoman Baker, Minority Chairwoman Schwank, Chairman Argall, members of the committees, and staff. I am pleased to be here today to provide testimony on the topic of the use of pharmacy benefit managers (PBMs) in the Medical Assistance (MA) program. I am Sally Kozak and I serve as the Deputy Secretary for the Office of Medical Assistance Programs (OMAP) for the Department of Human Services (DHS). Joining me today are Laurie Rock, Director of the Bureau of Managed Care Operations, and Kristin Hoover, Clinical Pharmacy Manager.

I was asked to come today and share information about the role of PBMs in the MA program, the steps DHS is taking to provide greater transparency in payment for drugs when a PBM administers pharmacy services for MA program beneficiaries, and what we have learned about the actions of neighboring states with managed care organizations (MCOs) that also use PBMs to administer pharmacy benefits for their Medicaid beneficiaries.

Approximately 2.9 million Pennsylvanians receive their physical health care under the MA program, which includes the coverage of outpatient drugs. The fee-for-service delivery system covers 17% of those individuals. The remaining 83% of MA beneficiaries are enrolled in one of the nine MCOs that have entered into an Agreement with DHS. All nine MCOs provide physical health services, including covering outpatient prescription drugs. Under the current managed care model, which is standard among most public and private third-party payers, DHS pays a per-member, per-month rate, also called a capitation rate, to MCOs. DHS holds the MCOs accountable for access to the amount, duration, and scope of covered medically necessary services. MCOs are

responsible for maintaining an adequate provider network and establishing payment rates and conditions for all providers in the MCO's network.

MCOs are permitted to use PBMs and establish their own drug rebates and discounts for drug products. Under the current structure, all nine MCOs report using a PBM in some manner. Three MCOs own their own PBMs and six subcontract with independent PBMs. There is no standard model or template for PBM subcontracts, and the way each MCO subcontracts with its PBM is customized depending on the responsibilities of the PBM. The scope of responsibility for a PBM that subcontracts with an MCO can range from standard processing of outpatient drug claims to full delegation of financial responsibility, including negotiating and collecting rebates and discounts and determining the provider payment methodology. At least one MCO uses its PBM for full clinical services, including development of the MCO's prior authorization policies and the review of requests for prior authorization.

Recently there has been a nation-wide discussion about transparency in drug pricing when an MCO uses a PBM, and whether subcontracting with a PBM increases the cost of health care. The term associated with the perceived lack of transparency and potential for increased cost is "spread pricing." Spread pricing occurs when the payment that the MCO makes to a PBM for a drug dispensed by a pharmacy is higher than the amount the PBM pays the pharmacy that dispensed the drug. The difference is considered the spread, which the PBM retains as revenue or profit. The spread can also include discounts and rebates, all or a portion of which may be retained by the PBM. PBM administrative fees are typically included in the spread price and are not paid separately by the MCO. The opposite of spread pricing is referred to as "pass-through"

pricing. In the pass-through model, the MCO's payment to the PBM is the same as the payment the PBM makes to the pharmacy for the ingredient cost and the dispensing fee for the outpatient drug. The PBM may also pass all rebates and discounts back to the MCO, and the MCO pays the PBM administrative fees separately.

There are currently two schools of thought regarding the impact of spread pricing versus pass-through pricing on the cost of pharmacy services, but we are not aware that either theory has been tested or validated. One theory is that the lack of transparency and the bundled payment under spread pricing provides PBMs with the opportunity to enhance their revenue and profit and inflate costs to the MCO that is subcontracting with the PBM. The opposing theory is that MCO and insurance executives are informed and sophisticated purchasers of PBM services who will strive to negotiate the best value from their vendors, and by separating out the costs in the pass-through model, administrative costs could increase and the result could even be an overall increase in the cost of pharmacy services.

Beginning in 2017, DHS periodically received complaints from an association of independent pharmacies claiming that the payments for drugs dispensed to MCO members were inadequate. The department investigated every complaint, and we found no evidence of MCO non-compliance with the terms and conditions of their agreements with DHS. MCOs are required to report their payment rates for pharmacy services and their paid drug claims to DHS, and the amounts paid listed on their paid drug claims were consistent with their reported payment rates. However, DHS could not verify the rates paid by the PBMs to the pharmacies. The investigation did show that the MCOs were not interpreting the term "paid amount" consistently. Some MCOs were

interpreting the term to mean the amount the MCO pays to the PBM; other MCOs were interpreting the term to mean the amount the PBM pays to the pharmacy.

In response to these findings, DHS is amending the 2019 MCO Agreements to provide for greater transparency in payment for drugs and more specificity in the requirements for reporting and documenting when a PBM administers pharmacy services to MA program beneficiaries. The amendments are as follows:

- The language requiring the MCOs to report drug rebates and discounts that have been collected has been revised to specify that the MCOs must report the full value of all drug rebates and discounts regardless of who negotiates or collects the rebates and discounts. PBMs must pass the full value of all rebates and discounts on drugs dispensed to the MCOs' members back to the MCOs. The PBMs may not retain any portion of the rebates or discounts.
- Language has been added to require MCOs to report both the payment methodology and payment rates. The MCO's payment rates to the PBM and the PBM's payment rates to pharmacies and dispensing prescribers must be broken down by ingredient cost and dispensing fee.
- The MCO must report any differences between the amount the MCO pays the PBM and the amount the PBM pays the pharmacy as PBM administrative costs. The MCO must report the PBM administrative costs separately and may not bundle those costs with other administrative costs.
- The MCO must have written procedures, approved by DHS, to monitor the PBM for compliance with the terms and conditions of the Agreement related to covered

outpatient drugs, actual payments to providers who dispense covered outpatient drugs, and provider dispute resolution.

- Upon request by DHS, the MCO must conduct an independent audit of the PBM's transparent pricing arrangements.
- The MCO must have in place both an informal process to resolve provider disputes and a formal process for provider appeals. The resolution of issues such as the payment issues raised by some pharmacies is currently handled at the PBM level. In response to providers' dissatisfaction with the current process, DHS revised the Agreement to require the MCO to provide an additional Second Level Provider Pricing Dispute Resolution Process at the MCO level, between the MCO and the provider.

DHS has also surveyed neighboring states to gather information on whether their Medicaid MCOs have spread pricing contracts and whether they are doing anything to either encourage or require a pass-through pricing model. Our findings include the following:

- In August, the Ohio Department of Medicaid notified its five MCOs to terminate contracts with PBMs that utilize spread pricing and adopt new practices based on a pass-through pricing model, effective January 2019.
- In Maryland, the state legislature included in the Fiscal Year 2019 budget bills a request for a report detailing the reimbursement rates used by the Medicaid MCO PBMs in calendar year 2018, and changes to those rates from those in effect in calendar years 2016 and 2017. Maryland reported no further action.

- New Jersey identified inconsistencies in MCO reporting of paid amounts on MCO paid claims and responded by revising its contract language to specify the requirement that their MCOs report the amount the pharmacy is paid.
- Delaware also reported inconsistencies in how MCOs were reporting paid amounts and intends to clarify that amounts reported on MCO paid claims must be the amounts paid to the pharmacies.
- New York shared its current requirement for MCO quarterly reports that detail the amount the MCO paid to a PBM for pharmaceutical services and the amount paid to a PBM for administrative services. New York reported no further action.
- In West Virginia, the Medicaid MCOs do not administer the pharmacy benefit. The West Virginia Medicaid Pharmacy Program is a fee-for-service benefit offered to all Medicaid beneficiaries, including those who are enrolled in Medicaid MCOs.

The survey showed that the state response to questions about the impact of spread pricing on transparency, accountability, and cost varies from state to state. We believe DHS' amendments to its Agreements with the MCOs to achieve the goal of transparency and accountability for pricing of pharmacy services when an MCO uses a PBM is a comprehensive approach that provides the potential to be more informative and effective in the long-term than the actions being taken by our neighboring states. The expanded requirements will support consistency in reporting and provide more detail on the components of payments for pharmacy services. The amendments will

also result in additional accountability from the MCOs for pharmacy pricing by requiring an MCO venue for pharmacies to dispute payments.

Thank you for the opportunity to provide this testimony on behalf of DHS and I welcome any questions the committee may have at this time for me or my staff.