COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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September 14, 2020

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

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

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

This report is submitted in compliance with the Virginia Acts of the Assembly – HB1700, Item 317 T, which 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 and 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 not withstanding 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 Chairman 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.

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Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Managed Care Pharmacy Benefit Manager (PBM) Transparency Report

A Report to the Virginia General Assembly

October 1, 2020

Report Mandate:

Item 317 T under HB30, Chapter 1289 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 provides 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.

DMAS's 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 for more than 1.6 million Virginians. Members have access to primary and specialty health services, inpatient care, behavioral health as well as 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 more than 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 in 2017 to 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 pricing 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

July 1, 2019 - June 30, 2020

As of July 1, 2019, four of the six MCOs contracted with DMAS reported utilizing pass-through pricing. One MCO switched from spread pricing to pass-through pricing beginning April 1, 2020. The last MCO reported utilizing spread pricing throughout the entire year, switching to pass-through pricing on July 1, 2020. As directed by HB 1291, DMAS included language in the Medallion 4.0 and Commonwealth Coordinated Care contracts to prohibit MCOs and/or their PBMs from utilizing spread pricing as of July 1, 2020.

Managed Care pharmacy encounter claims submitted from July 1, 2019 through June 30, 2020 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 net total encounters, excluding reversals, was 17,168,889 claims.

Encounter Claim Distribution by Calendar Quarter

7/1/2019 – 9/30/2019	4,103,236
10/1/2019 – 12/31/2019	4,318,187
1/1/2020 – 3/31/2020	4,685,615
4/1/2020 – 6/30/2020	4,061,851

Each claim transaction was then evaluated for the presence of necessary data elements. After excluding reversals, additional edits were applied to remove encounters as described below:

- 34,969 claims did not report an ingredient cost amount paid on the encounter
- 25,991 claims were for compound products with more than one ingredient, and component ingredient cost detail was not available for analysis
- 281,697 claims were dispensed under the 340B program (requires reimbursement at actual acquisition cost) and an applicable reference price point was not published or available for use in the evaluation
- 160,075 claims were submitted in conjunction with other health insurance payment amounts >$0.00 resulting in a reduced amount remaining that impacts assessment of MCO/PBM encounter payment
- 213 claims indicated they were “replaced”; these claims were removed to avoid any potential duplication in final aggregate totals.

Because a single encounter transaction may fall into one or more of the above listed categories, the final number of excluded claims did not equal the sum of claims listed above. A total of 493,954 claims were removed from the analysis.

The net encounter records eligible for analysis was 16,674,935 out of 17,168,889 total encounters, resulting in inclusion of 96.98 percent of records eligible for evaluation in the final analysis. This is a slight increase over the 96.57 percent of records eligible for analysis in the 2019 study. The increase reflects a change in DMAS process that mitigated the duplicate claims issue noted above.

The reported MCO payment was greater than the amount reported as paid to the pharmacy for 1,663,247 claims, or 9.97% of the 16,674,935 analyzed. This percentage is a slight increase over the 9.91% of claims identified with a positive variance in the 2019 study.

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 allows exclusion of 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 1,663,247 claims identified, the total amount reported in payment above the amount paid to the pharmacy was $32,707,582.00 for the period of measurement. This represents an average of $19.66 over the 1,663,247 claims with a minimum individual amount of $0.02 and a maximum individual amount of $8,321.54.

The average difference per claim identified in this report is higher than that identified in the 2019 study ($19.66 vs $17.58). The overall spend on spread pricing is also higher than that identified in the 2019 study ($32,707,582.00 over 12 months vs $29,000,276.00 over 18 months). This increase appears to be related to the continued increase in members and overall claims due to Medicaid expansion, as well as the increase in average spread per claim as noted above.

Only one MCO utilized spread pricing for the entire year. This MCO contributed 99.12% of the claims with spread found in this report. As directed by HB 1291, DMAS included language in the Medallion 4.0 and Commonwealth Coordinated Care contracts to prohibit MCOs and/or their PBMs from utilizing spread pricing as of July 1, 2020.

Summary

- For the 12-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% (1,663,247 claims), while the average amount per claim was $19.66.
- The total amount reported in payment by MCOs above the amount paid to the pharmacy (“PBM spread”) was $32,707,582.00.
- More than 99% of claims with spread originated from only one MCO contracted with DMAS. As directed by HB 1291, DMAS included language in the Medallion 4.0 and Commonwealth Coordinated Care contracts to prohibit MCOs and/or their PBMs from utilizing spread pricing as of July 1, 2020.
- DMAS acknowledges that while the prohibition of PBM spread pricing will likely result in both increased transparency and total cost savings, elimination of spread pricing may be offset by an increase in MCO administrative fees associated with PBM contracts.