COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 27, 2021

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 – HB1800, Item 317T which 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."*

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, 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, 2021

Report Mandate:

Item 317 T of the 2020-2022 Biennium Budget, authorized under HB1800 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.

About DMAS and Medicaid

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 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, 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 500,000 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 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 centers 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, 2020 - June 30, 2021

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. As of July 1, 2020, all six MCOs contracted with DMAS have reported utilizing pass-through pricing, in compliance with the contract with DMAS.

Managed Care pharmacy encounter claims submitted with a date of service from July 1, 2020 through June 30, 2021 were included in the analysis performed for this report. The same methodology was utilized for the initial analysis as that used in previous years' reports. 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 16,839,974 claims.

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

- 180,744 claims did not report an ingredient cost amount paid on the encounter
- 25,472 claims were for compound products with more than one ingredient, and component

ingredient cost detail was not available for analysis
- 318,253 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
- 213,383 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
- 10,626 claims indicated they were "replaced"; these claims were removed to avoid any potential duplication in final aggregate totals.

Because a single encounter transaction that may fall into one or more of the above listed categories was removed from the analysis, the final number of encounter records eligible for evaluation was 16,101,154. The removal of the above encounter records resulted in 95.61% of records eligible for evaluation.

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.

The reported MCO payment was greater than the amount reported as paid to the pharmacy for 25,922 claims, or 0.16% of the 16,101,154 analyzed. This represents a 98.4% decrease compared to the 9.97% of claims identified in the 2020 analysis.

For the 25,922 claims identified, the total amount reported in payment above the amount paid to the pharmacy was $362,570 for this 12 month window of encounters, a decrease of 98.9% compared to the 2020 analysis. This represents an average of $13.99 per claim.

As all MCOs had reported utilizing pass-through pricing for all of fiscal year 2021, the identification of 25,922 claims with apparent spread was unexpected. Therefore, a manual review of these claims was completed to determine if these claims truly represented spread pricing:

- 6,565 claims accounting for $123,544 of the apparent spread included payments >$0.00 from other insurance companies, before the claims were submitted to DMAS. These claims were not excluded by the original methodology due to differences in the data elements used to report the third party payment.
- 14,257 claims accounting for $208,271 of the apparent spread were claims for vaccines which include a payment for administration which was not captured by the original methodology.
- 3,671 claims accounting for $15,967 of the apparent spread were for medical supplies.
- 1,429 claims (or 0.009% of claims analyzed) remained without explanation. These claims accounted for a total of $29,159 in the identified spread under the original methodology.

Summary

- 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.

	Claims	Apparent Spread
Claims identified with spread under methodology used in previous reports	25,922	$362,570
Claims incorrectly identified with spread after further analysis	24,493	$333,412
Claims identified with spread without explanation after further analysis	1,429	$29,159

- The total amount reported in payment by the MCOs above the amount paid to the pharmacy (apparent spread) was $29,159, from 1,429 claims (or 0.009% of claims analyzed).
- DMAS notes the amount of apparent spread identified is negligible after the prohibition of spread pricing in the MCO contracts as of July 1, 2020. Therefore, DMAS recommends the removal of this report requirement.
- DMAS acknowledges that while the prohibition of PBM spread pricing resulted in both increased transparency and total cost savings, elimination of spread pricing may have been associated with an increase in administrative fees for MCO-contracted PBMs, which were not analyzed for this report.