COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

KAREN KIMSEY
DIRECTOR

804-786-7933
www.dmas.virginia.gov

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

Daniel Timberlake
Director, Department of Planning and Budget

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

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

The 2018-2020 Biennium Budget, authorized under HB1700, Item 307 T states, " 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 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 annually 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 October 1 of each year. Nothing in the report shall contain confidential or proprietary information."

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

KK /
Enclosure
pc: The Honorable Daniel Carey, MD, Secretary of Health and Human Resources

Managed Care Pharmacy Benefit Manager (PBM) Transparency Report

A Report to the Virginia General Assembly — *October 1, 2019*

Report Mandate:

Item 307 T of the 2018-2020 Biennium Budget, authorized under HB1700 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 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 annually 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 October 1 of each year. Nothing in the report shall contain confidential or proprietary information.

Background

Prescription drug prices in both private and public-sector programs have a long history of undisclosed terms, incentives, and network reimbursement rates. Enhanced pricing 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 evaluate the various pricing models that are 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.

About DMAS and Medicaid

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to close to 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

To increase the transparency of the relationships between MCOs and PBMs, DMAS amended its contract with the MCOs to now require disclosure of the 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 prescription 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 PBM's full volume of prescriptions to pay pharmacies at a much larger discount from a published price such as the Average Wholesale Price (AWP) with significantly lower professional dispensing fees. The resulting final prescription price paid to the pharmacy is calculated using the PBM's discounted network reimbursement rate while the PBM charges a reimbursement rate to the MCO that does not leverage or 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 PBM for the prescription. The difference between those two prices is referred to as the spread. In this context, spread pricing translates into a higher payment amount to the PBM by the MCO which is reported to the Department as the MCO paid amount for the prescription. Variations of these models exist in the public and private sector.

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. These additional price elements were collected by DMAS as components of the MCO encounter submission process. The 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. This is important because reimbursement rates below acquisition prices could place pharmacy providers in a negative fiscal position and 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 are 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 analysts.

The report detail 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 MCO Reported Prescription Data

January 1, 2018 – June 30, 2019

Managed Care pharmacy encounter claims submitted from January 1, 2018 through June 30, 2019 were included in the analysis performed for this report. If a submitted encounter was later reversed, indicating that the original encounter was not dispensed, both claims were removed from the data set. The resulting encounter claim total for this time period was 17,246,132 claims.

Encounter Claim Distribution by Calendar Quarter (reflecting increase in volume due to Medicaid Expansion):

1/1/2018 – 3/31/2018	2,173,332
4/1/2018 – 6/30/2018	2,651,376
7/1/2018 – 9/30/2018	2,564,887
10/1/2018 – 12/31/2018	2,768,259
1/1/2019 – 3/31/2019	3,515,274
4/1/2019 – 6/30/2018	3,573,004

Each claim transaction was evaluated for the presence of necessary data elements. The following encounters were excluded from the analysis for the reasons noted below:

- 39,051 claims did not report an ingredient cost amount paid on the encounter
- 36,908 claims were for compound products with more than one ingredient, component ingredient cost detail was not available for analysis
- 180,314 claims were dispensed under the 340B program (requires reimbursement at actual acquisition cost) and an applicable reference price point is not published or available for use in the evaluation
- 171,717 claims were submitted with other health insurance payment amounts >$0.00 resulting in a reduced amount remaining that impacts assessment of MCO/PBM encounter payment
- 176,309 claim status indicated that the claim "is replaced"; to avoid any potential duplication in final aggregated totals, those claims were removed

Because a single encounter transaction may fall into one or more of the above listed categories removed from the analysis, the final number of encounter records eligible for evaluation was 16,656,280.

The removal of those records resulted in 96.57 percent of records eligible for evaluation. This is a significant increase over the 73.28 percent of records eligible for evaluation in the 2017 study. The increase reflects DMAS staff's increased oversight of encounter transactions and improvements in the data quality of encounters submitted by the managed care plans.

The reported MCO payment was greater than the amount reported as paid to the pharmacy for 1,649,905 claims, or 9.91% of the 16,656,280 analyzed. This percentage is an increase over the 7.33% of claims identified with a positive variance in the 2017 analysis. A variance threshold of greater than or equal to $0.0101 was selected as the lowest difference; pharmacy claim pricing and reporting may use up to 5 places of significance to the right of the decimal. This threshold excluded an additional 1,417 encounters where the variance was "essentially" at or below $0.01 and could have been attributed to rounding policies at the PBM or MCO to ensure that rounding did not negatively impact the analysis.

For the 1,649,905 claims identified, the total amount reported in payment above the amount paid to the pharmacy was $29,000,276.00 for this 18 month window of encounters. This represents an average of $17.58 over the 1,649,905 claims with the minimum amount of $0.02 and maximum of $8,321.54.

The average difference per claim identified in this report is lower than that identified in the 2017 version ($17.58 versus $22.78) though that may be attributed to a smaller sample size for the 2017 report. The $29,000,276.00 represents an increase of almost 40% (annualized) over the extrapolated estimated annual total reported in 2017.

Summary

- For the 18-month observation period, the total number of claims where the reported MCO payment was greater than the amount paid to the pharmacy as a relative percentage of all claims was 9.91% (1,649,905 claims) while the average amount per claim was $17.58.
- The total amount reported in payment above the amount paid to the pharmacy (spread) was $29,000,276.00.
- Compared to the Agency's initial report and analysis in 2017, this current report utilized more complete claims data (97% versus 73%) due to improvements in data reporting.
- DMAS acknowledges that, while the number of complete encounter records improved during this cycle and more claims were eligible for analysis, there are additional measures that could improve the accuracy of the submitted data, ease of analysis, and reporting of Agency monitored claim variance.