LEGISLATIVE BUDGET AND FINANCE COMMITTEE

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Prescription Drug Pricing Under the Medical Assistance Managed Care Program

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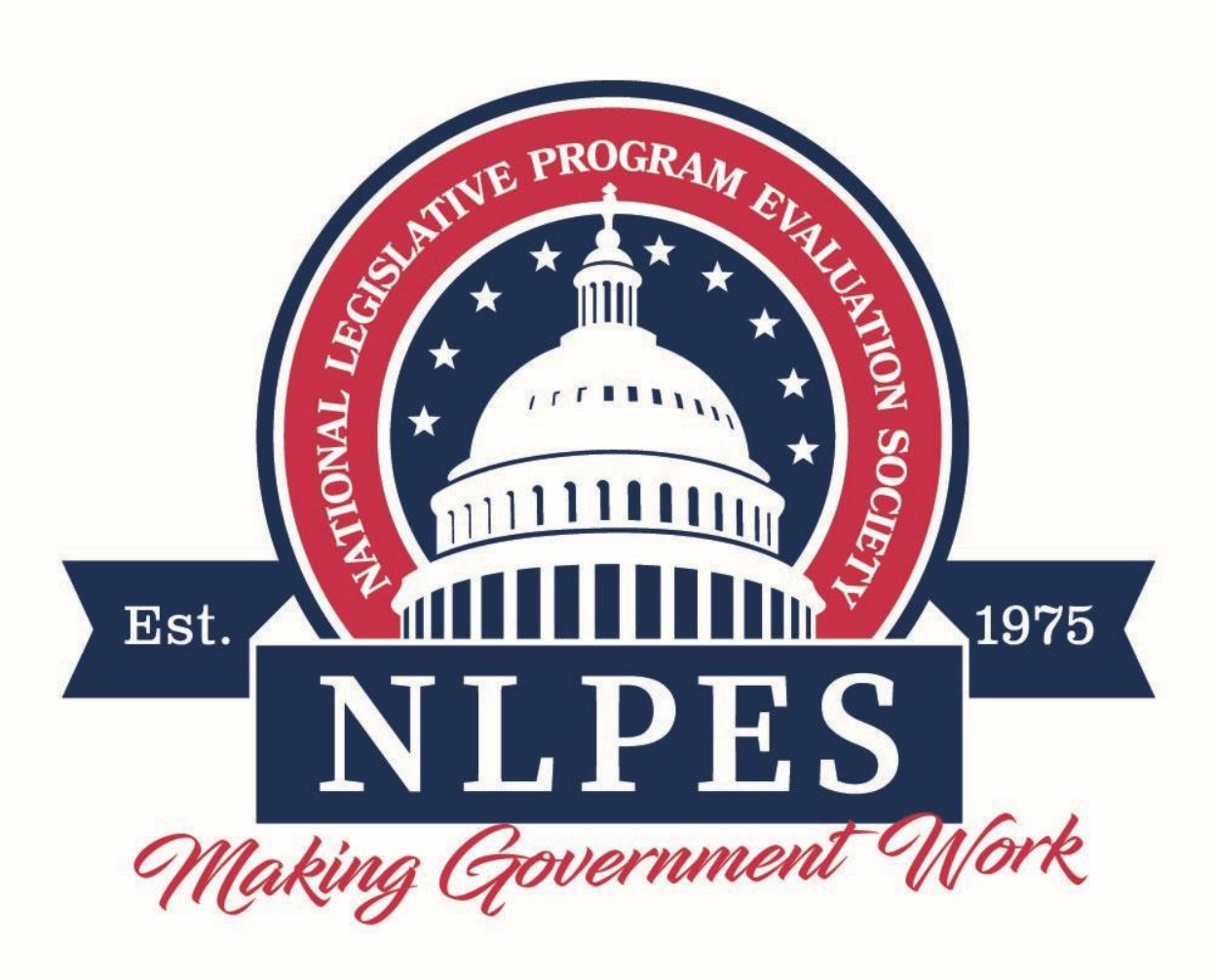

For the seventh straight year the National Legislative Performance Evaluation Society (NLPES) awarded the Legislative Budget and Finance Committee with a Certificate of Impact. The Certificate of Impact is presented to legislative offices that produce evaluations or audit reports that resulted in documented public policy changes, program improvements, dollar savings or other public impacts.

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Objectives and Scope

1. *Provide an overview of the distribution of and payment for pharmaceuticals in the Medical Assistance Managed Care program.*
2. *Review the reimbursement practices of pharmacy benefit managers to pharmacies.*
3. *Review the reimbursement practices of managed care organizations to pharmacy benefit managers.*
4. *Investigate and compare the reimbursement rates paid by pharmacy benefit managers to independent pharmacies and chain pharmacies.*
5. *Study best practices and laws adopted by other states to address concerns with pharmacy reimbursement practices of pharmacy benefit managers.*

The scope of this report is calendar years 2019 and 2020.

Report Overview

The Prescription Drug Pricing Study subsection of Act 2020-120 (see Appendix A) directed the Legislative Budget and Finance Committee (LBFC) to provide an overview of the distribution of and payment for pharmaceuticals in the medical assistance managed care program. The entities involved in the distribution and payment of pharmaceuticals for Pennsylvania Medical Assistance (MA) enrollees include:

- U.S. Department of Health and Human Services, Center for Medicare, and Medicaid Services
- Pennsylvania Department of Human Services
- Contracted managed care organizations (MCOs)
- Pharmacy benefit managers (PBMs)
- Pharmaceutical manufacturers
- Pharmaceutical wholesalers
- Pharmacies

Our objectives for this study were as follows:

1. To provide an overview of the distribution of and payment for pharmaceuticals in the medical assistance managed care program.
2. To review the reimbursement practices of pharmacy benefit managers to pharmacies within this Commonwealth.
3. To review the reimbursement practices of managed care organizations to pharmacy benefit managers.
4. To investigate and compare the reimbursement rates paid by pharmacy benefit managers to independent pharmacies and chain pharmacies.
5. To study the best practices and laws adopted by other states to address concerns with pharmacy reimbursement practices of pharmacy benefit managers.

The report focuses on calendar years 2019 and 2020.

We found:

- The distribution of and payment for pharmaceuticals in the MA MCO program is complex and opaque in certain areas (such as contracting and pricing).
- In the review of one sample month of 5 selected drug transactions across all 13 MA managed care plans, there were instances where the median ingredient cost reimbursement was equal among national chains and other pharmacies (regional chains and independents) and other instances where the median reimbursement "benefited" one over the other.
- During our review of ingredient cost reimbursements for some plans, we saw different coding for maximum allowable cost (MAC) rates depending on the pharmacy type. While it did not impact the median reimbursement analysis, the lack of transparency regarding MAC pricing allowed for reasonable speculation.
- In our review of one sample month, median dispensing fees greatly varied between MA managed care plans, and all were less than the $10 dispensing fee for the Fee for Service program during the same period.
- In 11 of 13 MA managed care plans, we did not find evidence of spread pricing in March 2020.
- In 2 out of 13 MA managed care plans, we found evidence of spread pricing in 2020; however, according to the MCO, this was unintentional, and the issue has since been resolved.
- In our review of a selected sample of pharmacy contracts with PBMs, we found varied contracted reimbursement rates between the different MA plans.
- In our review of a selected sample of pharmacy contracts with PBMs, some PBMs were unwilling to provide their contracted rates, despite Act 2020-120 mandating that data deemed relevant be provided to LBFC staff.[1]
- MCOs and PBMs must submit their reimbursement practices to DHS for review and approval before implementation.
- Any changes to an MCO's or PBM's reimbursement practices must be submitted to DHS for review and approval prior to implementing the changes.
- According to DHS, all MCOs and PBMs comply with the required payment methodologies in the DHS MCO Agreement.

[1] For more detail, please see page 3 in the methodology section.

We recommend:

1. PBMs, MCOs, and/or Pharmacy Services Administrative Organizations (PSAOs) should ensure MAC reimbursement practices are transparent to pharmacies prior to claim adjudication.

2. The General Assembly should require contracts between PBMs and pharmacies to be submitted to DHS and released to oversight organizations, e.g., the LBFC and the Auditor General, when conducting a study of the PBMs and/or pharmacies.

3. The General Assembly should require all pharmacies participating in the Pennsylvania managed care program to comply with any DHS request for information on pharmacy acquisition costs net of all discounts, rebates, chargebacks, and any other adjustments to the price of the drug, not including professional fees.

A. Distribution of and Payment for Pharmaceuticals in the MA MCO Program

Governance and Key Players

Medicaid is an entitlement program authorized by Title XIX of the Social Security Act of 1965. States administer the Medicaid program under federal statutes and regulations. However, states have the autonomy to establish eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines.

States and the Federal Government jointly fund the Medicaid program. Each state's government share varies and is based on a Federal Medical Assistance Percentage (FMAP), which is the amount of federal payment(s) to states based on two factors: (1) the actual amount spent that qualifies as matchable under Medicaid and the FMAP; and (2) the average per capita income for each State relative to the national average.

The Federal Government provides most of the Medicaid funds to the states. In the 2020-21 federal fiscal year, Pennsylvania's federal share of Medicaid spending was 64.0 percent, and the state share of Medicaid spending was 36.0 percent. The Commonwealth's share is below the national average of 69.3 percent and 30.7 percent, respectively.

Pennsylvania Department of Human Services. The federal government provides standards for the Medicaid program, and states provide additional laws and regulations while administering the program. In Pennsylvania, the Department of Human Services (DHS) manages the Medicaid program (also referred to as "Medical Assistance" or "MA"). The federal government gives states significant latitude to determine

eligibility, covered services, the program's structure, etc. DHS administers several contracts to carry out the Medicaid program in Pennsylvania.

Managed Care Organizations. A Managed Care Organization (MCO) is an entity that manages the purchase and provision of physical or behavioral health services for eligible Medical Assistance recipients. MCOs, through a contract agreement, assist state agencies with delivering healthcare benefits and other services. Pennsylvania has a set capitation payment through this agreement for each member for these services, even if the member does not use any services during a given period. Each MCO that holds a contract with Pennsylvania's DHS Medicaid program may contract with a Pharmacy Benefit Manager (PBM) to manage the pharmacy benefits portion of their services. As of December 2020, DHS contracts with nine MCOs who collectively offered thirteen total plans.

Pharmacy Benefit Managers. PBMs manage prescription drug plans for more than 266 million people enrolled in commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program, state government employee plans, managed Medicaid plans, and others. PBMs create formularies, process claims, create pharmacy networks, review drug utilization, and manage mail-order specialty pharmacies. As of December 2020, the nine MA contracted MCOs in turn contracted with a total of 5 PBMs to manage the pharmaceutical benefit.

Pharmacies. Pharmacies provide the pharmaceuticals directly to Medicaid enrollees. These pharmacies include mail services and brick-and-mortar stores. Mail pharmacies send prescription drugs to enrollees via mail versus traditional pharmacies, where enrollees get their prescription drugs in person. Pharmacies are either chain or independent. Chain pharmacies have multiple locations, either nationally or within a region (these include pharmacies such as CVS and Walmart). Independent pharmacies are privately owned, single-location (typically) pharmacies in a community. Due to being smaller, independent pharmacies sometimes join PSAOs.

Distribution and Payment Flow

Pharmaceuticals are a vital part of MA services provided to Pennsylvania enrollees; however, the delivery of such services is somewhat complicated. The system is a web of interconnected parties that lead to Medicaid enrollees receiving their prescription drugs. In the previous section, we defined each of these parties, but it is essential to know how they work together and relate to one another.

Relationship between Medicaid/MCOs and PBMs. DHS contracts with MCOs to provide health plans for MA enrollees. The MCOs in

Pennsylvania then contract with a PBM that administers the pharmaceutical benefit on their behalf including providing the pharmacy network and processing drug claims and payments. MCOs also contract with hospitals and providers who provide health care services to Medicaid enrollees. These services include preventative doctor visits, surgeries, emergency care, etc. While this is not specifically related to pharmacy benefits, it is the other significant portion of the MA program.

PBMs to Manufacturers. Before Act 2020-120, PBMs would negotiate rebates with manufacturers. However, Exhibit BBB of the current HealthChoices agreement forbids this practice.

PBMs to Pharmacies. PBMs negotiate contracts with pharmacies and PSAOs to form the PBM's provider network. Like commercial insurance plans, pharmacies agree to the terms of the agreement to submit claims to the PBM for MA MCO enrollees.

Prescription Drug Pricing. Pharmaceutical pricing is unique, complicated, and unlike many other consumer goods. Each link in the supply chain has a different price, and each buyer has a different price. Viewing the pharmaceutical industry as an outsider is like learning complex math equations in a foreign language. In Section II, we simplify this complex pricing model, particularly concerning the Commonwealth's MA pharmaceutical program.

Pharmaceutical pricing first starts with the manufacturer. Drug manufacturers have received significant attention in mainstream media for the price of prescription drugs – particularly lifesaving or life-sustaining medicines with significant price barriers for consumers. Drug development is a complex and highly regulated process. Those paying attention to the development of vaccines and treatments during the COVID-19 pandemic saw the research and development of pharmaceuticals play out in real-time. Research and Development (R&D) is a significant cost factor for developing new drugs.

The benchmark that best represents what wholesalers ultimately pay manufacturers is the Average Manufacturer Price (AMP), which is the average price wholesalers (and retail community pharmacies that purchase directly from manufacturers) pay.

After wholesalers purchase prescription drugs from manufacturers, the next pricing benchmark is the Average Wholesale Price (AWP). This is the list price the wholesalers set for retail pharmacies purchasing pharmaceuticals. Like the Manufacturer Suggested Retail Price (MSRP) or Wholesale Acquisition Cost (WAC), AWP is often not what is paid. Throughout this study, we often heard from the pharmacy community that AWP informally means "ain't what's paid." Wholesalers will offer discounts to

pharmacies based on factors such as volume. Therefore, what is paid is WAC multiplied by an agreed to percent discount.

Pennsylvania MA enrollees arriving at a pharmacy to pick up their prescription(s) pay a copayment of anywhere from $0.00 to $3.00. The pharmacy submits the claim to the PBM, and the amount that the pharmacy receives from the PBM depends on its terms with the PBM. Some standard reimbursement benchmarks used include:

- Maximum Allowable Cost (MAC).
- AWP minus % (% is outlined in the contract). For example, a contract might state that a pharmacy will be reimbursed for a 30-day supply of a brand-name drug at AWP minus 23.5%.
- Usual and Customary Price (U&C) is the cash price paid at a retail pharmacy.
- Federal Upper Limit (FUL).
- The National Average Drug Acquisition Cost (NADAC).

B. PBM Reimbursement to Chain Pharmacies

Independent and Regional Chain Pharmacy Concerns

Pharmacies play a critical role in providing Pennsylvanians access to prescription medicines, professional expertise, and other services. This is especially true for Pennsylvania's Medical Assistance (MA) program and its enrollees. MA relies on a network of pharmacies to provide enrollees with lifesaving and life-sustaining medicines. Although it utilized Medicare data (not Medicaid), a study by the University of Pittsburgh School of Pharmacy found that visits to community pharmacies were greater than visits to Primary Care Physicians by a median difference of five to seven trips annually in Pennsylvania.

Act 2020-120 required LBFC staff to compare reimbursement practices of PBMs to independent pharmacies versus chain pharmacies, and we made this comparison at times. However, throughout our analysis for this study, we found it helpful to view these questions using three subgroups of pharmacies:

(1) Independent pharmacies – locally owned pharmacies with one to three stores.

(2) Regional chain pharmacies – regional pharmacies with multiple locations.

(3) National chain pharmacies – pharmacies with locations across the country.

We found this breakdown helpful as regional chain pharmacies and independent pharmacies expressed similar concerns – mainly that national chains received favorable treatment compared to regional chains and independent pharmacies.

Concerns Over Reimbursement Fairness. Many of the same concerns outlined in a 2018 Pennsylvania Department of the Auditor General (DAG) Special Report were conveyed to us throughout this study. One of the three major themes from the 2018 DAG report was concern over a potential "reimbursement disparity." The report stated, "independent pharmacists believe that PBMs are not paying fair prices to reimburse pharmacies for all the medications they dispense." We found this same sentiment when talking with independent and regional chain pharmacies and their representatives.

Dispensing Fees. There were also concerns over dispensing fees. Kaiser Family Foundation states, "The dispensing fee is intended to cover reasonable costs associated with providing the drug to a Medicaid beneficiary. This cost includes the pharmacist's services and the overhead associated with maintaining the facility and equipment necessary to operate the pharmacy." While the ingredient cost is intended to cover the actual cost of the pharmaceutical drug, the dispensing fee is to cover costs associated with dispensing that drug. According to the independent pharmacies we spoke with (or their representatives), the dispensing fees paid in managed care were insufficient to cover the costs of dispensing these drugs. They also stated that over time these dispensing fees decreased in their contracts with PBMs, while at the same time, the cost of labor and overhead increased.

Spread Pricing. There was also a common concern over the practice of spread pricing. This occurred when the amount MCOs paid PBMs was higher than what the PBMs paid the pharmacies. While this issue is not necessarily related to whether independents/regional chains were reimbursed at a different rate than chain pharmacies, we were able to test this in the same transaction data.

Transaction Data Analysis

As required by Act 2020-120, Section 449.1(c), MCOs, through DHS, provided the following transaction data:

- The amount paid to a pharmacy provider per claim, including ingredient cost and the amount of any copayment deducted from the payment.
- The transmission fees charged by a PBM to a pharmacy provider.

- The amount charged by the PBM to the MCO per claim, including all administrative fees and processing charges associated with the claim.

We received data for nine MCOs and six PBMs,[2] covering thirteen plans for calendar years 2019 (36,281,462 transactions) and 2020 (37,391,684 transactions).

Generic Drug Selection. To select generic drugs, we requested a list of the ten most filled drugs in the MA program for 2019 and 2020.

Results of Full March Analysis. Because the 260 transactions were not a statistically significant number for the data population to analyze actual reimbursement between chain pharmacies and other pharmacies (we define "other" as regional chains or independent pharmacies), we expanded our review to all of March 2019 (3,170,614 transactions) and 2020 (4,505,898 transactions).

We conducted a median analysis for each plan and drug by calculating the median reimbursement for pharmacies coded as national chains and pharmacies coded as others. The results can be found in Section III of this report.

Dispensing Fee Analysis. We performed the same median analysis for dispensing fees. However, we expanded our analysis to include all March data (regardless of the filled medication) because, with few exceptions, the drug filled does not determine the dispensing fee. We again grouped national chains together and all other pharmacies together (regional chains and independent pharmacies). The results are presented in Section III.

Spread Pricing Analysis. During our review of March data, we also tested for "spread pricing," or when the PBM collected a higher rate from the MCO than what they paid the pharmacy for the same transaction. We did this by comparing the total the PBM paid to the pharmacy to the sum the MCO paid the PBM for the same transaction. In 2019 we found that four of the thirteen MA plans had discrepancies, including both transactions in which the PBM was reimbursed more (overpayment) and less (underpayment) than what they paid the pharmacies for the same claims. Detailed results of our spread pricing analysis are in Section III.

[2] As of December 2020, there were 5 PBMs contracted with MCOs in Pennsylvania, due to an MCO switching to a different PBM.

Contracts and Contracted Ingredient Cost Reimbursement Rates

A crucial part of determining the ingredient cost reimbursement rates pharmacies receive is their contracts with PBMs, because the contracts spell out the specific reimbursement rate type (i.e., MAC, NADAC, etc.) or reimbursement formula (i.e., Average Wholesale Price minus "X" percent) and dispensing fee. We determined that obtaining the contracts was essential to answering the objectives of Act 2020-120. We asked representatives of pharmacies to provide contracts related to our sample. However, they refused, citing concerns about retribution or loss of PBM business. We then asked the PBMs directly for contracts related to our sample.[3]

Only one PBM (of six) complied with this request, which covered one of the thirteen MA plans. We then made the request through the MCOs and DHS. We received all contracts this way except for contracts from one PBM. The PBM contacted us directly, stating their refusal to provide the contracts. Exhibit 1 summarizes what we found within the contracts, which plans refused to provide information, or which specifically redacted information.

Exhibit 1

Contracted Ingredient Cost Reimbursement Rates Review Results

MCO Plan	Contract Notes
Plan 1	There were differences among all pharmacies (regardless of type) in the sample.
Plan 2	There were no differences in contracted rates between chains and independent pharmacies in the sample.
Plan 3	PBM refused to provide contracts. PBM claimed there was "no variation between chain and independent pharmacies," although we could not verify this without the contracts.
Plan 4	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 5	Chains and pharmacies in contracted PSAOs in the sample had the same contracted rates. Independent pharmacies (not in PSAOs) had different contracted reimbursement rate types in the sample.
Plan 6	There were no differences in contracted rates between chains and independent pharmacies in the sample.

[3] For more detail, please see page 3 in the methodology section.

Exhibit 1 Continued

MCO Plan	Contract Notes
Plan 7	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 8	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 9	PBM provided the contracts but excluded the pages containing the rate formulas. We could not determine if there was a difference between pharmacy types in the sample.
Plan 10	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 11	Rates varied between pharmacies in the sample – including rates among similar types of pharmacies.
Plan 12	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 13	PBM refused to provide contracts. PBM claimed there was "no variation between chain and independent pharmacies," although we could not verify this without the contracts.

Source: Developed by LBFC staff from information provided by PBMs, MCOs, and DHS.

Of the plans in which the MCOs/PBMs were transparent in providing the contracts as requested, we found a variety of contract reimbursement rates. The terms varied greatly by the plan. Some plans had no difference in contracted rates between different pharmacy types, while others did. We could not draw conclusions about contract reimbursement rates across all MA managed care from the reviewed contracts.

It was concerning that PBMs refused to provide these contracts or redacted the specific rate information. Act 2020-120 stated we were to be provided with "any other data the Legislative Budget and Finance Committee deems necessary." This is another area in which we believe there should be greater transparency, particularly as transparency relates to DHS having access to contracts pertaining to MA in their complete and unredacted form at DHS's request.

C. Reimbursement Practices of MCOs and PBMs

Department of Human Services Requirements

Before implementation, all drug policies, programs, and utilization management programs must be submitted to DHS for review and written approval. DHS requires all contracted MCOs to include in their written policies and procedures an assurance that all requirements and conditions governing coverage and payment for covered drugs ensure access to all medically accepted indications. MCOs may use a PBM to process prescription claims if the MCO has received advance written approval from DHS.

MCOs must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary. The MCO must submit to DHS the policies and procedures for developing network pharmacy payment methodologies, including ensuring that brand and generic payment rates reflect the pharmacy's acquisition cost, and the professional dispensing fee accurately reflects the pharmacist's professional services and cost to dispense the prescription.

DHS requires MCOs to develop and implement a pharmacy dispute resolution process. The process must include a first-level pricing dispute process with the PBM and a second-level process with the MCO.

Before implementing its dispute resolution process, the MCO must submit its policies and procedures for resolving pricing disputes to DHS. DHS must approve the policy.

In its oversight of payment rates, DHS requires MCOs to report the PBM's payment methodology for actual payment to all network pharmacy providers of covered drugs, including community pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for PBM subcontractors. Further, MCOs must report the per claim amount paid by the MCO to the PBM and the per claim amount paid by the PBM to the pharmacy.

Reimbursement Practices of PBMs and MCOs

All MCOs providing services in the HealthChoices and Community HealthChoices programs use a PBM to process prescription drug claims.

Section IV details the most common practices employed by MCOs and PBMs in general oversight, network payment methodology, pricing appeals, and oversight of payment rates to PBM contracted pharmacies.

According to the documentation provided by DHS, all MCOs and PBMs have adopted pharmacy management procedures that comply with DHS requirements. Detailed information on the practices of PBMs and MCOs relating to general oversight, network payment methodology, pricing appeals, and oversight of payment rates can be found in Section IV.

D. Managed Care Use of PBMs in Other States

Act 2020-120 directs the Legislative Budget and Finance Committee to study the best practices of other states regulating PBM reimbursement methods. However, there remains little available data to conclusively measure the efficacy of recently passed laws across the country. Therefore, the analysis in this section focuses on alternative practices not currently mandated by Pennsylvania law. Data presented in this section will represent projections from agencies in other states tasked with administering and enforcing their respective policies.

As highlighted in Section VI, since the passage of the Affordable Care Act, states have taken a more active role in administering their managed care plans. Some of the legislation Pennsylvania has passed in recent years, such as banning spread pricing, banning gag clauses, and introducing cost disclosure and appeals processes, reflect this shift in policy across the country.

MAC Publishing Transparency

A PBM-generated MAC list is a catalog of the upper limit or maximum amount that a health plan will pay for generic and brand-name drugs with generic alternatives. There is no industry standard for the methodology PBMs use to determine the maximum price and how those prices are subsequently changed or updated. Similarly, there are no established criteria for how PBMs select specific drugs to be included in their MAC lists.

In 2019, Maine passed a law regulating PBM business practices by imposing more transparency provisions for PBMs. Chief among these provisions is creating a single MAC list that must be identified by the PBM so that prices are transparent and accessible to all parties. Under 24-A M.R.S.A. §4350 (2019), a PBM under contract with an MCO must use the same maximum allowable cost list for each pharmacy provider.

Establishing and publishing a single publicly accessible MAC list enhances transparency.

Carve-In vs. Carve-Out Models for High-Cost Specialty Drugs

Specialty and high-cost drugs are among the most significant cost drivers of pharmacy spending growth in most states. Medicaid covers a disproportionate share of high-cost specialty drugs for high-need and at-risk populations, placing additional pressure on state governments to control drug spending.

State Medicaid managed care plans generally follow either carve-in or carve-out models. Most states that contract with MCOs, including Pennsylvania, "carve-in" Medicaid pharmacy benefits to MCO contracts, while a few states "carve-out" prescription drug coverage from managed care.

In 2021, the Kaiser Family Foundation (KFF) reported that seventeen states had implemented high-cost drug carve-outs.

Single PBM Models (SPBMs)

Some states are transitioning from utilizing multiple PBMs under contract for Managed Medicaid towards a single PBM (SPBM) for managed care. In theory, using a single PBM streamlines pharmacy administration as states contract directly with the SPBM and have more direct management over healthcare networks, reimbursement rates, and rebate negotiations.

Ohio has implemented an SPBM model. The Ohio Department of Medicaid (ODM) anticipates that an SPBM will allow the state to regulate the consistency of service outcomes better. By consolidating core services from multiple PBMs, the state expects to identify and eliminate potential conflicts of interest more readily. This is due to the state having greater leverage in negotiating contractual terms by engaging directly with the SPBM and reducing the number of stakeholders in the process. Additionally, the Ohio SPBM model is expected to minimize out-of-network restrictions, allowing Medicaid recipients to have more choices in selecting their pharmacy.

California issued an RFP for a carve-out of its pharmacy benefit effective January 1, 2021, opting to adopt an SPBM model and delegate control of its Medicaid drug program to Magellan Health. The administration estimated the new SPBM would save the state $414 million in the 2022-23 budget year as the state's Medicaid managed care program would receive more significant drug discounts than managed-care insurance plans.

In the months before the transition, the Department told patients and doctors the system would grandfather medications for 180 days. As reported in the LA Times, however, the change has not been smooth. Since its inception, California's SPBM has been overwhelmed by the state's volume of Medicaid recipients. Patients have experienced long customer service wait times, delayed prescription dispensing, and improper claim denials.

Reverse Auction PBMs

In traditional PBM procurement models, competitive bids are primarily kept confidential. The reverse auction model is designed to promote cost transparency by utilizing an online bidding process where PBMs compete for a state's contract by allowing bidders to counteroffer a lower price until a bid is accepted.

New Jersey was the first state to enact legislation to create a PBM reverse auction. In 2016, New Jersey enacted a law (L. 2016, c. 67) requiring the state to conduct an automated reverse auction to procure a PBM for the state health benefits plan and school employees' health benefits plan. The state benefit plan covers roughly 800,000 public employees, and the New Jersey Department of the Treasury's Division of Pensions and Benefits Office manages the program. While performance data is currently unavailable, the state projected savings of $2.5 billion in reduced prescription drug spending by the end of 2022.

No state Medicaid agencies have utilized the reverse auction model to procure a PBM contract for Medicaid Pharmacy Services.

SECTION I
OBJECTIVES, SCOPE, AND METHODOLOGY

Why we conducted this study…

- *Act 2020-120 (see Appendix A) directs the Legislative Budget and Finance Committee to provide an overview of the distribution of and payment for pharmaceuticals in the Medical Assistance Managed Care program.*
- *The Act further directs LBFC to submit a report of our findings and recommendations to the General Assembly and the Department of Human Services.*

Objectives

Our objectives for this study were as follows:

1. To provide an overview of the distribution of and payment for pharmaceuticals in the medical assistance managed care program.
2. To review the reimbursement practices of pharmacy benefit managers to pharmacies within this Commonwealth.
3. To review the reimbursement practices of managed care organizations to pharmacy benefit managers.
4. To investigate and compare the reimbursement rates paid by pharmacy benefit managers to independent pharmacies and chain pharmacies.
5. To study the best practices and laws adopted by other states to address concerns with pharmacy reimbursement practices of pharmacy benefit managers.

Scope

This report focuses on the calendar years 2019 and 2020.

Methodology

We conducted research and interviews with relevant stakeholders to provide an overview of the distribution of and payment for pharmaceuticals in the medical assistance managed care program.

We conducted extensive research to investigate and compare the reimbursement rates paid by pharmacy benefit managers to independent pharmacies and chain pharmacies. We obtained Medical Assistance (MA) program drug claims data from Managed Care Organizations for 2019 and 2020.

We spoke with representatives from the Department of Humans Services, MCOs, pharmacy trade groups, lobbyists, subject matter experts/researchers, and other states.

DHS provided a list of the ten most common generic drugs based on the total number of prescriptions (scripts) filled for 2019 and 2020. DHS also provided a list of the top spend brand name drugs from 2019 and 2020.

We used a random number generator to determine our sample month and entered 1 through 12 to represent each calendar month. The random number generator selected three. Therefore, we used March to select our sample of pharmacy transactions. We selected five drugs based on: possible overlap of the two lists, brand name drugs, generic drugs, drugs not on the statewide preferred drug list (PDL), drugs that, according to independent pharmacies, may unfairly benefit a chain over an independent, etc.

In addition, we selected additional generic and brand name drugs in case a "backup" was needed – for example, if we could not locate a transaction for the month chosen for both a chain and an independent pharmacy.

We used a non-statistical judgment sample based on the American Institute of Certified Public Accountants (AICPA) standards, which states that 60 is an appropriate selection size for a population of 250+ with a high risk. Due to the number of transactions in the data, we deemed this data to be high risk. Because there are 13 MA plans, we increased the sample size and selected 130 transactions per year that could be evenly divided into 10 for each MA MCO.

We selected drug claims for independent and chain pharmacies with the same National Drug Code (NDC) number, basis of payment, quantity, and dispense date (if applicable). The drug claims were numbered, and a sample claim was generated using a true random number generator. If an MCO plan did not have sufficient drug claims from our sample or an independent and chain pharmacy, an alternate drug from our sample list was used.

We sent letters with an overview of Act 2020-120 and a request for specific drug claim information to each of the pharmacies in our sample. Each letter included the pharmacy National Provider Identifier (NPI) number, the Internal Control Number (ICN), the date dispensed, NDC, NDC description, the quantity, and MCO name. Further, we requested from the adjudicated claim transaction the total dollar amount authorized by the Pharmacy Benefit Manager (PBM), ingredient cost paid, dispensing fee paid, and copay amount to be collected. Lastly, we asked the pharmacy to provide a copy of their wholesaler invoice showing the medication's cost. In addition, we asked that they include all discounts or rebates (in dollar figures) applied.

We worked with independent pharmacy trade groups and government affairs representatives to assist LBFC with obtaining their members' contact information, email, and mailing addresses.

We gathered contact information for chain pharmacies through the National Plan and Provider Enumeration System (NPPES)/National Provider Identifier (NPI) Registry. The registry provided the pharmacy provider's contact information, which included the authorized official, phone number, physical address, and mailing address.

We began mailing letters on August 1, 2022, with a requested deadline of August 19, 2022. Letters were sent out through the U.S. Postal Service and by email (if available).

We conducted a review of the adjudicated claim transactions received from pharmacies. We compared the claim(s) transaction to the PBM/MCO paid fields within the pharmacy drug claims dataset(s) for each pharmacy that responded to the data request.

We reviewed contracts for our review period, held between the PBM and pharmacies within our sample, for any differences in reimbursement methodology among national chain pharmacies, regional pharmacies, and independent pharmacies.

To comply with Act 2020-120 subsection requirement to publish only aggregate data in the report and provide useful analysis, we combined specific individualized data by MA MCO plan and presented it with generic labeling. In addition, we combined data for national chains and other pharmacies or chain pharmacies and independent pharmacies (where applicable).

We also conducted a median analysis of ingredient costs paid to national chain pharmacies and other pharmacies. We published the aggregated results for each MA MCO plan by only providing the percentage difference between the median ingredient cost by pharmacy type.

We also conducted a median analysis of dispensing fees paid to national chains compared to other pharmacies aggregated by MA MCO plan.

To review the reimbursement practices of MCOs and PBMs, we reviewed contracts between the Commonwealth and MCOs, MCOs and PBMs, and PBMs and pharmacies. We also reviewed payment methodologies provided to LBFC by DHS. Not all PBMs provided contracts, some refused to provide or redacted the specific rate information. Therefore, we could not draw conclusions about contract reimbursement rates across all MA management care from the reviewed contracts.

To study practices and laws adopted by other states regarding concerns with pharmacy reimbursement, we utilized legislative tracking sources such as the National Academy for State Health Policy (NASHP), the National Conference of State Legislators (NCSL), and the Kaiser Family Foundation (KFF) to observe nationwide policy trends and research how other states have reformed PBM practices. Pennsylvania has adopted several key reforms in recent years following the legislative directives of other states in addressing PBM reimbursement practices and adding additional quality control and oversight measures. These reforms, enacted through Act 2016-169, Act 2020-67, and Act 2020-120, have included cost disclosure requirements (banning gag clauses), prohibiting the practice of spread pricing, creating a standardized pharmacy auditing appeals process, and adopting network adequacy standards. LBFC then worked closely with the Department of Human Services to analyze how these reforms are enforced and delivered.

We then considered other state strategies beyond those reforms already instituted in Pennsylvania. It is vital to emphasize that there remains little available quantitative data to conclusively measure the efficacy of recently passed laws across the country. Therefore, the analysis regarding Objective 5 focuses on "alternative" practices not currently mandated by Pennsylvania law rather than "best" practices. We used case study examples of Ohio and California transitioning towards a Single PBM model to highlight policy goals, projected benefits, and potential shortcomings. New Jersey was used as a case study example to observe how the state implemented a reverse auction system to procure PBM services for its State Employee Health Benefits Program.

Frequently Used Abbreviations and Definitions

This report uses several abbreviations for government-related agencies, terms, and functions. These abbreviations are defined as follows:

Abbreviation	Name	Definition
AAC	Average/Actual Acquisition Cost	A state Medicaid agency's determination of pharmacy providers' actual prices paid to acquire drug products marketed or sold by a specific manufacturer. AAC is the current Medicaid benchmark to set payment for drug ingredients.
ACA	Affordable Care Act	A federal statute enacted in 2010, formally known as the Patient Protection and Affordable Care Act, comprehensively reformed healthcare law in the United States.

Abbreviations and Definitions Continued

Abbreviation	Name	Definition
AICPA	Association of International Certified Professional Accountants	The largest and most influential body of professional accountants comprises nearly 700,000 members worldwide. AICPA sets industry standards and issues guidance and technical support to individuals, communities, businesses, and governments.
AMP	Average Manufacturer Price	The average price paid to the manufacturer by wholesalers and retail community pharmacies that purchase drugs directly from the manufacturer. AMP is used to calculate drug rebates under the Medicaid Drug Rebate Program.
AWP	Average Wholesale Price	The published list price for a drug sold by wholesalers to retail pharmacies and nonretail providers. It is akin to a sticker price and is a starting point for negotiating payments to retail pharmacies.
CHC	Community HealthChoices	A Medicaid managed care program for Pennsylvanians 21 and older who qualify for Medicaid.
CMS	Centers for Medicare and Medicaid Services	A federal agency within the United States Department of Health and Human Services that administers healthcare coverage to over 100 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace.
DAG	Department of the Auditor General	Executive branch agency in Pennsylvania responsible for conducting audits and oversight to ensure that all state funds are spent legally and properly.
DHS	Department of Human Services	Cabinet-level state agency in Pennsylvania tasked with administering programs and services that provide care and support to the Commonwealth's most vulnerable citizens.
ERISA	Employee Retirement Income Security Act	U.S. federal tax and labor law enacted in 1974 that established minimum standards for pension plans in private industry. It contains rules on the federal income tax effects of transactions associated with employee benefit plans.
FFS	Fee For Service	A payment methodology by which health care providers are paid for each service performed in the MA program.
FTC	Federal Trade Commission	An independent federal agency of the United States government whose principal mission is to enforce civil antitrust law and promote consumer protection.

Abbreviations and Definitions Continued

Abbreviation	Name	Definition
HHS	Department of Health and Human Services	Cabinet-level executive branch department of the U.S. federal government created to protect the health of Americans and provide essential human services.
ICN	Internal Control Number	A 13-digit number assigned by the Pennsylvania Department of Human Services to identify Medical Assistance claims.
KFF	Kaiser Family Foundation	A leading nonprofit organization focusing on U.S. health policy analysis and national health issues.
MA	Medical Assistance	Pennsylvania's state-run Medicaid program that pays for health care services for eligible members.
AWP	Average Wholesale Price	The published list price for a drug sold by wholesalers to retail pharmacies and nonretail providers. It is akin to a sticker price and is a starting point for negotiating payments to retail pharmacies.
MACPAC	Medicaid and CHIP Payment and Access Commission	A nonpartisan legislative branch agency that provides policy analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and states on various issues affecting Medicaid and the State Children's Health Insurance Program (CHIP).
MCO	Managed Care Organization	A healthcare company or a health plan focused on reducing costs while keeping the quality of care high. Standard managed care features include provider networks, provider oversight, and prescription drug tiers.
MDRP	Medicaid Drug Rebate Program	A federal program created under the Omnibus Budget Reconciliation Act of 1990 by which CMS, state Medicaid agencies, and participating drug manufacturers work together to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.
NADAC	National Average Drug Acquisition Cost	A national average of the prices at which pharmacies purchase a prescription drug from manufacturers or wholesalers. NADAC can be used to calculate AAC.
NASHP	National Academy for State Health Policy	A nonpartisan organization committed to developing and advancing state health policy solutions. NASHP provides a forum for exchanging strategies across state governments, including the executive and legislative branches.
NDC	National Drug Code	A unique 10 or 11-digit number assigned by the federal Food and Drug Administration to identify drugs intended for human use in the United States.

Abbreviations and Definitions Continued

Abbreviation	Name	Definition
NPPES	National Plan and Provider Enumeration System	A national registry system managed by the US Department of Health and Human Services designed to assign unique identifiers to healthcare providers and health plans.
NPI	National Provider Identifier	A unique 10-digit identification number issued to individual healthcare providers in the United States by the Centers for Medicare and Medicaid Services.
ODM	Ohio Department of Medicaid	ODM's care network comprises over 130,000 active providers who deliver coverage and services to roughly 3 million residents in Ohio.
OECD	Organization for Economic Co-operation and Development	OECD is an intergovernmental organization with 38 member countries, founded in 1961 to stimulate economic progress and global trade.
PBM	Pharmacy Benefit Manager	Third-party administrators that manage prescription drug programs for health insurers and public/private health plans. PBMs act as intermediaries between all stakeholders in the prescription drug marketplace. They are responsible for administering benefits to more than 266 million Americans.
PCMA	Pharmaceutical Care Management Association	A national association representing and advocating for America's pharmacy benefit managers.
PDL	Preferred Drug List	A list of outpatient drugs that states encourage providers to prescribe over others as a mechanism to negotiate higher supplemental rebates. A state may attach a higher copay or require prior authorization for drugs not on the PDL.
PHC	Physical HealthChoices	Pennsylvania's mandatory managed care programs, administered by the Department of Human Services, for Medical Assistance recipients. Through physical health managed care organizations, enrollees receive quality medical care and timely access to all appropriate inpatient and outpatient physical health services.
PPAC	Pharmacy Pricing and Audit Consultant	A predesignated vendor within an SPBM model whose role is to conduct fiscal oversight of the single pharmacy benefit manager, help establish fair pharmacy prices, and to eliminate potential SPBM conflicts of interest.
PSAO	Pharmacy Services Administrative Organization	A collective bargaining group of independent community pharmacies who leverage their membership to negotiate contracts with other parties in the pharmaceutical supply and payment chain.

Abbreviations and Definitions Continued

Abbreviation	Name	Definition
RFP	Request for Proposal	A formal document frequently used by governments or businesses to announce a project, describe its function, or purpose, and solicit bids from qualified entities to procure financing for the project's completion.
SPBM	Single Pharmacy Benefit Manager	Whereas conventional PBM marketplaces consist of multiple vendors to administer benefits, an SPBM model involves the state contracting with a single PBM to save costs, ensure greater oversight, and streamline processes.
UPDL	Unified Preferred Drug List	A consolidated list of multiple PDLs that encompass an entire Medicaid population regardless of enrollment in Managed Care or Fee for Service.
WAC	Wholesale Acquisition Cost	The represented determination of a manufacturer's list price for brand and generic drugs to wholesalers.

Acknowledgments

We acknowledge and appreciate the excellent cooperation we received from the Department of Human Services. We also thank the company representatives and other stakeholders who spoke with us and assisted with this study.

Important Note

This report was developed by the staff of the Legislative Budget and Finance Committee, including project manager, Christopher Latta and staff analysts, Rebanta Mukherjee, Shanika Mitchell-Saint Jean and Stevi Sprenkle. The release of this report should not be construed as an indication that the Committee as a whole, or its individual members, necessarily concur with the report's findings, conclusions, or recommendations.

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SECTION II
DISTRIBUTION AND PAYMENT FOR PHARMACEUTICALS IN THE MA MCO PROGRAM

Fast Facts...

- *Pharmacy Benefit Managers are sub-contractors and act as intermediaries between Managed Care Organizations and pharmacies.*
- *As of January 2020, all MA MCOs have pass through agreements with PBMs and are no longer permitted to collect rebates from drug manufacturers; additionally, PBMs are no longer allowed to collect "spread pricing."*
- *In PA, the federal share of MA spending was 64% and the state share of MA spending was 36%, in federal fiscal year ended 2021.*

Overview

As part of the Prescription Drug Pricing Study subsection of Act 2020-120, the Legislative Budget and Finance Committee (LBFC) is to provide an overview of the distribution of and payment for pharmaceuticals in the Medical Assistance managed care program. The entities involved in the distribution and payment of pharmaceuticals for Pennsylvania Medical Assistance (MA) enrollees include:

- U.S. Department of Health and Human Services, Center for Medicare, and Medicaid Services
- Pennsylvania Department of Human Services
- Contracted managed care organizations (MCOs)
- Pharmacy benefit managers (PBMs)
- Pharmaceutical manufacturers
- Pharmaceutical wholesalers
- Pharmacies

This section will provide an overview of and show the relationships between these entities as they relate to Pennsylvania MA pharmaceutical benefits.

We found:

1. The distribution of and payment for pharmaceuticals in the MA MCO program is complex and opaque in certain areas (such as contracting and pricing).

Issue Areas

A. Governance and Key Players

Medicaid is an entitlement program authorized by Title XIX of the Social Security Act of 1965. States administer the Medicaid program under federal statutes and regulations.[4,5,6] However, states have the autonomy to establish eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines.[7]

States and the Federal Government jointly fund the Medicaid program.[8] Each state's government share varies and is based on a Federal Medical Assistance Percentage (FMAP), which is the amount of federal payment(s) to states based on two factors: (1) the actual amount spent that qualifies as matchable under Medicaid and the FMAP; and (2) the average per capita income for each State relative to the national average.[9]

The Federal Government provides most of the Medicaid funds to the states. In the last federal fiscal year,[10] Pennsylvania's federal share of Medicaid spending was 64.0 percent, and the state share of Medicaid spending was 36.0 percent.[11] The Commonwealth's share is below the national average of 69.3 percent and 30.7 percent, respectively.

Centers for Medicare and Medicaid Services (CMS).[12] The Centers for Medicare and Medicaid Services (CMS), through Medicaid and the Children's Health Insurance Program (CHIP), provides health coverage to

[4] Entitlement definition: a federal program or provision of law that requires payments to any person or unit of government that meets the eligibility criteria established by law. (Source: *Glossary*. United States Senate. https://www.senate.gov/reference/glossary_term/entitlement.html. Accessed on September 13, 2022).
[5] Pennsylvania Department of Human Services *HealthChoices Physical Health Agreement* effective January 1, 2021. The Medical Assistance Program is authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §§1396 et seq., and regulations promulgated thereunder, and 62 P.S. §§441.1 et seq. and regulations at 55 Pa. Code Chapters 1101 et seq.
[6] 42 CFR § 400.200 - General definitions. Medicaid - medical assistance provided under a state plan approved under title XIX of the Act.
[7] *Medicaid 101.* Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/medicaid-101/. Accessed September 13, 2022.
[8] *Medicaid May 2022 Enrollment Report*. https://www.medicaid.gov/medicaid/index.html. Accessed September 13, 2022.
[9] *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, FY 2023.* Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier. Accessed September 13, 2022.
[10] October 1, 2020, through September 30, 2021.
[11] *Federal and State Share of Medicaid Spending, FY 2021.* Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on September 13, 2022.
[12] The Centers for Medicare and Medicaid Services fall under the U.S. Department of Health and Human Services.

low-income adults, children, pregnant women, the elderly, and people with disabilities. Medicaid provides health coverage to 81.9 million people and is one of the largest payers for health care in the United States.[13,14]

Pennsylvania Department of Human Services. The federal government provides standards for the Medicaid program, and states provide additional laws and regulations while administering the program. In Pennsylvania, the Department of Human Services (DHS) manages the Medicaid program (also referred to as "Medical Assistance" or "MA"). The federal government gives states significant latitude to determine eligibility, covered services, the program's structure, etc. DHS administers several contracts to carry out the Medicaid program in Pennsylvania.

Eligibility. To be eligible for Pennsylvania Medicaid, someone must be (1) a resident of the state of Pennsylvania, (2) a U.S. national, citizen, permanent resident, or legal alien, (3) meet specific income levels (outlined below), and (4) need health care/insurance assistance.[15]

MA eligibility is grouped by:

- Modified Adjusted Gross Income (MAGI): children aged 18 and under, pregnant women, parents, and caretakers of children under 21, adults ages 19-64 with incomes at or below 133 percent of the Federal Income Poverty Guidelines (FIPG), or [individuals receiving] family planning services.[16]
- Non-MAGI: individuals ages 65 and older, individuals who are blind or disabled, Medical Assistance for Workers with Disabilities (MAWD), or individuals receiving long-term care (LTC) or home and community-based services (HCBS).[17]

[13] *May 2022 Enrollment Report*. Medicaid. https://www.medicaid.gov/medicaid/index.html. Website accessed September 15, 2022.
[14] The Children's Health Insurance Program (CHIP) provides federal matching funds to states to provide health coverage to children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. As of the 2018 Statistical Enrollment Report, there are 9.6 million children enrolled. The most recent annual enrollment reports are for FY 2020. There were 44,259,975 children enrolled in Medicaid and CHIP during the FY 2020 reporting period. Of these 44,259,975 children, 35,197,225 children were enrolled in Medicaid and 9,062,750 children were enrolled in CHIP.
[15] Who is Eligible for Pennsylvania Medicaid Program. https://www.benefits.gov/benefit/1148.
[16] Medical Assistance General Eligibility Requirements. Department of Human Services. https://www.dhs.pa.gov/Services/Assistance/Pages/MA-General-Eligibility.aspx. Accessed on September 13, 2022.
[17] Ibid.

Exhibit 2 outlines the current income eligibility levels.[18]

Exhibit 2

Pennsylvania Medicaid Eligibility Income Levels

Household Size	Maximum Income Level (Per Year)
1	$18,075
2	$24,353
3	$30,630
4	$36,908
5	$43,186
6	$49,463
7	$55,741
8	$62,018
For households with more than 8 people	Add $6,277 per additional person

Source: Developed by LBFC staff from Pennsylvania MA information on Benefits.Gov.

Fee for Service Program. Fee-for-service (FFS) is a payment per-service basis for health care (services) provided to Medical Assistance recipients.[19] A set payment is made directly to a provider for each covered service received.[20] In Pennsylvania, once an individual is deemed eligible for Medical Assistance, they are placed in the FFS program for three to six weeks. After that, beneficiaries are assisted with their enrollment into a Physical HealthChoices Managed Care Organization (PHC-MCO) and selecting a Primary Care Physician from within the MCOs network.[21]

HealthChoices Program. The HealthChoices (HC) program is the name of Pennsylvania's managed care programs for eligible Medical Assistance (MA) recipients. The Physical HealthChoices program provides recipients

[18] Example of income include wages, interest, dividends, Social Security, veterans' benefits (except MAGI MA), pensions, and spouses' income if living with him/her. Examples of income not counted when determining eligibility include Temporary Assistance for Needy Families (TANF) benefits, Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP) benefits, Low Income Home Energy Assistance Program (LIHEAP) benefits, Foster Care payments, certain housing or utility subsidies, Weatherization Payments, child support payments (only for MAGI MA).

[19] *Medical Assistance Program Dictionary*. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Dictionary.aspx. Accessed on September 13, 2022.

[20] *Provider Payment and Delivery Systems*. Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/. Accessed on September 13, 2022.

[21] *Medical Assistance and Children's Health Insurance Program Managed Care Quality Strategy*, December 2020. Pennsylvania Department of Human Services. https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/Medical%20Assistance%20Quality%20Strategy%20for%20Pennsylvania.pdf. Accessed September 13, 2022.

with medical care and access to appropriate physical health services through physical health managed care organizations (PH-MCOs).[22,23,24]

The Community HealthChoices (CHCs) managed care program is for older Pennsylvanians and adults 21 and older that are dually eligible for Medicare and Medicaid and individuals who qualify for Medicaid Long-Term Services and Supports (LTSS).[25,26] Through the CHC managed care program, MA recipients receive Physical Health Services and LTSS. LTSS can be provided in the community and private or county nursing facilities.[27]

Managed Care Organizations. A Managed Care Organization (MCO) is an entity that manages the purchase and provision of physical or behavioral health services for eligible Medical Assistance recipients.[28] MCOs, through a contract agreement, assist state agencies with delivering healthcare benefits and other services. Pennsylvania has a set capitation payment through this agreement for each member for these services, even if the member does not use any services during a given period. Each MCO that holds a contract with Pennsylvania's DHS Medicaid program subcontracts with a Pharmacy Benefit Manager (PBM) to manage the pharmacy benefits portion of their services. As of December 2020, DHS has MCO agreements with nine MCOs who subcontract with five PBMs.

Pharmacy Benefit Managers. PBMs manage prescription drug plans for more than 266 million people enrolled in commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program, state government employee plans,

[22] The Department of Human Services' Office of Medical Assistance Programs (OMAP) oversees the physical health component of the HealthChoices program. https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/PhysicalHealthChoices-Main.aspx. Accessed on September 13, 2022.
[23] Physical Health Managed Care Organization (PH-MCO) is a risk-bearing entity that has an agreement with the Department of Human Services to manage the purchase and provision of Physical Health Services under the HealthChoices Program.
[24] Basic benefits for all Medical Assistance (Medicaid) programs include doctor and hospital visits, Medicine, OB/GYN, Dental care, Vision care, medical equipment, Chiropractic care, physical therapy, foot care, and home health care. https://www.enrollnow.net/index.php/learn/your-health-benefits. Accessed on September 13, 2022.
[25] The Department of Human Services' Office of Long-Term Living (OLTL) oversees the Community Health Choices component of the HealthChoices program.
[26] *Section 1915(b) Waiver Proposal For MCO, PIHP Programs, And FFS Selective Contracting Programs*, Department of Human Services. https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/CHC-1915bWaiver.pdf. Accessed on September 9, 2022.
[27] CHC is Pennsylvania's managed Long-Term Services and Supports (LTSS) initiative. The 1915(b)/1915(c) waivers allow the Commonwealth to require Medicaid beneficiaries to receive both LTSS, including nursing facility, hospice, home and community-based services (HCBS), and physical health services through managed care organizations (MCOs). <https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/CHC-Supporting-Documents.aspx>
[28] *Medical Assistance Programs Dictionary.* Pennsylvania Department of Human Services. https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/MA-Dictionary.aspx. Accessed September 13, 2022.

managed Medicaid plans, and others.[29] PBMs create formularies,[30] process claims, create pharmacy networks, review drug utilization, and manage mail-order specialty pharmacies.[31]

Some states have "carved out" the pharmacy benefit, meaning they do not include pharmaceuticals in their agreements with MCOs. These states vary in their delivery of medications, and some utilize fee for service while others have a single PBM contract directly with the state. Pennsylvania is a "carved-in" state because MCO agreements include pharmaceuticals; in turn, the use of PBMs is allowable.

Pharmaceutical Manufacturers and Wholesalers. Pharmaceutical manufacturers develop and produce prescription drugs, and pharmaceutical wholesalers buy prescription drugs in bulk from manufacturers and, in turn, sell the drugs to pharmacies.

Pharmacy Services Administrative Organizations. Pharmacy Services Administrative Organizations (PSAOs) are voluntary service organizations that provide administrative services to assist independent, small chain, and franchise pharmacies with third-party payers or their PBMs.[32] PSAOs are owned by wholesalers, independent pharmacy cooperatives (member-owned), group purchasing organizations, and private entities.[33,34] A pharmacy pays its PSAO a monthly (or annual) membership fee; other services may be provided at additional cost.[35] PSAOs can negotiate and enter contracts on behalf of their members through contractual agreements.

Pharmacies. Pharmacies provide the pharmaceuticals directly to Medicaid enrollees. These pharmacies include mail services and brick-and-mortar stores. Mail pharmacies send prescription drugs to enrollees via mail versus traditional pharmacies, where enrollees get their prescription drugs in person. Pharmacies are either chain or independent. Chain pharmacies have multiple locations, either nationally or within a region (these include pharmacies such as CVS and Walmart). Independent

[29] *Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers*, Visante, prepared for Pharmaceutical Care Management Association (PCMA), February 2020. Accessed June 4, 2021.
[30] Formulary definition: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.
(Source: https://www.healthcare.gov/glossary/formulary/. Accessed on September 14, 2022).
[31] https://www.naic.org/cipr_topics/topic_pharmacy_benefit_managers.htm
[32] *Prescription Drugs, The Number, Role, and Ownership of Pharmacy Services Administrative Organizations*, U.S. Government Accountability Office, January 2013. Accessed on June 22, 2021.
[33] Ibid.
[34] Three of the five largest PSAOs are owned by the three largest wholesalers in the U.S.: AmerisourceBergen Corporation, Cardinal Health Inc., and McKesson Corporation.
[35] Other services, such as assistance with claims, audit assistance, central payment, certification in specialized care program, compliance support, flat generics (sell generics for a flat fee), front of store layout assistance, inventory management, marketing support, reconciliation or access to a reconciliation vendor, and retail cash cards (discount programs); all may vary by PSAO.

pharmacies are privately owned, single-location (typically) pharmacies in a community. Due to being smaller, independent pharmacies sometimes join PSAOs.

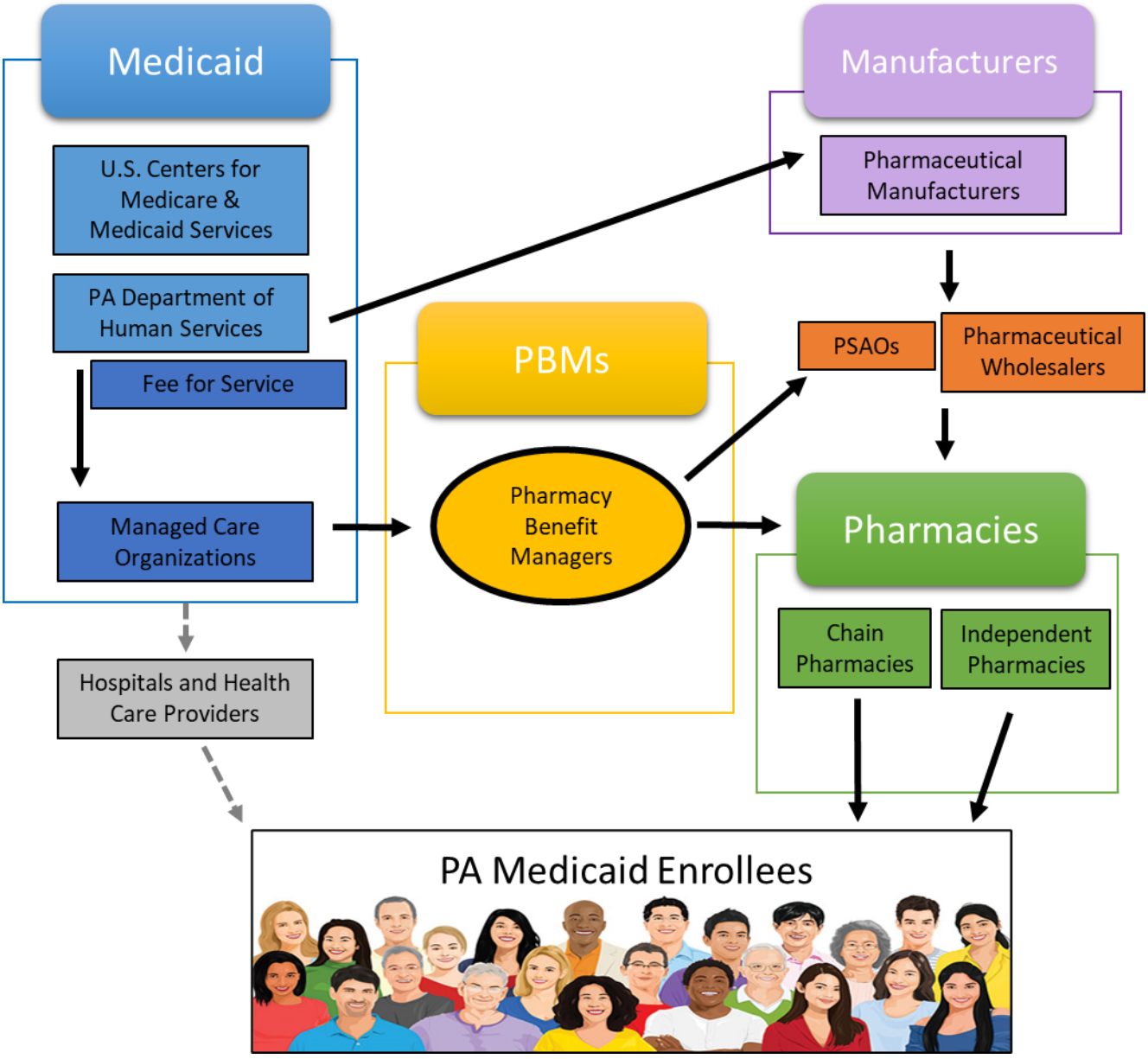
B. Distribution and Payment Flow

Pharmaceuticals are a vital part of MA services provided to Pennsylvania enrollees; however, the delivery of such services is somewhat complicated. In the following section, we map out the distribution and payment for pharmaceuticals. We will first provide a higher-level overview of the process and then highlight specific areas to explain more in-depth.

Exhibit 3 provides an overview of the Pennsylvania Medicaid program's pharmaceutical distribution and payment flow. This system is a web of interconnected parties that lead to Medicaid enrollees receiving their prescription drugs. In the previous section, we defined each of these parties, but it is essential to know how they work together and relate to one another.

Exhibit 3

MA Pharmaceutical Benefit Flow Chart



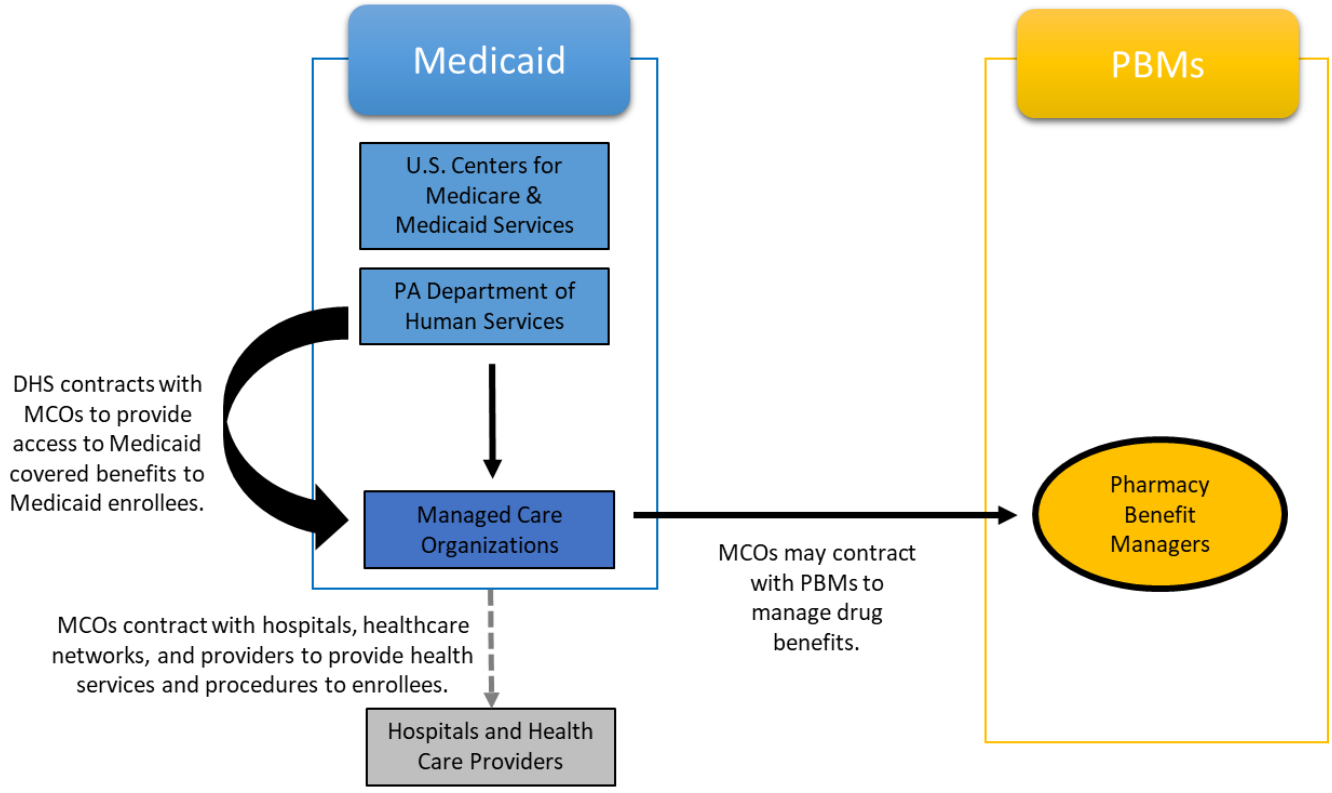
Source: Developed by LBFC staff.

As shown in Exhibit 3, the PBMs play a central intermediary role in managing the pharmacy benefit. While the enrollee will likely never interact directly with a PBM, PBMs do the behind-the-scenes work to coordinate the pharmaceutical benefit of the MA MCO program.

Relationship between Medicaid/MCOs and PBMs. As previously mentioned, DHS contracts with MCOs to provide health plans for MA enrollees. The MCOs in Pennsylvania then contract with a PBM that administers the pharmaceutical benefit on their behalf. MCOs also contract with hospitals and providers who provide health care services to Medicaid enrollees. These services include preventative doctor visits, surgeries, emergency care, etc. While this is not specifically related to pharmacy benefits, it is the other significant portion of the MA program. The relationship between Medicaid, MCOs acting on Medicaid's behalf, and PBMs is highlighted in Exhibit 4 below.

Exhibit 4

Medicaid/MCOs and PBMs



Source: Developed by LBFC staff.

Spread Pricing. Spread pricing is the difference (spread) between the amount paid by the MCO to the PBM versus the amount the PBM reimburses the pharmacy.[36] Therefore, in a spread pricing model, the PBM keeps a portion of the amount paid from an MCO for prescription drugs instead of passing the total payment to pharmacies. Act 2020-120 prohibits PBMs and PSAOs from charging or retaining a differential between what is billed to a managed care organization as a reimbursement for a pharmacy service and what is paid to pharmacies for those same services.[37] More than a dozen states have prohibited the use of spread pricing models in PBM and health plan contracts.[38,39]

PBMs to Manufacturers. Before Act 2020-120, PBMs would negotiate rebates with manufacturers. However, according to DHS, this practice is no longer allowed.

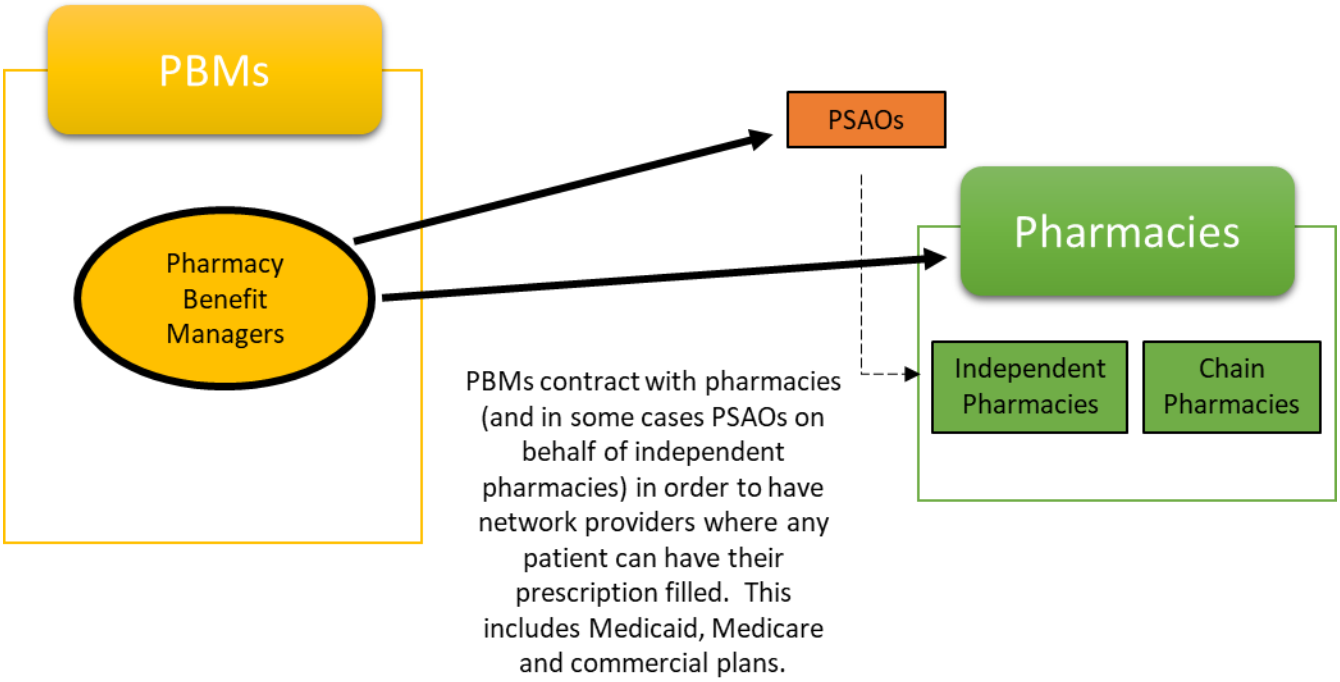
PBMs to Pharmacies. PBMs negotiate contracts with pharmacies and PSAOs to form the PBM's network. Like commercial insurance plans, pharmacies agree to the terms of the agreement to receive the business from MA enrollees.

See Exhibit 5 for the relationship between PBMs and pharmacies.

[36] *CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensure Pharmacy Benefit Managers are not Up-Charging Taxpayers.* Centers for Medicare and Medicaid Services, May 2019. https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not. Accessed on September 13, 2022.
[37] Human Service Code Title 55, Article IV Public Assistance, (f) Medical Assistance, § 449 (h)(3).
[38] *State Policy Options and Pharmacy Benefit Managers (PBMs).* National Conference of State Legislatures. https://www.ncsl.org/research/health/state-policy-options-and-pharmacy-benefit-managers.aspx#/. Accessed on September 13, 2022.
[39] States with spread pricing legislation: Pennsylvania, South Dakota, Indiana, Kentucky, Arizona, Louisiana, Georgia, North Carolina, Maryland, Virginia, New York, Vermont, Maine, and the District of Columbia.

Exhibit 5

PBMs and Pharmacies



Source: Developed by LBFC staff.

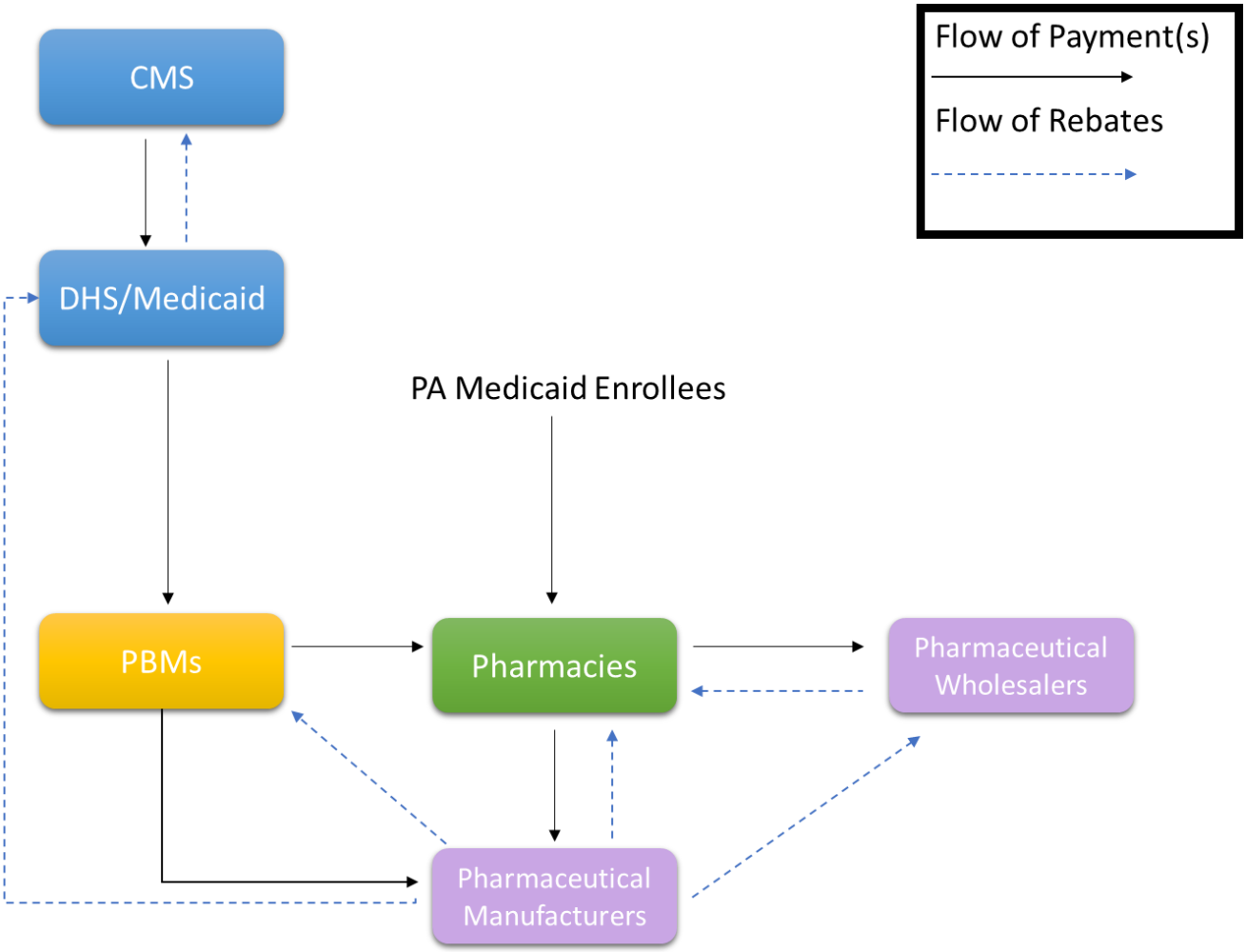
Rebates. There are two types of rebates that state Medicaid programs are entitled to (1) the Medicaid Drug Rebate Program (MDRP) and (2) Supplemental Rebate Agreements (SRA). Congress instituted the MDRP program as part of the Omnibus Reconciliation Act of 1990.[40] The program includes the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and participating drug manufacturers.[41] The rebates help to offset the Federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.[42] For manufacturers to have their drugs covered under the rebate program, they are required to "enter into, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in exchange for state Medicaid coverage of most of the manufacturer's drugs."[43]

[40] OBRA-90; Pub. L. 101–508, 104 Stat. 1388, enacted November 5, 1990.
[41] *Medicaid Drug Rebate Program*. Medicaid. https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html. Accessed on September 13, 2022.
[42] Ibid.
[43] Ibid.

SRAs allow a state Medicaid program to offset program drug costs further by negotiating supplemental rebates with manufacturers.[44] Exhibit 6 below shows the flow of prescription drug rebates and payments.

Exhibit 6

MA MCO Payment and Rebate Flow



Source: Developed by LBFC staff.

Lastly, as of January 1, 2020, all MCOs have agreements with their PBMs, which prohibit both (MCOs and PBMs) from collecting rebates from drug manufacturers. According to DHS, per the MCO agreements, the MCOs

[44] *The Medicaid Drug Rebate Program, and the impact of "best practice" rules*, Kaiser Permanente, Institute of Health Policy, October 2020. Accessed on August 8, 2021.

may not collect any drug rebate for any Medicaid-covered drug. There is no PBM collection of rebates for MA MCO utilization.

Prescription Drug Pricing. Pharmaceutical pricing is unique, complicated, and unlike many other consumer goods. Each link in the supply chain has a different price, and each buyer has a different price. Viewing the pharmaceutical industry as an outsider is like learning complex math equations in a foreign language. We attempt to simplify this complex pricing model, particularly concerning the Commonwealth's MA pharmaceutical program.

Pharmaceutical pricing first starts with the manufacturer. Drug manufacturers have received significant attention in mainstream media for the price of prescription drugs – particularly lifesaving or life-sustaining medicines with significant price barriers for consumers. Drug development is a complex and highly regulated process. Those paying attention to the development of vaccines and treatments during the COVID-19 pandemic saw the research and development of pharmaceuticals play out in real-time. Research and Development (R&D) is a significant cost factor for developing new drugs. In short, developing new drugs takes a considerable amount of capital. According to research from the Congressional Budget Office: "In 2019, the pharmaceutical industry spent $83 billion on R&D. Adjusted for inflation, that amount is about ten times what the industry spent per year in the 1980s."[45]

Aside from R&D, other inputs in manufacturers' pricing are raw materials, patents, liability and legal costs, and profit/shareholder considerations. The list price is the manufacturer's suggested retail price (MSRP). Like a vehicle, MSRP may be different from the invoice price (what the dealer pays for the car), and pharmaceutical MSRPs are often not the final price a wholesaler pays. The MSRP or published list price for wholesalers in the pharmaceutical industry is referred to as the Wholesale Acquisition Cost (WAC). Wholesalers typically pay WAC multiplied by a percent discount.

The benchmark that best represents what wholesalers ultimately pay manufacturers is the Average Manufacturer Price (AMP), which is the average price wholesalers (and retail community pharmacies that purchase directly from manufacturers) pay.

After wholesalers purchase prescription drugs from manufacturers, the next pricing benchmark is the Average Wholesale Price (AWP). This is the list price the wholesalers set for retail pharmacies purchasing pharmaceuticals. Like the MSRP or WAC, AWP is often not what is paid. Throughout this study, we often heard from the pharmacy community that AWP

[45] *Research and Development in the Pharmaceutical Industry.* Congressional Budget Office, April 2021. https://www.cbo.gov/publication/57126#_idTextAnchor000. Accessed on September 13, 2022.

informally means "ain't what's paid." Wholesalers will offer discounts to pharmacies based on factors such as volume. Therefore, what is paid is WAC multiplied by an agreed-to percent discount.

Pennsylvania MA enrollees arriving at a pharmacy to pick up their prescription(s) pay a copayment of anywhere from $0.00 to $3.00. The pharmacy submits the claim to the PBM, and the amount it receives from the PBM depends on its terms with the PBM. Some standard reimbursement benchmarks used include:

- Maximum Allowable Cost (MAC)[46]
- AWP minus % (% is outlined in the contract). For example, a contract might state that a pharmacy will be reimbursed for a 30-day supply of a brand-name drug at AWP minus 23.5%.
- Usual and Customary Price (U&C) is the cash price paid at a retail pharmacy.
- Federal Upper Limit (FUL).[47]
- The National Average Drug Acquisition Cost (NADAC)[48]

For the contracts between PBMs and pharmacies that we reviewed, typically brand-name drugs were reimbursed at AWP minus a percentage (contracts are discussed further in Section III). Generic drugs had more variation in the reimbursement rates because the contracted reimbursement comes from multiple benchmarks – depending on which is lower at any given time. For example, a contract might state that generic drugs are reimbursed at AWP minus percentage or MAC price, whichever is less.

While some of these reimbursement rates for pharmacies are published and public, a PBM's MAC is not. For FFS, the DHS publishes the state MAC (SMAC) list on its website.[49,50] However, PBM MAC lists are considered proprietary and are not made public unless required by a state, and in Pennsylvania, there is no such requirement for PBMs to make MAC lists public. This pricing benchmark has caused concern among pharmacies. The National Academy for State Health Policy noted that "the methodology used to determine which drugs are included is often unclear.

[46] The MAC price is the maximum amount a PBM will reimburse a pharmacy for a particular drug.
[47] KFF defines FUL as: "a reimbursement limit for some generic drugs; calculated as 175% average manufacturer price." (Source: https://files.kff.org/attachment/Issue-Brief-Pricing-and-Payment-for-Medicaid-Prescription-Drugs)
[48] KFF defines NADAC as: "intended to be a national average of the prices at which pharmacies purchase a prescription drug from manufacturers or wholesalers, including some rebates." (Source: https://files.kff.org/attachment/Issue-Brief-Pricing-and-Payment-for-Medicaid-Prescription-Drugs)
[49] *State MAC List.* Pennsylvania Department of Human Services. https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/State-MAC-List.aspx. Accessed on September 13, 2022.
[50] Per DHS, While the MAC is not required to be publicly available, the DHS MCO Agreement requires that the MCO or PBM must report all changes to the payment methodology and rates, including but not limited to the MAC rates to network pharmacy providers.

Additionally, MAC lists may not be updated promptly, which could result in a pharmacy losing money each time a drug is dispensed at a lower cost if the PBM has increased the MAC."[51]

PBMs have a different opinion of MAC pricing. On CVS Health's website, they state:

> CVS Health regularly assesses aggregated information (not specific to any pharmacy) from drug wholesalers and third-party sources, including publicly available lists such as those published by Medicaid, CMS, and pharmacy feedback, to determine market pricing for generic drugs to establish our MAC pricing. Given the complex and dynamic nature of market pricing for generic drugs, the MAC will change throughout the year. We believe our MAC prices reflect current marketplace pricing and our best understanding of the marketplace and product availability.
>
> We believe our MAC process establishes a fair but competitive reimbursement price that incentivizes pharmacies to negotiate competitive acquisition costs, including volume discounts. Independently owned pharmacies in our network receive a fair and competitive reimbursement rate that is generally higher than the rate for national chain pharmacies in our network (including CVS Pharmacy). Sometimes, an individual pharmacy may be disproportionately impacted by a MAC pricing change. This can occur because the pharmacy has a higher than usual share of their business concentrated in one area, such as Medicaid, or has a history of high levels of dispensing for a particular drug or category of drugs. There are other factors that may influence generic pricing, such as supply and demand, so at CVS Caremark, we have invested in analytics to help us better predict trends and necessary adjustments.[52]

Express Scripts echoes similar sentiments on their website: "MAC lists are a common cost management tool that are developed from a review of information available from wholesalers, manufacturers, and nationally recognized drug pricing sources. Express Scripts updates its MAC list frequently to ensure it remains reflective of the current market dynamics."[53]

[51] *Legislative Approaches to Curbing Drug Costs Target at PBMs: 2017-2021*. National Academy for State Health Policy. https://www.nashp.org/pbm-laws-and-trends-over-time/. Accessed on September 13, 2022.
[52] *Our Maximum Allowable Cost (MAC) Pricing is a Commonly Used Tool to Manage Drug Costs*. CVS Health. https://www.cvshealth.com/news-and-insights/articles/our-maximum-allowable-cost-mac-pricing-is-a-commonly-used-tool-to-manage. Accessed September 12, 2022.
[53] *Mac Pricing Keeps Generics Affordable*. Express Scripts. https://www.express-scripts.com/corporate/articles/mac-pricing-keeps-generics-affordable. Access September 12, 2022.

Concerns with MAC pricing will be discussed in further detail later, but PBMs utilizing MAC pricing without oversight from DHS or MCOs is an acceptable practice in Pennsylvania today.

SECTION III
PBM REIMBURSEMENT TO CHAIN PHARMACIES VERSUS INDEPENDENT PHARMACIES

Fast Facts...

- *For Medical Assistance (MA) managed care prescription drugs, we received data for 36 million transactions in 2019 and 37 million in 2020.*
- *PA's Fee for Service program must pay a $10 dispensing fee; however, this requirement does not apply to managed care.*
- *Gabapentin was the most-filled prescription drug in the MA MCO program in 2019, and Albuterol Sulfate HFA was in 2020.*
- *The practice of spread pricing was banned by PA law starting in 2020.*

Overview

Section 449.1 of Act 2020-120 directs the Legislative Budget and Finance Committee (LBFC) to investigate and compare the reimbursement rates paid by pharmacy benefit managers (PBMs) to independent and chain pharmacies. To do this, we performed various tests on pharmaceutical benefit claims from the Managed Care Organization (MCO) and PBM levels to the pharmacy. We reviewed millions of transactions across two Medical Assistance (MA) program years and the contracts between PBMs and pharmacies. The claims we reviewed were from March 2019 and 2020.

Our analysis focused on two reimbursement areas:

1. Ingredient Cost: the reimbursement for the actual pharmaceutical drug.

2. Dispensing Fee: the payment for the pharmacy's costs to dispense the drug.

We found:

1. In the review of one sample month of 5 selected drug transactions across all 13 MA managed care plans, there were instances where the median ingredient cost reimbursement was equal among national chains and other pharmacies (regional chains and independents) and other instances where the median reimbursement "benefited" one over the other.

2. During our review of ingredient cost reimbursements for some plans, we saw different coding for maximum allowable cost (MAC) rates depending on the pharmacy type. While it did not impact the median reimbursement analysis, the lack of transparency regarding MAC pricing allowed for reasonable speculation.

3. In our review of one sample month, median dispensing fees varied greatly between MA managed care plans, and all were less than the $10 dispensing fee for the Fee for Service program during the same period.

4. In 11 of 13 MA managed care plans, we did not find evidence of spread pricing in March 2020.

5. In 2 out of 13 MA managed care plans, we found evidence of spread pricing in 2020; however, according to the MCOs, this was unintentional, and the issue has since been resolved.

6. Our review of a selected sample of pharmacy contracts with PBMs showed that contracted reimbursement rates varied between the different MA plans.

7. In our review of a selected sample of pharmacy contracts with PBMs, some PBMs were unwilling to provide their contracted rates, even though Act 2020-120 mandated that data deemed relevant must be provided to LBFC staff.

We recommend:

1. PBMs, MCOs, and/or PSAOs should ensure MAC reimbursement practices are transparent to pharmacies prior to claim adjudication.

2. The General Assembly should require the contracts between PBMs and pharmacies to be submitted to DHS and released to oversight organizations, e.g., the LBFC and the Auditor General, when conducting a study of the PBMs and/or pharmacies.

3. The General Assembly should require all pharmacies participating in the Pennsylvania managed care program to comply with any DHS request for information on pharmacy acquisition costs net of all discounts, rebates, chargebacks, and any other adjustments to the price of the drug, not including professional fees.

Issue Areas

A. Independent and Regional Chain Pharmacy Concerns

Pharmacies are critical in providing Pennsylvanians access to prescription medicines, professional expertise, and other services. This is especially true for Pennsylvania's Medical Assistance (MA) program and its enrollees. MA relies on a network of pharmacies to provide enrollees with life-saving and life-sustaining medicines. Although it utilized Medicare data (not Medicaid), a study by the University of Pittsburgh School of Pharmacy found that visits to community pharmacies were greater than visits

to Primary Care Physicians by a median difference of five to seven trips annually in Pennsylvania.[54]

Act 2020-120 required LBFC staff to compare reimbursement practices of PBMs to independent pharmacies versus chain pharmacies, and we made this comparison at times. However, throughout our analysis for this study, we found it helpful to view these questions using three subgroups of pharmacies:

(1) Independent pharmacies – locally owned pharmacies with one to three stores.[55]
(2) Regional chain pharmacies – regional pharmacies with multiple locations.[56]
(3) National chain pharmacies – pharmacies with locations across the country.[57]

We found this breakdown helpful as regional chain pharmacies and independent pharmacies expressed similar concerns – mainly that national chains received favorable treatment compared to regional chains and independent pharmacies.

Throughout this section, when we label data as independent pharmacies and chain pharmacies, this data utilized the coding completed by PBMs. Chain pharmacies, in these instances, included both national chains and regional chains. If the data is labeled as "national chain" pharmacies and "other" pharmacies, this is an area where we combined regional chains and independent pharmacies.

Independent and Regional Chain Pharmacies' Concerns Over Reimbursement Fairness. Many of the same concerns outlined in a 2018 Pennsylvania Department of the Auditor General (DAG) Special Report were conveyed to us throughout this study. One of the three major themes from the 2018 DAG report was concern over a potential "reimbursement disparity." The report stated, "independent pharmacists believe that PBMs are not paying fair prices to reimburse pharmacies for all the medications they dispense."[58] We found this same sentiment when talking with independent and regional chain pharmacies and their representatives.

[54] Berenbrok, Lucas, et al. *Evaluation of Frequency of Encounters with Primary Care Physicians vs. Visits to Community Pharmacies Among Medicare Beneficiaries.* July 2020. JAMA Network Open.
[55] *Prescription Drugs: The Number, Role, and Ownership of Pharmacy Services Administration Organizations*. The United States Government Accountability Office. January 2013. https://www.gao.gov/assets/gao-13-176.pdf. Accessed on October 24, 2022.
[56] These are mostly grocery stores with pharmacies in them, such as Giant Eagle or Weis Markets.
[57] There are pharmacies such as Walmart, CVS, Rite Aid, and Walgreens.
[58] *Bringing Transparency & Accountability to Drug Pricing: A special report on the role of pharmacy benefit managers by Pennsylvania Auditor General Eugene A. DePasquale.* Pennsylvania Department of the Auditor General. https://www.paauditor.gov/Media/Default/Reports/RPT_PBMs_FINAL.pdf. Accessed on October 24, 2022.

There were concerns that ingredient cost reimbursement rates created an unfair advantage for national chain pharmacies. Due to wholesale volume discounts, national chain pharmacies acquired prescription drugs at a lower rate than regional chain pharmacies and independent pharmacies. According to those we spoke to, PBMs also rewarded chain pharmacies with higher reimbursement rates because of the volume of business they brought to PBMs. Exhibit 7 is a hypothetical example to explain these disparity concerns of independent and regional chain pharmacies.

Exhibit 7

Hypothetical Example to Highlight Reimbursement Disparity Concerns of Independent and Regional Chain Pharmacies

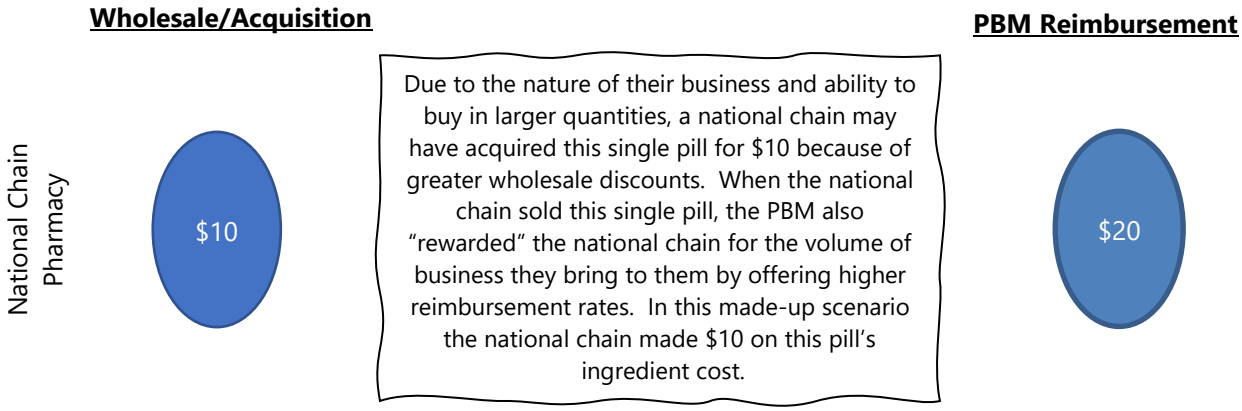
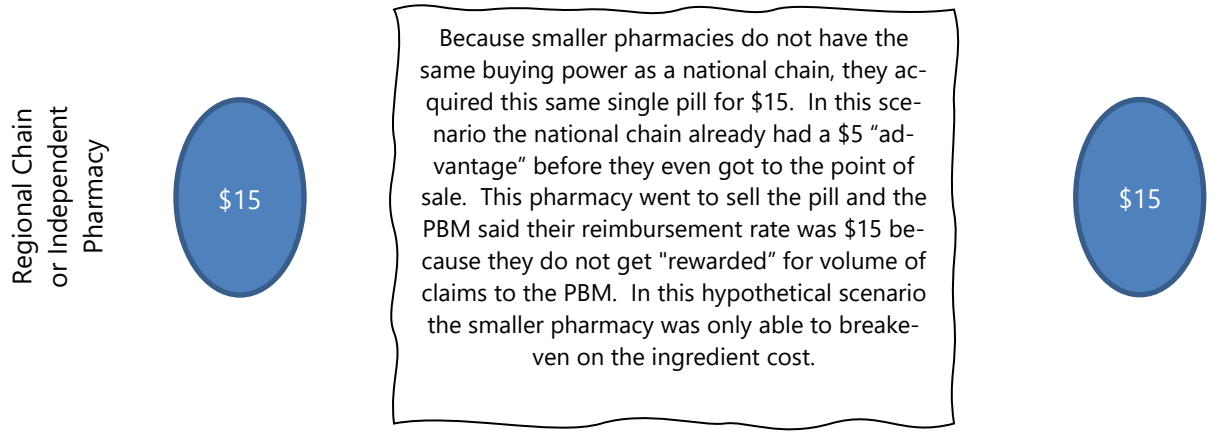


Exhibit 7 Continued



Note: This is a hypothetical example created from discussions with independent and regional chain pharmacies. This was not a confirmed scenario by LBFC.

Source: Developed by LBFC staff.

There were also concerns over contracted reimbursement rates, especially the Maximum Allowable Costs (MAC) that some PBMs paid. Independent pharmacies and regional chains shared their concerns that there was a lack of transparency in how PBMs set their MAC rates and that different MAC lists exist for national chains, regional chains, and independent pharmacies.

Dispensing Fees. There were also concerns over dispensing fees. Kaiser Family Foundation states, "The dispensing fee is intended to cover reasonable costs associated with providing the drug to a Medicaid beneficiary. This cost includes the pharmacist's services, the overhead associated with maintaining the facility, and the equipment necessary to operate the pharmacy."[59] While the ingredient cost is intended to cover the actual cost of the pharmaceutical drug, the dispensing fee is to cover costs associated with dispensing that drug.[60] According to the independent pharmacies we spoke with (or their representatives), the dispensing fees paid in managed care were insufficient to cover the costs of dispensing these drugs. They also stated that over time these dispensing fees

[59] Dolan, Rachel, and Marina Tian. *Pricing and Payment for Medicaid Prescription Drugs*. Kaiser Family Foundation. Jan 2020. https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/. Accessed on September 13, 2022.

[60] There are also other payments to a pharmacy such as copayments and third-party liability. However, we did not review copayments (or the enrollees cost share) as those are determined by CMS (sets maximums), and DHS/Commonwealth regulations, which would be subtracted from ingredient cost. We also did not review third party liability amounts. These amounts are the contribution of another insurer or party. Note, MA is the last payer on a claim.

decreased in their contracts with PBMs, while at the same time, the cost of labor and overhead increased.

There is no consensus on the appropriate dispensing fee rate. During our review period, the Commonwealth's Fee for Service (FFS) program paid $10.00. In 2017, DHS commissioned a study of Pennsylvania to "capture expenses incurred by the pharmacies to dispense a prescription to FFS beneficiary."[61] The study concluded that $7.00 was an appropriate dispensing fee; however, CMS rejected this as too low.[62] The CMS requirements for FFS do not apply to managed care plans; therefore, the PBMs determine the dispensing fees.

A national study released in 2020 (note: this was paid for by organizations representing pharmacies[63]) concluded that in 2018: "The mean overall cost of dispensing per prescription was $12.40. Payroll costs were the biggest drivers of the overall cost, accounting for roughly 58% of the overall cost of dispensing ($7.22 out of the $12.40)."[64] Conversely, the Pharmaceutical Care Management Association claims research shows that "paying pharmacies more for dispensing medications will raise prescription drug costs without improving value."[65]

Spread Pricing. There was also a common concern over the practice of spread pricing. This occurred when the amount MCOs paid PBMs was higher than what the PBMs paid the pharmacies. While this issue is not necessarily related to whether independents/regional chains were reimbursed at a different rate than chain pharmacies, we were able to test this in the same transaction data.

[61] *Medical Assistance Bulletin: Payment for Covered Outpatient Drugs – Pharmacy Services*. (# 99-17-09). Pennsylvania Department of Human Services. Jun 2017. https://www.dhs.pa.gov/providers/Pharmacy-Services/Documents/Payment%20for%20Covered%20Outpatient%20Drugs%20MAB%2020170630.pdf. Accessed on October 24, 2022.
[62] According to DHS, CMS expressed concerns that $7.00 was lower than neighboring states. DHS reconsidered and revised the State Plan Amendment that was being considered by CMS.
[63] The study was paid for by National Association of Chain Drug Stores, National Association of Specialty Pharmacy, and National Community Pharmacists Association.
[64] *National Cost of Dispensing Study*, Q&A. National Association of Chain Drug Stores. 2018. https://www.nacds.org/pdfs/government/2018_COD_QA.pdf. Accessed on October 24, 2022.
[65] *Mandating Pharmacy Reimbursement Will Increase Prescription Drug Spending*. Pharmaceutical Care Management Association. August 2021. https://www.pcmanet.org/mandating-pharmacy-reimbursement-increase-spending/#. Accessed on October 24, 2022.

B. Transaction Data Analysis

As required by Act 2020-120, Section 449.1(c), the MCOs, through DHS, provided the following transaction data:

- The amount paid to a pharmacy provider per claim, including ingredient cost and the amount of any copayment deducted from the payment.
- The transmission fees charged by a PBM to a pharmacy provider.
- The amount charged by the PBM to the MCO per claim, including all administrative fees and processing charges associated with the claim.

We received data for nine MCOs and six PBMs,[66] covering thirteen plans for calendar years 2019 and 2020. Exhibit 8 contains the total number of transactions we received.

Exhibit 8

Total Number of MA Managed Care Pharmaceutical Transactions Received

2019	2020
36,281,462	37,391,684

Source: Developed by LBFC staff from information provided by MCOs and PBMs.

We first tested the data's reliability. To do this, we used the Association of International Certified Professional Accountants (AICPA) standards for a non-statistical judgmental sample which states that 60 is an appropriate selection size for a large population of data with high risk. We considered there to be an increased risk of error simply because of the high volume of claims. We decided on ten transactions per plan per year, totaling 130 transactions per year and 260 transactions across our review period.

[66] As of December 2020, there were 5 PBMs contracted with MCOs in Pennsylvania, due to a MCO switching to a different PBM.

To determine which transactions to review, we selected five prescription drugs to focus on – three generic drugs and two brand name drugs, as shown in Exhibit 9.

Exhibit 9

Testing Selection Explanation

To answer Objective 4 (reimbursement practices to independent pharmacies compared to chain pharmacies): For each MA plan, we planned to compare a similar transaction for the same drug at an independent pharmacy with one at a chain pharmacy under the same plan.

Independent Pharmacy Transaction	Comparison	Chain Pharmacy Transaction
Generic #1	⟷	Generic #1
Generic #2	⟷	Generic #2
Generic #3	⟷	Generic #3
Brand #1	⟷	Brand #1
Brand #2	⟷	Brand #2

Source: Developed by LBFC staff.

Due to the volatility of drug prices in the generic market, we narrowed the selection to one month by utilizing a random number generator, which selected the month of March.

Generic Drug Selection. To select generic drugs, we requested a list of the ten most filled drugs in the MA program for 2019 and 2020. Because the most common medications utilized in the MA program are generic, the top 10 were all generic. DHS provided the list shown below in Exhibit 10.

Exhibit 10

Pennsylvania MA Top 10 Generic Drugs by Script Count (2019 and 2020)

2019		2020	
Drug Name	**Paid Scripts**	**Drug Name**	**Paid Scripts**
Gabapentin	797,279	Albuterol Sulfate HFA	811,139
Atorvastatin Calcium	621,895	Gabapentin	790,851
Ibuprofen	579,383	Atorvastatin Calcium	598,408
Albuterol Sulfate HFA	545,855	Omeprazole	573,731
Lisinopril	539,986	Ibuprofen	516,174

Exhibit 10 Continued

2019		2020	
Drug Name	**Paid Scripts**	**Drug Name**	**Paid Scripts**
Omeprazole	527,725	Lisinopril	494,835
Amoxicillin	514,201	Fluticasone Propionate	450,333
Fluticasone Propionate	481,171	Buprenorphine Hydrochloride	446,406
Amlodipine Besylate	436,517	Cetirizine Hydrochloride	420,939
Levothyroxine Sodium	429,482	Amlodipine Besylate	417,082

Source: Developed by LBFC staff from information provided by DHS.

For two of the three generics in our testing selection, we selected the most often filled in 2019: Gabapentin and 2020: Albuterol Sulfate HFA. To pick the third generic drug, we asked representatives of the independent pharmacy community which generic drugs they found particularly concerning regarding PBM reimbursement. They suggested we look at the work done by 46brooklyn Research,[67] which included a state-by-state analysis that they referred to as "Medicaid Markup Universe." According to 46brooklyn, this dataset represented their estimate of a drug's "markup" by comparing CMS' state utilization data with CMS' National Average Drug Acquisition Cost (NADAC)[68] data with a lag effect calculated for NADAC.[69] We sorted by selecting Pennsylvania, managed care, and quarter one (since our randomly selected month was in the first quarter). We ultimately chose Buprenorphine-Naloxone because, according to 46brooklyn's data, it had one of the highest markups per script ($48.98) for those with more than 10,000 scripts filled (37,128 filled) in the Pennsylvania Medical Assistance program in 2019.

Since we could not guarantee that we could find a transaction for all three selected drugs for every MA plan for both an independent pharmacy and a chain pharmacy, we selected two "backup" drugs. We chose Ibuprofen and Atorvastatin as the backup generic drugs because they were within the top three medications by script in the MA program in 2019 and 2020.

[67] According to their website, "46brooklyn Research is an Ohio non-profit corporation whose purpose is to improve the accessibility and useability of U.S. pricing data." (Source: 46brooklyn.com)
[68] See Section II for an explanation of pricing.
[69] *Visualize "Markup" On Medicaid Generic Drugs*. 46brooklyn Research. https://www.46brooklyn.com/markup-universe. Accessed on June 3, 2022.

Brand Name Drug Selection. To select brand-name drugs, we requested the drugs on which DHS spent the most. The top drugs by spend in the MA program for 2019 and 2020 (not ranked):

- Lantus Solostar
- Trulicity Solution
- Biktarvy Tablets
- Januvia Tablets
- Spiriva Respimat Inhaler
- Flovent HFA Inhaler
- Symbicort Inhaler
- Eliquis Tablets
- Vimpat Tablets
- Jardiance Tablets

We selected Lantus Solostar (insulin for treating diabetes) and Biktarvy Tablets (for treating HIV/AIDS). We found pricing concerns with insulin and HIV treatments throughout interviews with stakeholders and our research. We also selected Eliquis and Vimpat as backup drugs. Exhibit 11 shows our final selections for our data reliability review of transactions.

Exhibit 11

Selected Drugs for Testing

Generic	Brand Name
1. Albuterol Sulfate HFA	1. Lantus Solostar
2. Gabapentin	2. Biktarvy
3. Buprenorphine-Naloxone	
Backup Selections	Backup Selections
4. Ibuprofen	3. Eliquis
5. Atorvastatin	4. Vimpat

Source: Developed by LBFC staff from information provided by DHS.

Pharmacy Information Requests. After determining which transactions to select, we sorted the data by drug. We attempted to find transactions with the same or similar National Drug Code (NDC), quantity, basis of payment, and dispensing date. We then found two transactions for each selected drug as similar as possible: one for an independent pharmacy and one for a chain pharmacy.[70] If there were multiple transactions to pick from, we utilized a random number generator to select the specific pharmacy/transaction.

[70] Note: A pharmacy was coded independent or chain by the PBMs in the data. For our own analysis, later we utilized our own system of coding.

After we selected 260 total transactions, we requested transaction information from the pharmacies. To get contact information for the pharmacies in our selection, we utilized the National Provider Identifier (NPI) in the data on the National Plan and Provider Enumeration System (NPPES) online to look up mailing addresses.[71] Additionally, trade organizations representing pharmacies were very helpful in providing email addresses and other contact information when possible. For chains/retailers, we worked through their government affairs representatives to request the information. Every pharmacy, regardless of type, was mailed a copy of the request to the mailing address for the specific store. We also emailed a copy to independent pharmacies for which we had an email address. For national and regional chains, we emailed their corporate contacts with a compiled list (or their government affairs representatives were asked to forward the information to the correct corporate contact).

In the requests to the pharmacies, we asked for the following:

1. Adjudicated claim transaction: total dollar amount authorized by the PBM, ingredient cost paid, dispensing fee paid, and copay amount to be collected. A screenshot showing the requested transaction fields (highlighted or circled) would be sufficient. (With all patient identifying information redacted).
2. A copy of their wholesaler invoice showing the cost to purchase the medication. In addition, any discounts or rebates that were applied to that invoice.

In the request, we provided Pharmacy NPI, Internal Control Number (ICN), Date Dispensed, NDC, drug description, quantity, and MCO name from the data we received from DHS and the MCOs.

Of the 130 transactions requested for 2019, we received information for 43 (32 independent and 11 chain pharmacies transactions), or 32.3 percent of the requested transactions. Of the 130 transactions requested for 2020, we received information for 45 (31 independent and 14 chain pharmacy transactions), or 34.6 percent of the requested transactions.

Of the chains that responded, regional chains were the only chain pharmacies to respond to our request by providing data. National chains, with one exception, did not provide the requested information. The largest retailer in the world, which has pharmacies in its stores, was the only national chain that submitted data. The other national pharmacy chains refused to provide the information or did not respond to our multiple correspondences.

For the transactions in which we received the requested information from the pharmacies, we found no discrepancies between PBM-provided data

[71] *Search NPI Records*. NPPES NPI Registry. https://npiregistry.cms.hhs.gov/search

and actual receipts from the pharmacy. To complete the rest of our analysis with the data, we relied on the data being reliable and complete as it was given to us.

We planned to analyze the acquisition data; however, we could not without the national chains cooperating by providing their information. It is well documented[72,73,74] that national chains have lower acquisition costs than independent and regional chains; however, the extent to which this is the case in Pennsylvania could not be measured without the data. The impact of acquisition costs is an area that DHS should further explore. DHS relayed to us and publicly stated that obtaining this acquisition cost information has been difficult.[75] We believe this is an area where the General Assembly should further expand to require the release of acquisition cost information (net of discounts, rebates, etc.) to give a clearer picture of pricing at all levels of the pharmaceutical supply chain in the MA managed care program.

Results of Full March Analysis. Because the 260 transactions were not a statistically significant number for the data population to analyze actual reimbursement between chain pharmacies and other pharmacies (we define "other" as regional chains or independent pharmacies), we expanded our review to all of March 2019 and 2020. Exhibit 12 contains the total number of transactions received for March.

Exhibit 12

Total Number of March Transactions Received

2019	2020
3,170,614 or 8.7% of total claims	4,505,898 or 12.1% of total claims

Source: Developed by LBFC staff from information provided by MCOs and PBMs.

From the March datasets, we filtered out our five selected drugs: Albuterol Sulfate HFA, Gabapentin, Buprenorphine-Naloxone, Lantus Solostar, and Biktarvy. To control for variations in quantities, we filtered by the

[72] *Follow the Pill: Understanding the U.S. Commercial Pharmaceutical Supply Chain.* Kaiser Family Foundation. March 2005.
[73] *Prescription Drug Pricing in the Private Sector*. United States Congressional Budget Office. January 2007.
[74] Seeley, Elizabeth, and Surya Singh. *Competition, Consolidation, and Evolution in the Pharmacy Market: Implications for Efforts to Contain Drug Prices and Spending*. The Commonwealth Fund. August 2021. https://www.commonwealthfund.org/publications/issue-briefs/2021/aug/competition-consolidation-evolution-pharmacy-market. Accessed on November 16, 2022.
[75] *Department of Human Services Statement*. Pennsylvania Senate Health and Human Service Committee Hearing - June 22, 2020. https://health.pasenategop.com/062220/

most filled quantity for each plan. We then coded national chain pharmacies as "national chains" and all other pharmacies (independent and regional chain pharmacies) as "others."

We conducted a median analysis for each plan and drug by calculating the median reimbursement for pharmacies coded as national chains and pharmacies coded as others.[76] The results are reflected in Exhibits 13 through 17 that follow. The percent indicates the pharmacy type reimbursed at the higher median rate between national chains and others. We calculated the percent difference based on the higher of the two, with the lower number always as the denominator. Equal signs indicate that the median reimbursement rate was the same for national chains as other pharmacies.

For example, in 2019, Plan 1 MCO's PBM reimbursed National Chains and Others the same amount for Albuterol Sulfate HFA ingredient costs. However, in 2020, the PBM reimbursed National Chains 26.5 percent more.

Exhibit 13

Ingredient Cost Payment Comparison
Albuterol Sulfate HFA

MCO Plan	Pharmacy Type	2019	2020
1	National Chains Others	=	+26.5%
2	National Chains Others	+7.1%	+6.9%
3	National Chains Others	=	+35.9%
4	National Chains Others	=	=
5	National Chains Others	+40.0%	+36.8%
6	National Chains Others	+23.4%	=
7	National Chains Others	=	=

[76] We used median to control for pricing outliers we were concerned would dominate the average. This is how the federal government utilizes median household income versus average household income as outliers can blur the true picture of what is the central number.

Exhibit 13 Continued

MCO Plan	Pharmacy Type	2019	2020
8	National Chains Others	+14.2%	=
9	National Chains Others	+3.4%	=
10	National Chains Others	=	=
11	National Chains Others	=	+20.0%
12	National Chains Others	=	=
13	National Chains Others	+36.5%	+35.4%

Source: Developed by LBFC staff from information provided by MCOs.

Exhibit 14

Ingredient Cost Payment Comparison
Gabapentin

MCO Plan	Pharmacy Type	2019	2020
1	National Chains Others	=	+65.7%
2	National Chains Others	+77.7%	=
3	National Chains Others	+38.3%	=
4	National Chains Others	+5.7%	=
5	National Chains Others	+33.5%	+49.6%
6	National Chains Others	=	+0.8%
7	National Chains Others	=	=
8	National Chains Others	+5.7%	=
9	National Chains Others	+11.2%	+2.1%
10	National Chains Others	=	+59.9%

Exhibit 14 Continued

MCO Plan	Pharmacy Type	2019	2020
11	National Chains Others	+97.1%	+97.3%
12	National Chains Others	=	=
13	National Chains Others	+79.3%	=

Source: Developed by LBFC staff from information provided by MCOs.

Exhibit 15

Ingredient Cost Payment Comparison Buprenorphine-Naloxone

MCO Plan	Pharmacy Type	2019	2020
1	National Chains Others	N/A	+127.7%
2	National Chains Others	=	=
3	National Chains Others	N/A	N/A
4	National Chains Others	=	=
5	National Chains Others	+60.4%	+82.0%
6	National Chains Others	=	+4.6%
7	National Chains Others	=	+8.5%
8	National Chains Others	=	=
9	National Chains Others	+114.6%	=
10	National Chains Others	N/A	N/A
11	National Chains Others	+16.5%	=

Exhibit 15 Continued

MCO Plan	Pharmacy Type	2019	2020
12	National Chains Others	=	=
13	National Chains Others	+128.7%	=

Notes:
N/A – Insufficient data to complete comparison. There were either no national chains or no others that filled this prescription during March.

Source: Developed by LBFC staff from information provided by MCOs.

Exhibit 16

Ingredient Cost Payment Comparison
Lantus Solostar

MCO Plan	Pharmacy Type	2019	2020
1	National Chains Others	=	=
2	National Chains Others	+0.3%	+0.4%
3	National Chains Others	+3.2%	+1.0%
4	National Chains Others	N/A	+0.6%
5	National Chains Others	=	+0.5%
6	National Chains Others	+0.3%	=
7	National Chains Others	+0.6%	+0.6%
8	National Chains Others	+10.4%	+0.6%
9	National Chains Others	+3.2%	=

Exhibit 16 Continued

MCO Plan	Pharmacy Type	2019	2020
10	National Chains Others	N/A	+0.6%
11	National Chains Others	+0.6%	+0.6%
12	National Chains Others	+0.6%	+0.6%
13	National Chains Others	+3.9%	+1.0%

Notes:
N/A – Insufficient data to complete comparison. There were either no national chains or no others that filled this prescription during March.

Source: Developed by LBFC staff from information provided by MCOs.

Exhibit 17

Ingredient Cost Payment Comparison
Biktarvy

MCO Plan	Pharmacy Type	2019	2020
1	National Chains Others	=	+0.4%
2	National Chains Others	+4.0%	+0.4%
3	National Chains Others	+1.4%	+0.2%
4	National Chains Others	+4.3%	+0.6%
5	National Chains Others	+8.7%	+14.0%
6	National Chains Others	+0.7%	+0.2%
7	National Chains Others	=	+0.6%
8	National Chains Others	+2.3%	+0.9%
9	National Chains Others	+0.1%	=
10	National Chains Others	+4.3%	+0.2%

Exhibit 17 Continued

MCO Plan	Pharmacy Type	2019	2020
11	National Chains Others	+0.8%	+2.2%
12	National Chains Others	=	+0.6%
13	National Chains Others	+1.4%	+0.2%

Source: Developed by LBFC staff from information provided by MCOs.

Overall, across all 13 plans, there were instances where the median ingredient cost reimbursement was equal among national chains and others and other cases in which the median reimbursement "benefited" one over the other. We could not draw any conclusions from the sample selection for the entire managed care system because there were no common themes.

While we found that not all plans utilized MAC pricing, we did see evidence of different MAC reimbursement coding between national chains and others.[77] This did not impact the median reimbursement rates, but we could see how that would lead to speculation about why there is not one MAC reimbursement rate for all pharmacies. According to one of the provider manuals for a PBM we were given access to, the PBM states that pharmacies have access to MAC pricing via the PBM's pharmacy portal and appeals process. Because this document was confidential and proprietary, we could not share this specific information with the pharmacies we spoke to; however, pharmacies with these concerns should investigate this with their contracted PBMs and/or PSAOs.

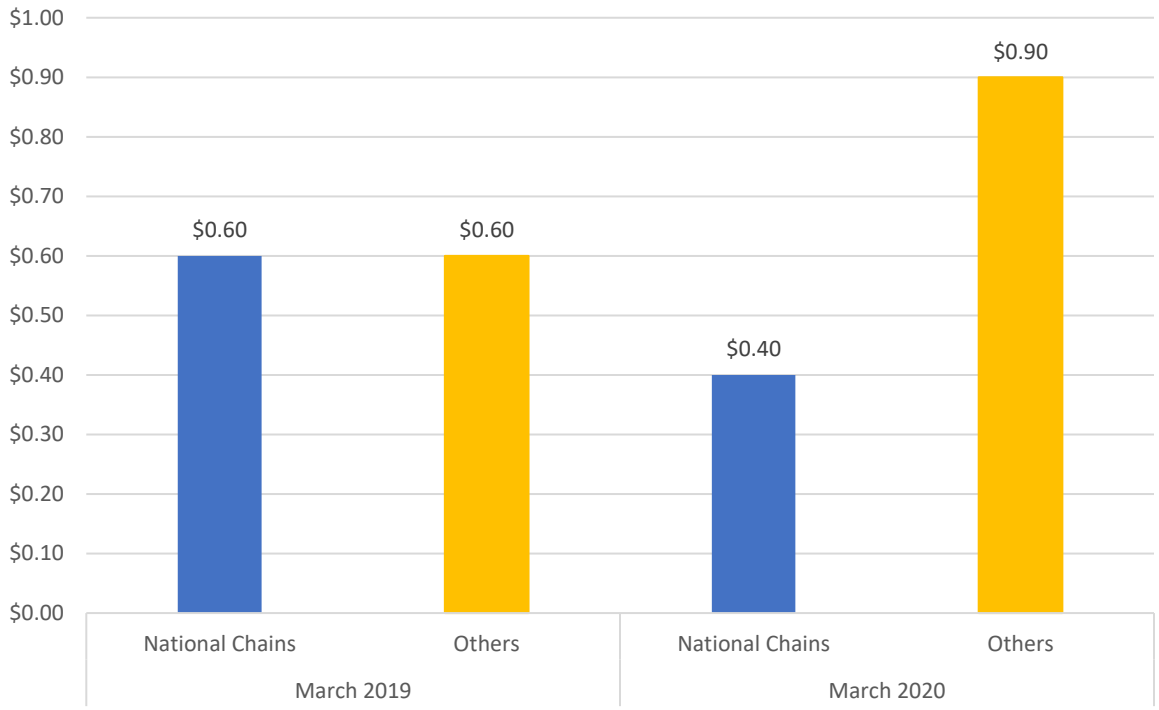
Dispensing Fee Analysis. We performed the same median analysis for dispensing fees. However, we expanded our analysis to include all March data (regardless of the filled medication) because, with few exceptions, the drug filled does not determine the dispensing fee.[78] We again grouped national chains together and all other pharmacies together (regional chains and independent pharmacies). The results are presented in Exhibits 18 through 30, with an analysis of each plan following the related exhibit.

[77] See Section II for further explanation of pricing.

[78] Note: we again utilized median instead of average to control for outliers. Some plans have different dispensing fees for generic and brand name drugs, and/or a lower dispensing fee for larger quantity prescriptions. For these reasons, we determined that median was the best test to compare dispensing fees across all plans for March 2019 and 2020 without the skewing caused by outliers.

Exhibit 18

Plan 1
Median Dispensing Fee



Source: Developed by LBFC staff from information provided by MCOs.

In Plan 1, national chains and other pharmacies had the same median dispensing fee in 2019. In 2020, national chains saw a decrease in the median dispensing fee, whereas other pharmacies saw an increase in the median.

Exhibit 19

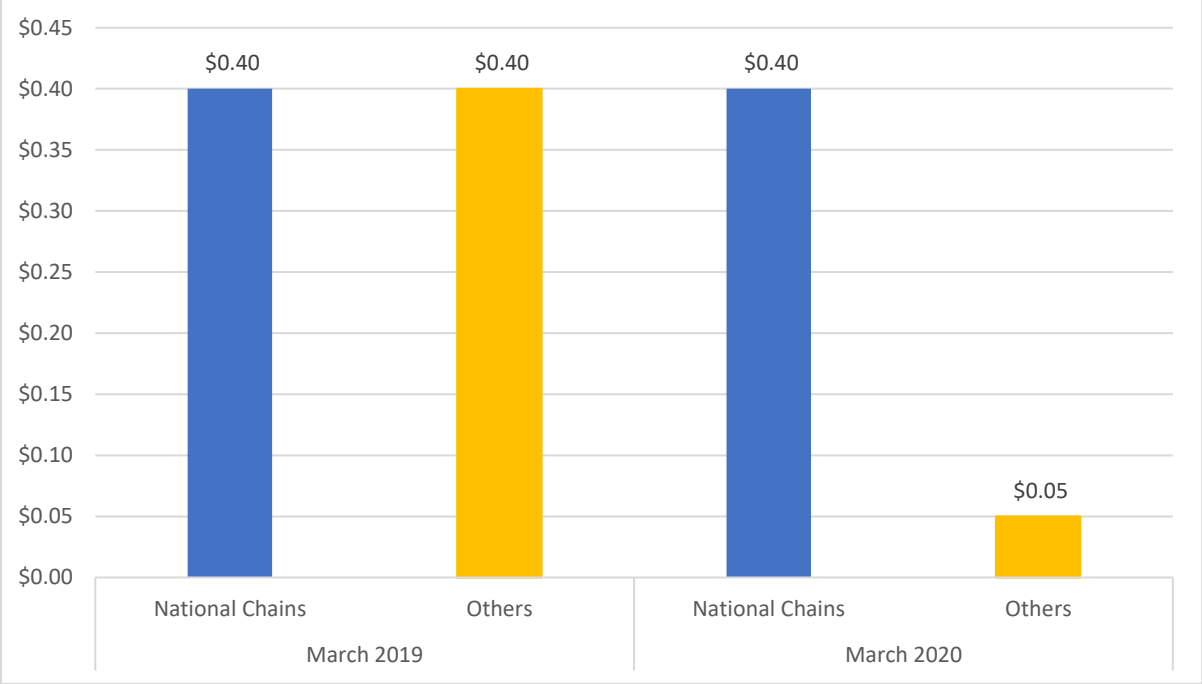
Plan 2
Median Dispensing Fee

Source: Developed by LBFC staff from information provided by MCOs.

In Plan 2, the median 2019 dispensing fee was the same between national chains and other pharmacies. In 2020, national chains and other pharmacies' median dispensing fees decreased. However, national chains had a higher median dispensing fee.

Exhibit 20

Plan 3
Median Dispensing Fee

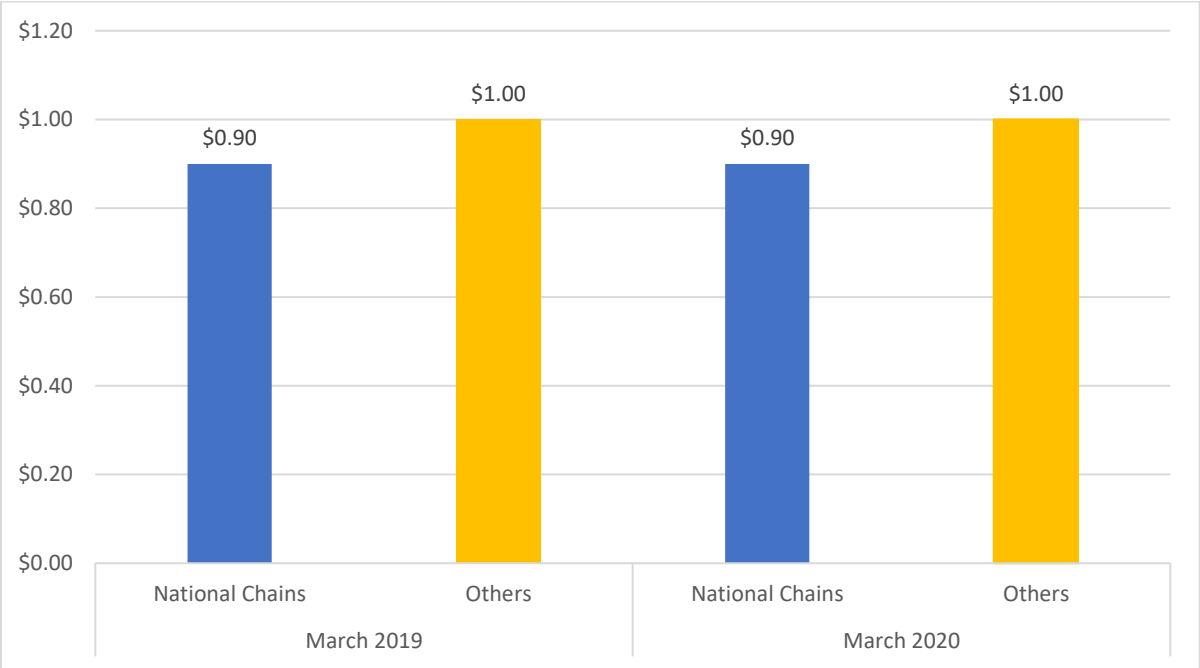


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 3, the median 2019 dispensing fee was the same among national chains and other pharmacies. In 2020 the national chains median fee remained the same; however, the other pharmacies received a decrease in the median fee to 5 cents (the lowest median dispensing fee we saw in our analysis).

Exhibit 21

Plan 4
Median Dispensing Fee

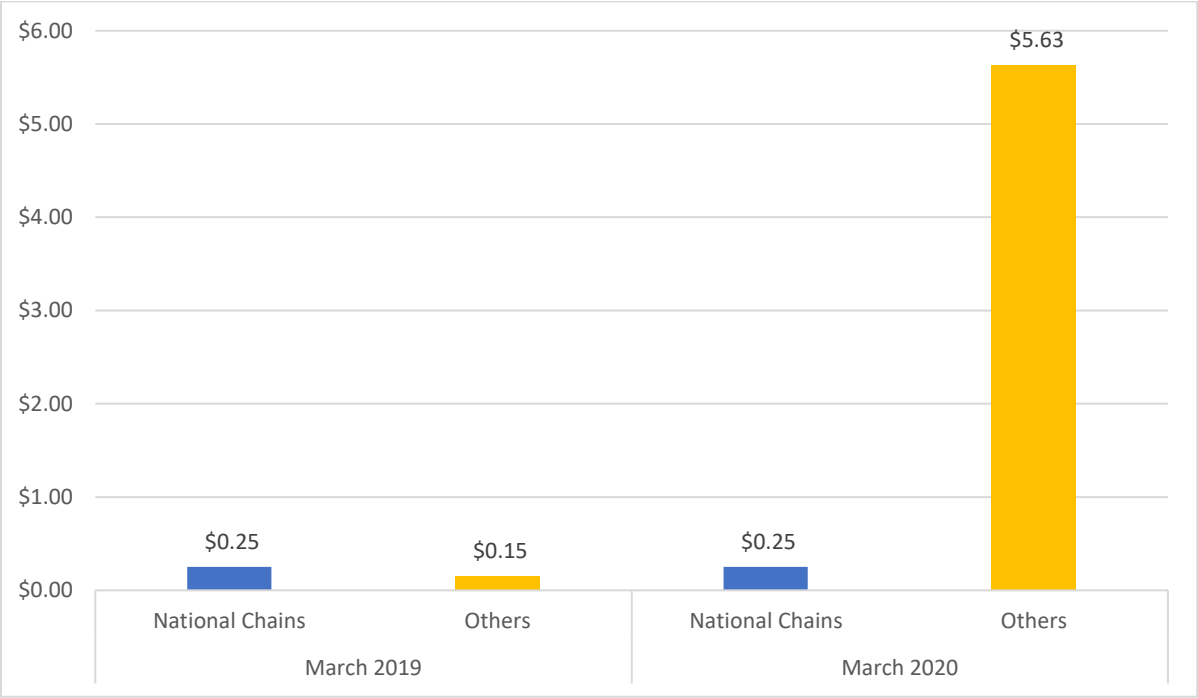


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 4, other pharmacies had a higher median dispensing fee in 2019 and 2020. There were no changes between 2019 and 2020 in the actual median fee.

Exhibit 22

Plan 5
Median Dispensing Fee

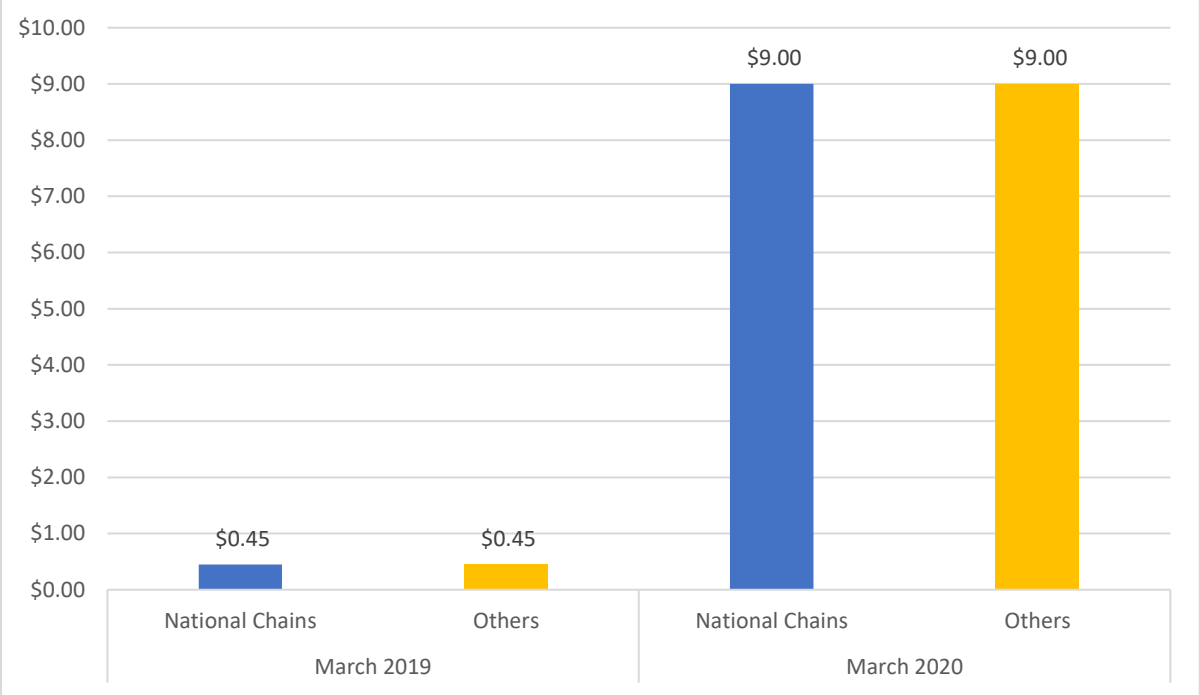


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 5, national chains had a slightly higher median dispensing fee, which remained unchanged in 2020, whereas other pharmacies had a significant increase (and higher median fee) in 2020.

Exhibit 23

Plan 6
Median Dispensing Fee

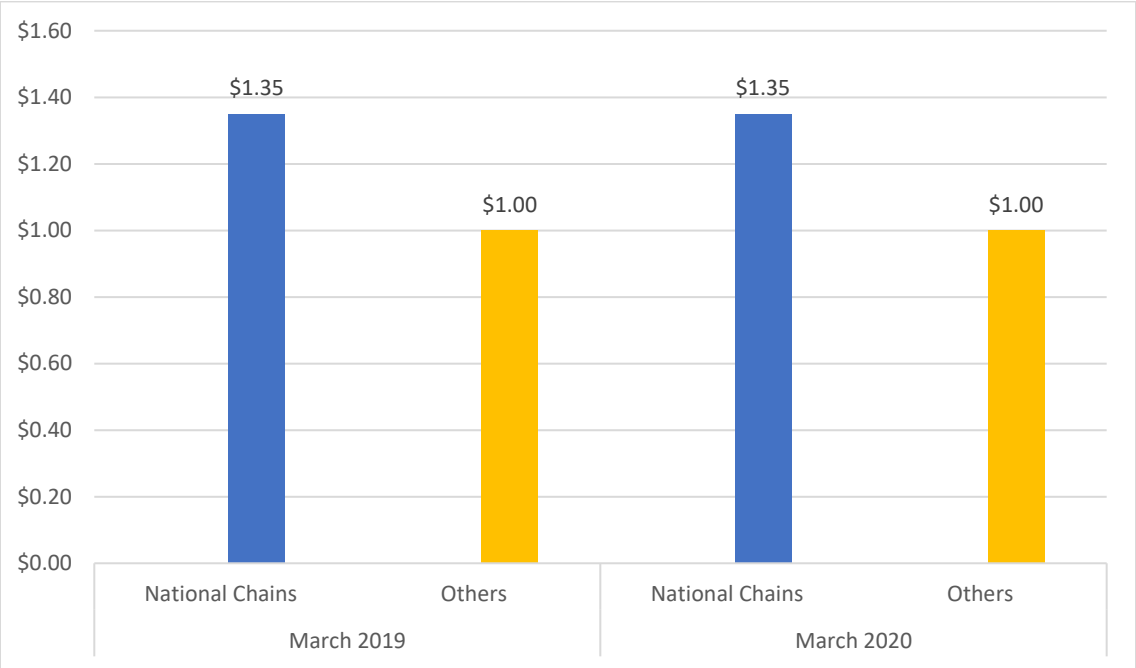


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 6, national chains and other pharmacies had the same median dispensing fee in 2019, and both saw the same (significant) increase in 2020.

Exhibit 24

Plan 7
Median Dispensing Fee

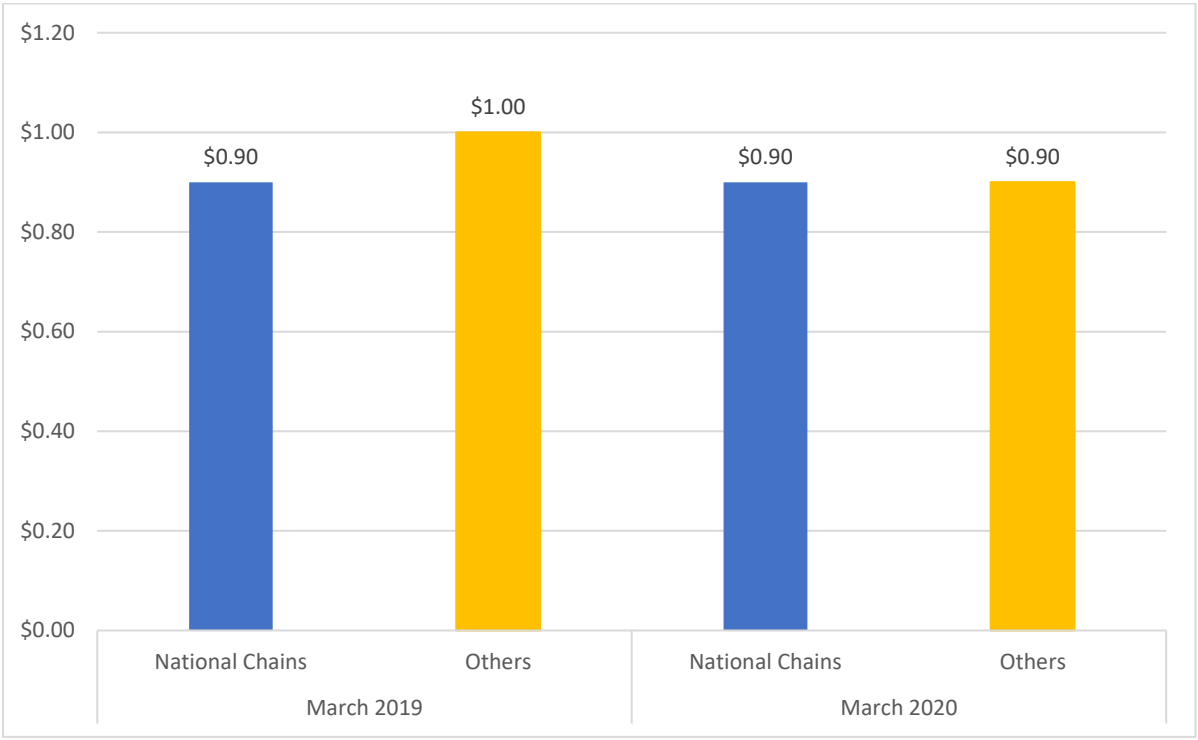


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 7, national chains had a higher median dispensing fee in 2019, which was unchanged in 2020. Other pharmacies had the same median dispensing fee in 2019 and 2020.

Exhibit 25

Plan 8
Median Dispensing Fee

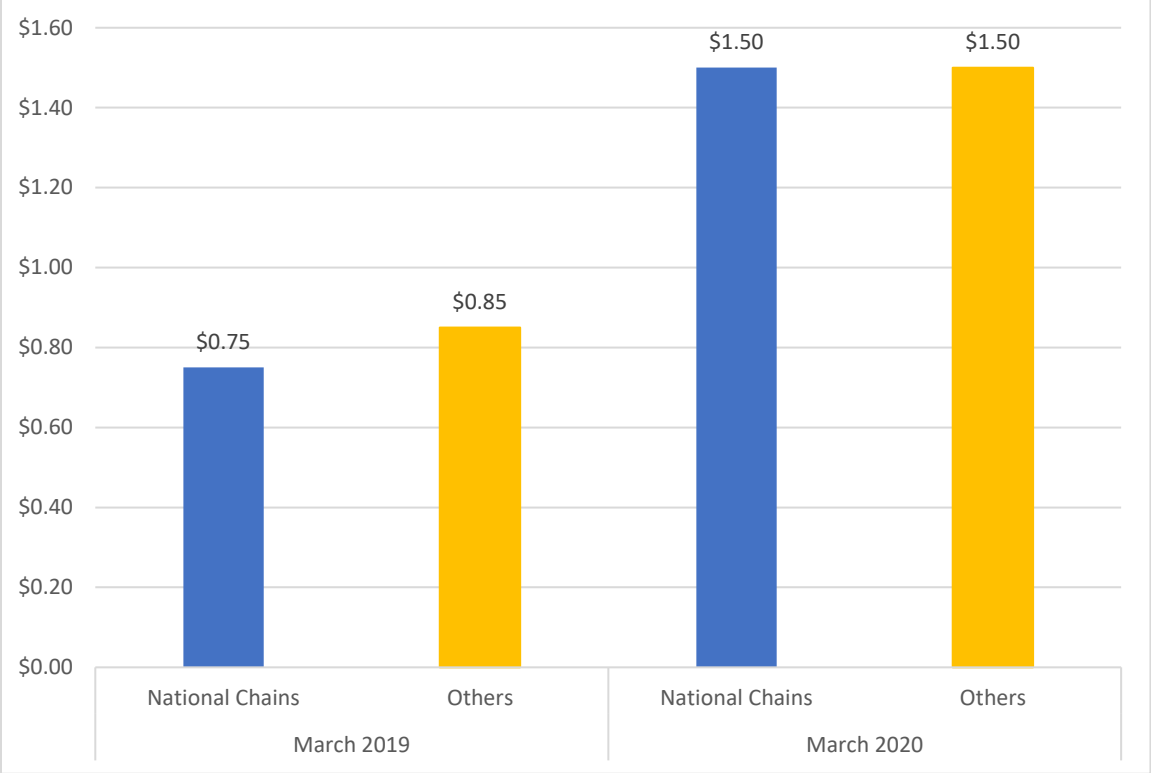


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 8, other pharmacies had a slightly higher median dispensing fee in 2019. In 2020, national chain and other median dispensing fees were equal, meaning there was a decrease in median dispensing fees for other pharmacies.

Exhibit 26

Plan 9
Median Dispensing Fee

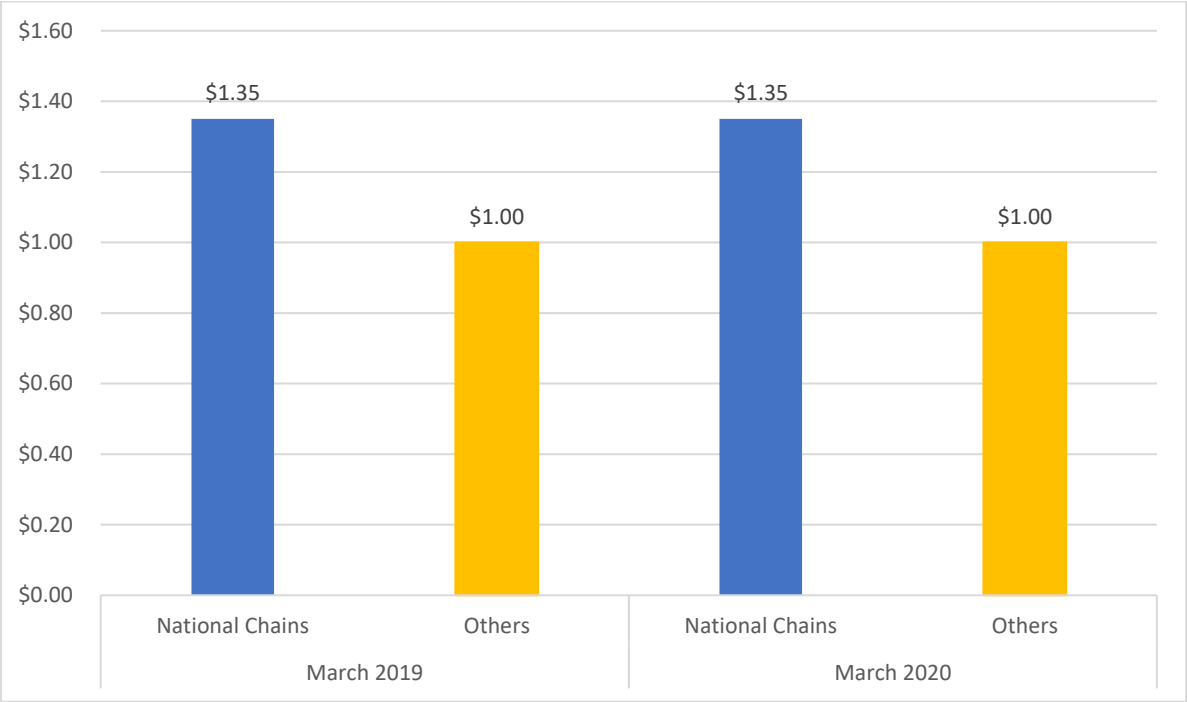


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 9, other pharmacies had a higher median dispensing fee in 2019. In 2020, national chains and others increased to the same median dispensing fee.

Exhibit 27

Plan 10
Median Dispensing Fee

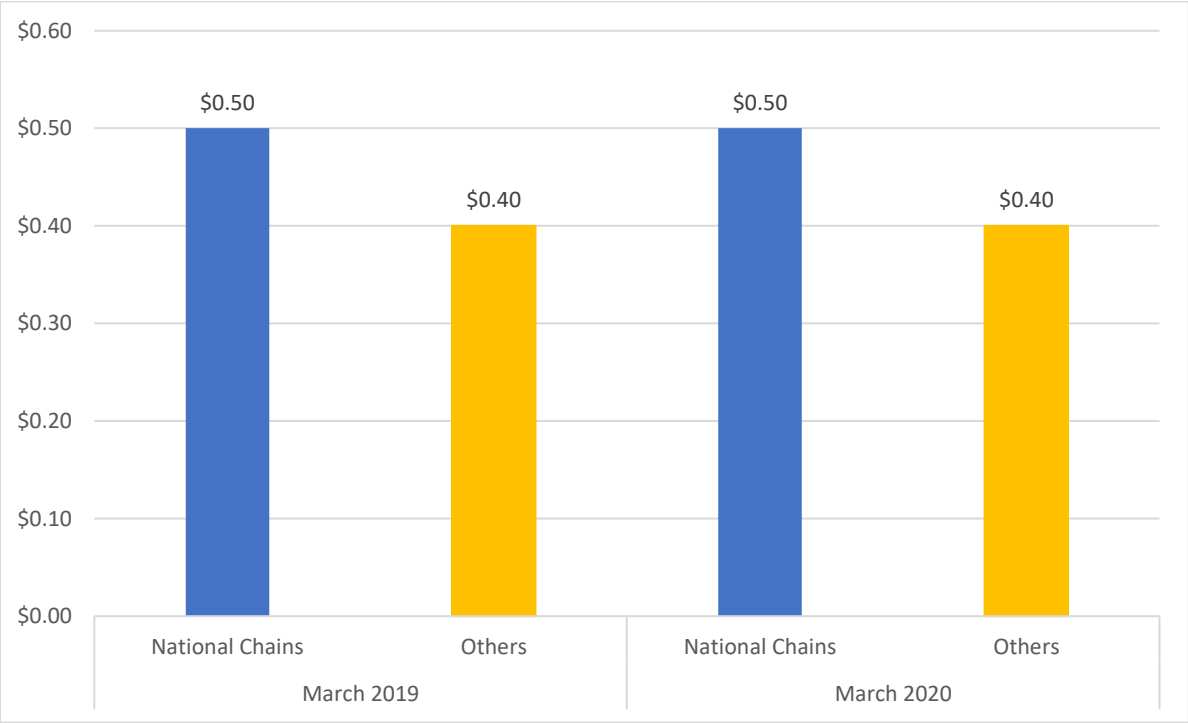


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 10, the median dispensing fee was higher for national chain pharmacies, and there was no change between 2019 and 2020.

Exhibit 28

Plan 11
Median Dispensing Fee

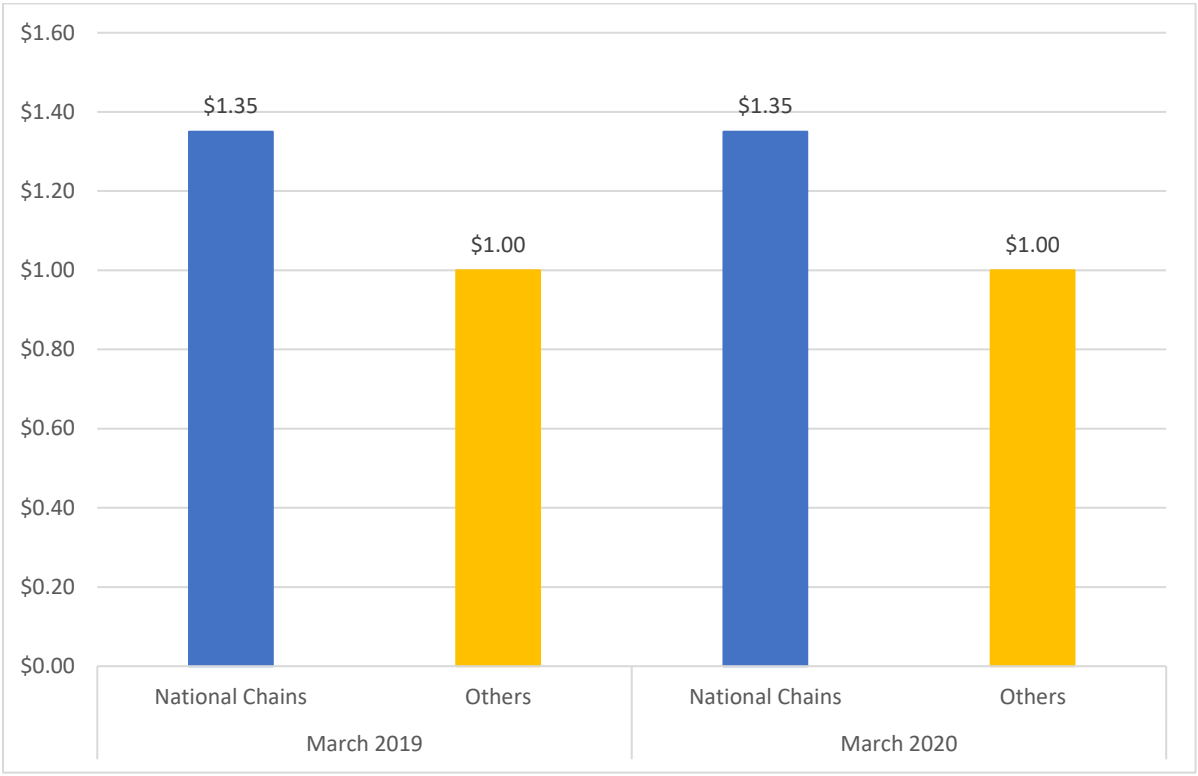


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 11, the median dispensing fee was higher for national chain pharmacies, and there was no change in fees between 2019 and 2020.

Exhibit 29

Plan 12
Median Dispensing Fee

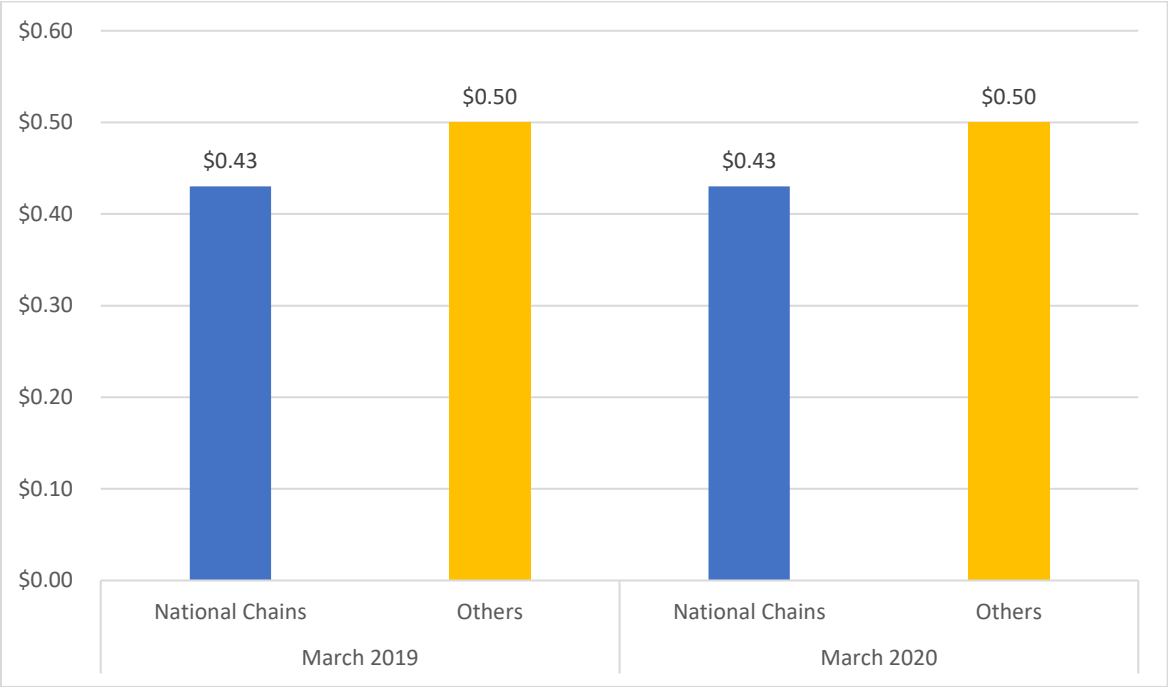


Source: Developed by LBFC staff from information provided by MCOs.

In Plan 12, the median dispensing fee was higher for national chain pharmacies, and there was no change between 2019 and 2020.

Exhibit 30

Plan 13
Median Dispensing Fee



Source: Developed by LBFC staff from information provided by MCOs.

In Plan 13, other pharmacies had a slightly higher median dispensing fee than national chains in 2019. Both median dispensing fees remained the same in 2020.

Overall, there was no general trend across the 13 MA plans regarding the median dispensing fee in March 2019 and 2020. The lowest median dispensing fee was 5 cents, and the highest was $9.00. As we previously noted, there is not a consensus as to what a fair fee would be; however, we did find it odd there were cases where the dispensing fee was decreasing while overhead costs for businesses such as pharmacies were increasing, such as payroll and employee benefits. Although managed care does not have the same requirements as FFS, we question how there can be a significant difference in dispensing fees - the 5 cents in Plan 3, compared to the $10.00 the Commonwealth must pay in FFS. Put another way; it is unclear whether dispensing fees reflect the actual cost of dispensing medications.

Spread Pricing Analysis. During our review of March data, we also tested for "spread pricing," or when the PBM collected a higher rate from the MCO than what they paid the pharmacy for the same transaction.

We did this by comparing the total the PBM paid to the pharmacy to the sum the MCO paid the PBM for the same transaction. In 2019 we found that four of the thirteen MA plans had discrepancies, including both transactions in which the PBM was reimbursed more (overpayment) and less (underpayment) than what they paid the pharmacies for the same claims. All four ultimately had a net overpayment, as shown in Exhibit 31.

Exhibit 31

Net Overpayments in March 2019 by Plan

MCO Plan	Net Difference Between What MCO Paid PBM Compared to What PBM Paid Pharmacies
Plan 1	$128,659.80
Plan 3	$563,169.80
Plan 5	$2.5 million
Plan 13	$3.6 million

Source: Developed by LBFC staff from information provided by PBMs, MCOs, and DHS.

Spread pricing was permitted in 2019. Therefore, it was not surprising to see pricing variance in the data. In 2020, spread pricing was banned. We expected to find no evidence of such in the 2020 data.[79]

We found no evidence of overpayments in most plans in March 2020. In 11 of the 13 plans, for every transaction in March 2020, the amount paid by the PBM to the pharmacy was the same as the amount the MCO paid to the PBM for the same transaction. This also included two of the plans, which had evidence of spread pricing in March 2019 and no longer did in 2020.

For one PBM we found instances where there were overpayments on many claims in March 2020. In performing this analysis, we realized data concerns that we did not have when we analyzed the March ingredient cost for the five selected drugs.[80] For example, in the overall March 2020 data (meaning all drugs included, not only our five selected), there were over 160,000 (or about 16 percent) negative transactions[81] (negative quantities dispensed and negative dollar amounts in transaction

[79] Human Service Code Title 55, Article IV Public Assistance, (f) Medical Assistance, § 449 (h)(3).
[80] After these findings, we redid the dispensing fee analysis since it dealt with all the March data and not just the five selected drugs.
[81] This was an unusually high amount compared to the other data we reviewed.

columns) and over 12,000 rows of transactions that had data shifted in the incorrect columns.[82]

When we spoke with the MCO contracted with this PBM, to get clarification on what we were seeing, they stated that in the data submitted to LBFC, the total columns (total PBM paid to pharmacy vs. total MCO paid to PBM) would not match because it was the total of all the payments made to the pharmacy including third-party liability and copayments.

This differed from what the other MCOs submitted. The totals presented by the other MCOs represented what the PBM paid, not the sum of all payers (although there were columns for third-party liability and copay separate from the total column). To control for this, for this PBM, we reviewed only the PBM ingredient cost paid compared to the MCO ingredient cost paid. Overall, in our analysis, the net sum of overpayment for this PBM for March 2020 totaled $13,743.04.

The MCO explained this variance by stating it was due to "a network set-up issue" that was discovered when this MCO and PBM converted to a "pass [-] through arrangement" on January 1, 2020. Further, they stated, "as a result [,] there was a large adjustment process run back in 2020 to correct the unintentional spread." Additionally, the MCO stated that "looking at just a single month of data may not" have captured "all of the adjustments." The overview they provided, with all months in 2020, showed an ingredient cost overpayment of $72,243 for the calendar year. While this was less than 1 percent of the total MCO ingredient cost paid, no amount is permitted per Act 2020-120.

According to the MCO, after a "more recent analysis" by the PBM, there were a "small number of claims that appear to have been missed in the adjustment process." They further stated that this had been fixed, and the variance amount for this PBM is now $0. The MCO provided the following overview of the process to LBFC:

> During quality review of data for the state's Q1 Pricing Transparency report in early May 2020, a pricing setup issue was identified where a subset of pharmacy network claims was adjudicating using Spread pricing logic rather than contractually required Pass Through (transparent) pricing.
>
> There were no members negatively affected by this pricing error. The error resulted in an overbilling to [MCO] by [PBM] for a subset of pharmacy providers.

[82] The data was submitted to us in both Microsoft Excel and Access, multiple times. In all instances these data shifts existed.

> The pricing error was corrected, validated, and impacted claims were adjusted using [PBM]'s standard process in Q3 2020.
>
> The adjustment process re-adjudicates all impacted claims using the updated pricing methodology. [PBM] and [MCO] have confirmed all claims now support the pass [-] through arrangement as required in the PBM contract.

While spread pricing may no longer be an intentional practice by PBMs, our experience with data from this PBM highlights the need to provide DHS with additional tools to oversee contractors and subcontractors.

C. Contracts and Contracted Ingredient Cost Reimbursement Rates

A crucial part of determining the ingredient cost reimbursement rates pharmacies receive is in their contracts with PBMs, because the contracts spell out the specific reimbursement rate type (i.e., MAC, NADAC, etc.) or reimbursement formula (i.e., Average Wholesale Price minus "X" percent) and dispensing fee.[83] We determined that obtaining the contracts was essential to answering the objectives of Act 2020-120. We asked representatives of pharmacies to provide contracts related to our sample.[84] However, they refused, citing concerns about retribution or loss of PBM business. We then asked the PBMs directly for contracts related to our sample.

Only one PBM (of six) complied with this request, which covered one of the thirteen MA plans. We then made the request through the MCOs and DHS. We received all contracts this way except for contracts from one PBM. The PBM contacted us directly, stating their refusal to provide

[83] See Section II for further explanation of pricing.

[84] This was the same sample as the 260 transactions previously mentioned. We used these selected transactions to create lists of specific pharmacies to request contracts between those pharmacies and the PBM. We utilized the coding by the PBM to identify independent and chain pharmacies, we did not utilize our system of national chains versus other pharmacies in this analysis.

the contracts. Exhibit 32 summarizes what we found within the contracts, which plans refused to provide information, or which specifically redacted information.

Exhibit 32

Contracted Ingredient Cost Reimbursement Rates Review Results

MCO Plan	Contract Notes
Plan 1	There were differences among all pharmacies (regardless of type) in the sample.
Plan 2	There were no differences in contracted rates between chains and independent pharmacies in the sample.
Plan 3	PBM refused to provide contracts. PBM claimed there was "no variation between chain and independent pharmacies," although we could not verify this without the contracts.
Plan 4	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 5	Chains and pharmacies in contracted PSAOs in the sample had the same contracted rates. Independent pharmacies (not in PSAOs) had different contracted reimbursement rate types in the sample.
Plan 6	There were no differences in contracted rates between chains and independent pharmacies in the sample.
Plan 7	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 8	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 9	PBM provided the contracts but excluded the pages containing the rate formulas. We could not determine if there was a difference between pharmacy types.
Plan 10	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 11	Rates varied between pharmacies in the sample – including rates among similar types of pharmacies.
Plan 12	PBM specifically redacted rate formulas in the contracts provided. We could not determine if there were different rates between chain and independent pharmacies in the sample.
Plan 13	PBM refused to provide contracts. PBM claimed there was "no variation between chain and independent pharmacies," although we could not verify this without the contracts.

Source: Developed by LBFC staff from information provided by PBMs, MCOs, and DHS.

Of the plans in which the MCOs/PBMs were transparent in providing the contracts as requested, we found a variety of contract reimbursement rates. The terms varied greatly by the plan. Some plans had no difference in contracted rates between different pharmacy types, while others did. We could not draw conclusions about contract reimbursement rates across all MA management care from the reviewed contracts.

It was concerning that PBMs refused to provide these contracts or redacted the specific rate information. In the context of Act 2020-120 which stated we were to be provided with "any other data the Legislative Budget and Finance Committee deems necessary." This is another area in which we believe there should be greater transparency, particularly as transparency relates to DHS having access to contracts pertaining to MA.

SECTION IV
REIMBURSEMENT PRACTICES OF MCOs AND PBMs

Fast Facts...

- *Before implementation, all drug policies, programs, and utilization management programs must be submitted to DHS for review and written approval.*
- *DHS requires MCOs and PBMs to contract on an equal basis with any pharmacy qualified to participate in the MA Program willing to comply with the MCO's or PBM's payment rates and terms.*
- *MCOs must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary.*

Overview

Section 449.1 of Act 2020-120 directs the Legislative Budget and Finance Committee to review the reimbursement practices of pharmacy benefit managers (PBMs) and Managed Care Organizations (MCOs). To accomplish this, we reviewed contracts between DHS and MCOs, MCOs and PBMs, between PBMs and pharmacies, and payment policies and methodologies of both PBMs and MCOs.

We found:

1. MCOs and PBMs must submit their reimbursement practices to DHS for review and approval before implementation.
2. Any changes to an MCO's or PBM's reimbursement practices must be submitted to DHS for review and approval prior to implementing the changes.
3. According to DHS, all MCOs and PBMs comply with the required payment methodologies in the MCO Agreements.

Issue Areas

A. Department of Human Services Requirements

MCO Agreements

The HealthChoices program is the name of Pennsylvania's Medicaid waiver program to provide mandatory managed healthcare to low-income Pennsylvanians. The Commonwealth enters competitively procured agreements with MCOs to provide pharmacy services within the program, and MCOs must comply with covered pharmacy services standards and requirements determined by DHS.

Oversight. Before implementation, all drug policies, programs, and utilization management programs must be submitted to DHS for review and written approval. DHS requires all contracted MCOs to include in their written policies and procedures an assurance that all requirements and

conditions governing coverage and payment for covered drugs ensure access to all medically accepted indications.

MCOs may use a PBM to process prescription claims if the MCO has received advance written approval from DHS. PBMs must meet the same requirements for any willing pharmacy as described above. The MCO must indicate to DHS the intent to use a PBM and submit the proposed PBM subcontract, the PBM's payment methodology (ingredient cost and dispensing fee) for actual payment to the providers of covered drugs, and the ownership of the proposed PBM subcontractor.

DHS requires MCOs and PBMs to contract on an equal basis with any pharmacy qualified to participate in the MA Program willing to comply with the MCO's or PBM's payment rates and terms. Subcontracts with PBMs and agreements with specific pharmacies to provide defined drugs or services must be submitted to the Department for advance written approval. Any changes to subcontracts or agreements must also be submitted to DHS for prior written consent.

The MCO and PBM must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary. The MCO must submit to DHS the policies and procedures for the development of network pharmacy payment methodology, including the process to ensure that brand and generic payment rates reflect the pharmacy's acquisition cost from a readily available distributor doing business in Pennsylvania. The professional dispensing fee must accurately reflect the pharmacist's professional services and cost to dispense the prescription to a Medicaid beneficiary.

Before implementation, the MCO or PBM must submit all payment methodology changes to DHS for review and approval.

DHS has provided documentation indicating the Department has approved the pharmacy payment methodology policies of the MCOs and PBMs providing services under the MCO Agreement.

Network Payment Methodology. MCOs must develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary. The MCO must submit to DHS the policies and procedures for developing network pharmacy payment methodologies, including ensuring that brand and generic payment rates reflect the pharmacy's acquisition cost, and the professional dispensing fee accurately reflects the pharmacist's professional services and cost to dispense the prescription.

All changes to the payment methodology must be submitted to the Department prior to implementation. The MCO or PBM must report all changes to the payment methodology and rates, including MAC, to network pharmacy providers.

Pricing Appeals. DHS requires MCOs to develop and implement a pharmacy dispute resolution process. The process must include a first-level pricing dispute process with the PBM and a second-level process with the MCO.

Before implementing its dispute resolution process, the MCO must submit its policies and procedures for resolving pricing disputes to DHS. DHS must approve the policy.

At a minimum, the MCO policy on pharmacy pricing disputes and appeals must establish a "first level" process including the following:

- Informal and formal processes for settling pricing disputes.
- Acceptance and usage of DHS's requirements regarding pharmacy appeals and pharmacy disputes.
- Timeframes for submission and resolution of pharmacy disputes and appeals.
- Processes to ensure equitabilities for all pharmacies.
- Mechanisms and timeframes for reporting decisions to pharmacies and DHS.
- Establishment of an MCO Committee to process formal disputes and appeals.

The MCO must also establish a "second level" pricing dispute process. The second level policies and procedures must include the following:

- The process for submission and settlement of second level PBM pharmacy pricing disputes.
- A requirement that the pharmacy must exhaust all its remedies against the PBM before requesting an MCO second level pharmacy appeal.
- Timeframes for submission and resolution of second level appeals.
- A process to ensure equal treatment of all pharmacies in resolving pricing disputes.
- A process to ensure the paid amount reflects the pharmacy's drug acquisition cost, professional services, and cost to dispense the prescription.
- A requirement for both the pharmacy and the PBM to provide documentation supporting each entity's position related to the pricing appeal.
- Mechanisms and timeframes for reporting second level appeal decisions to the pharmacy, the PBM, and DHS. If the MCO

denies the appeal, the findings must include the specific rationale for the denial.
- A requirement that the PBM inform all pharmacies of the process and conditions to request a second level appeal.

Oversight of Payment Rates. In its oversight of payment rates, DHS requires MCOs to do the following:

- Report the PBM's payment methodology, or methodologies for actual payment to all network pharmacy providers of covered drugs, including community pharmacies, long-term care pharmacies, network pharmacies contracted to provide specialty drugs, and dispensing prescribers for PBM subcontractors.
- Report the amount paid by the MCO to the PBM (ingredient cost and dispensing fee) and the amount paid by the PBM to the pharmacy.
- Report any differences between the amount paid by the MCO to the PBM and the amount paid by the PBM to the pharmacy.
- Submit a written description of the MCO's procedures to monitor the PBM for compliance with the terms and conditions of the HealthChoices Agreement related to covered drugs and actual payments to pharmacies.
- Conduct an independent audit of the PBM's transparent pricing arrangement in compliance with the HealthChoices Agreement.

B. Reimbursement Practices of PBMs and MCOs

All MCOs providing services in the Medical Assistance Program use a PBM to process prescription drug claims. The following are the most common practices employed by MCOs and PBMs in general oversight, network payment methodology, pricing appeals, and oversight of payment rates.

General Oversight

According to the documentation provided by DHS, all MCOs and PBMs have adopted pharmacy management procedures that comply with DHS requirements. In the area of general oversight, the most common practices used across MCOs and PBMs include:

- Transmitting eligibility files daily.
- Monitoring timeframes for payment to pharmacies.
- Establishing pharmacy help desks.

- Reviewing pricing surveillance reports quarterly to validate that pharmacy reimbursements comply with the aggregate rates agreed to within the contracts between the PBM and its pharmacy network.
- Requiring documentation that PBMs provide and maintain a pharmacy network of independent and chain pharmacies.
- Immediate notification of a pharmacy leaving the network.
- Requiring that PBMs cooperate with oversight of services delegated to the PBM.
- MCOs working directly with pharmacies to understand and intervene to address any PBM contract compliance issues.
- Contract termination if a PBM is determined to be out of compliance with its obligations.
- Monthly reporting requirements on subjects such as call center statistics, prior authorization statistics, claim submission fees, rebates, turn-around times, MAC list reporting, mail-order pharmacy reporting, and pharmacy network reports.
- Comprehensive audits.
- Continuous monitoring of network access, online claims processing, claims accuracy, and benefit change requests.
- Periodic site visits.
- Independent market checks using third-party vendors concerning pharmacy price points.

Network Payment Methodology

MCOs and PBMs must pay pharmacies an amount that reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription. The most common elements of MCO and PBM methodologies include the following:

- Use of pricing benchmarks, including signed contracts with individual network pharmacies, verified pricing appeals from network pharmacies, NADAC, PBM acquisition costs if they own a mail-order pharmacy, and the number of generics available.
- AWP minus a discount for brand drugs.
- Use of daily drug files from the AWP Price Index.
- Reviews of WAC, CMS data, and publicly available MAC prices.
- Dispensing fee negotiations with chain pharmacies, PSAOs, and independent pharmacies.
- Weekly updates of unit ingredient costs based on NADAC.
- Lesser of a pharmacy's usual and customary price, submitted price, MAC, and discounted AWP.

Pricing Appeals

The MCO agreements requires MCOs and PBMs to employ a robust system of pricing appeals to ensure payments to pharmacies reflect their actual costs.

- Informal and formal appeals processes.
- Notification of pharmacy rights to appeal.
- Notification of all appeal procedures.
- Online pricing appeals system that allows a network pharmacy to access patient information, rejected claims, pharmacy communications, and other relevant documents.
- Appeals are processed and determined within 14 days.
- Second level appeals are made directly to the MCO.
- Specific and detailed reasons for any denials.

Oversight of Payment Rates

The MCO Agreement requires all MCOs to monitor payment rates to ensure pharmacies receive a payment that reflects their actual costs. MCO policies use the following common methods to oversee payment rates:

- Regular review of pharmacy point-of-sale paid claims.
- Monthly reviews of the PBM MAC drug pricing list.
  - The review verifies that the MAC price is equally applied to all pharmacies for randomly selected drugs.
  - Discrepancies are addressed with the PBM.
- Periodic market checks using independent third parties to ensure PBM rates paid to network pharmacies are competitive. Market checks often include:
  - Comparing dispensing fees and drug pricing from competitor PBMs.
  - Medicaid pharmacy claims analysis.
- Monitoring the PBM initial appeals process. Generally, MCOs expect the PBM to make accurate payments 98 percent of the time.
- Independent reviews of ingredient costs, dispensing fees, administrative fees, and the actual amount paid by the PBM to the pharmacy.
- Annual independent audits of a PBM's pricing methodologies, arrangements, and pharmacy reimbursement.

SECTION V
MANAGED CARE USE OF PBMs IN OTHER STATES

Fast Facts…

- *As MCOs have become increasingly reliant upon PBMs to act as third-party administrators, there have been growing concerns over the regulation or oversight of how states manage their care plans.*
- *A particular area of concern for pharmacies is the PBM practice of utilizing multiple MAC lists to potentially issue different reimbursement rates to national chains vs other pharmacies.*

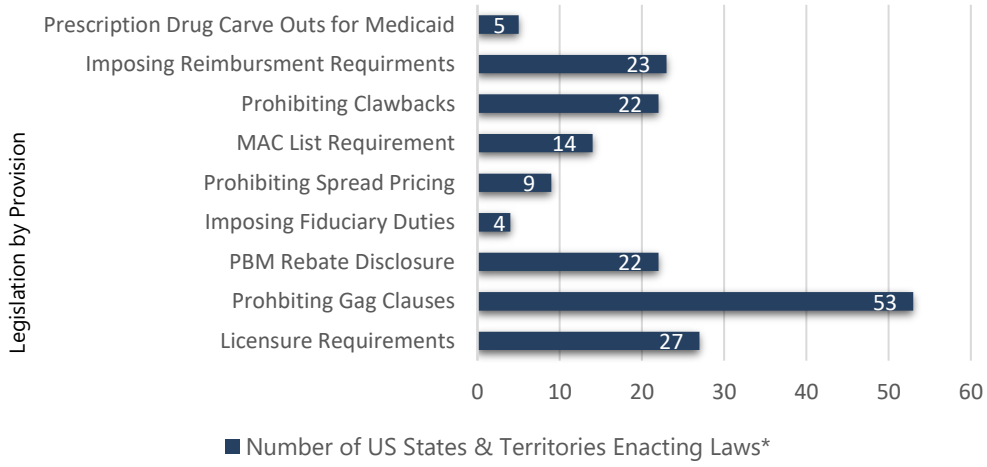
Overview

Act 2020-120 directs the Legislative Budget and Finance Committee to study the best practices of other states regulating PBM reimbursement methods. However, there remains little available data to conclusively measure the efficacy of recently passed laws across the country. Therefore, the analysis in this section will focus on alternative practices not currently mandated by Pennsylvania law. Data presented in this section will represent projections from agencies in other states tasked with administering and enforcing their respective policies.

As highlighted in Section VI, since the passage of the Affordable Care Act, states have taken a more active role in administering their managed care plans. Some of the legislation Pennsylvania has passed in recent years, such as banning spread pricing, banning gag clauses, and introducing cost disclosure and appeals processes, reflect this shift in policy across the country. Exhibit 33 presents the various kinds of legislation states and U.S. territories have enacted to regulate Pharmacy Benefit Managers (PBMs) from 2017 to 2021.

Exhibit 33

States' Legislation Regulating PBMs by Provision 2017 – 2021*



*/ Includes District of Columbia and U.S. Territories of Puerto Rico and Guam.

Source: Developed by LBFC Staff from National Academy for State Health Policy data.

A. Medicaid Contracting Provisions

Concerned about Medicaid prescription drug spending, states have changed how they manage and administer Medicaid pharmacy benefits. While some states deliver Medicaid pharmacy benefits on their own, most contract with third-party administrators who execute various functions, including claims payment, utilization management, and negotiating rebates and reimbursements.[85] Over time, states' reliance on third-party administrators has raised concerns about this system's cost-benefit, oversight, and regulation.[86]

In recent years, Pennsylvania has enacted reforms to PBM reimbursement practices, including banning spread pricing and claw backs, mandating licensure, utilizing Maximum Allowable Cost (MAC) pricing, and ending gag clause provisions.

MAC Publishing Transparency

A PBM-generated MAC list is a catalog of the upper limit or maximum amount that a health plan will pay for generic and brand-name drugs with generic alternatives. There is no industry standard for the methodology PBMs use to determine the maximum price and how those prices are subsequently changed or updated. Similarly, there are no established criteria for how PBMs select specific drugs to be included in their MAC lists.

A common practice for PBMs is to utilize multiple MAC lists. For example, PBMs use one MAC list to pay pharmacies for dispensing a drug and another to bill the Managed Care Organization (MCO). No two MAC price lists are alike because each PBM will utilize different criteria for the pricing methodology of their MAC lists.[87] As a result of this process, some pharmacies are concerned that PBMs are using low MAC price lists to reimburse their contracted pharmacies and a different, higher-priced list when conducting business with other clients and plan sponsors.[88]

Pennsylvania, through its Department of Human Services (DHS), also has a MAC list that details eligible drugs and their respective pricing under state Medical Assistance programs. Nearly all states utilize their MAC list

[85] Gifford, Kathleen, et al. Kaiser Family Foundation, 2020, *How State Medicaid Programs Are Managing Prescription Drug Costs*, https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/. Accessed August 8, 2022.
[86] Ibid
[87] The Need for Legislation Regarding "Maximum Allowable Cost" (MAC) Reimbursement [Review of The Need for Legislation Regarding "Maximum Allowable Cost" (MAC) Reimbursement]. Ncpa.org; National Community of Pharmacists Association. http://www.ncpa.co/pdf/leg/mac-one-pager.pdf. Accessed September 20, 2022.
[88] Ibid.

to establish reimbursement limits for designated multi-source drugs.[89] Although states are granted the flexibility to determine MAC pricing, state MAC lists are far more transparent, as most states identify the benchmarks they use. According to a 2020 Kaiser Family Foundation report, most surveyed states indicated they use pharmacy acquisition costs as part of the benchmark to set state MAC prices.[90]

DHS publishes the state MAC list for fee-for-service programs on the department's website, which is usually updated every three months. However, there are currently no requirements for PBMs to publish information on their MAC lists due to proprietary restrictions.

In 2019, Maine passed a law regulating PBM business practices by imposing more transparency provisions for PBMs. Chief among these provisions is creating a single MAC list that must be identified by the PBM so that prices are transparent and accessible to all parties. Under 24-A M.R.S.A. §4350 (2019), a PBM under contract with an MCO must use the same maximum allowable cost list for each pharmacy provider.[91] Establishing and publishing a single publicly accessible MAC list enhances transparency.

Carve-In vs. Carve-Out Models for High-Cost Specialty Drugs

Specialty and high-cost drugs are among the most significant cost drivers of pharmacy spending growth in most states. Medicaid covers a disproportionate share of high-cost specialty drugs for high-need and at-risk populations, placing additional pressure on state governments to control drug spending.[92]

State Medicaid managed care plans generally follow either carve-in or carve-out models. Most states that contract with MCOs, including Pennsylvania, "carve-in" Medicaid pharmacy benefits to MCO contracts, while a few states "carve-out" prescription drug coverage from managed care. Although a carve-in approach simplifies pharmacy administration and management, the state may sacrifice the ability to alter plan design. Another financial risk mitigation strategy is adopting a policy to carve out specific subsets of high-cost specialty drugs instead of the full benefit.

[89] Dolan, R., & Tian, M. *Pricing and Payment for Medicaid Prescription Drugs* (2020, January 23). Kff.org; Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/. Accessed September 20, 2022.
[90] Ibid.
[91] 24-A M.R.S.A. §4350. Accessed September 14, 2022.
[92] Gifford, Kathleen, et al. Kaiser Family Foundation, 2020, *How State Medicaid Programs Are Managing Prescription Drug Costs*, https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-pharmacy-benefit-administration/. Accessed August 8, 2022.

By utilizing a carve-out model, states can tailor programs targeting specific drugs to prioritize cost reduction.[93]

In 2021, the Kaiser Family Foundation (KFF) reported that seventeen states had implemented high-cost drug carve-outs.

B. Single PBM Models (SPBMs)

Some states are transitioning from utilizing multiple PBMs under contract for Managed Medicaid towards a single PBM (SPBM) for managed care. In theory, using a single PBM streamlines pharmacy administration as states contract directly with the SPBM and have more direct management over healthcare networks, reimbursement rates, and rebate negotiations.

Ohio. Ohio has implemented an SPBM model. The Ohio Department of Medicaid (ODM) anticipates that an SPBM will allow the state to regulate the consistency of service outcomes better. By consolidating core services from multiple PBMs, the state expects to identify and eliminate potential conflicts of interest more readily.[94] This is due to the state having greater leverage in negotiating contractual terms by engaging directly with the SPBM and reducing the number of stakeholders in the process. Additionally, the Ohio SPBM model is expected to minimize out-of-network restrictions, allowing Medicaid recipients to have more choices in selecting their pharmacy.[95]

In 2019, Ohio began transitioning to an SPBM program scheduled to become operational on October 1, 2022.[96] Under the new SPBM model, the ODM will select and contract with a single vendor to manage and administer pharmacy benefits for managed care recipients. ODM's legislative directive is to increase financial accountability, reduce costs, promote greater transparency, and align the state's clinical and policy goals.[97]

[93] Anderson, Brian N, and Angela Reed. "PBM Best Practices Series: Carve-In vs Carve-Out Programs." *Milliman*, 12 Dec. 2016, https://www.milliman.com/en/insight/pharmacy-benefits-carve-in-versus-carve-out. Accessed August 17, 2022.
[94] "About the SPBM and PPAC." *Ohio Medicaid Managed Care*, Ohio Department of Medicaid, https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager/odm-spbm-ppac. Accessed September 1, 2022.
[95] Ohio Department of Medicaid, 2022, *Ohio Medicaid Next Generation Pharmacy Program*, https://medicaid.ohio.gov/static/Providers/SPBM/SPBM+PPAC+Stakeholder+Review+03112022.pdf. Accessed September 1, 2022.
[96] "Single Pharmacy Benefit Manager (SPBM) and Pharmacy Pricing and Audit Consultant (PPAC)." *Ohio Medicaid Managed Care*, Ohio Department of Medicaid, https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager. Accessed September 1, 2022.
[97] "Single Pharmacy Benefit Manager (SPBM) and Pharmacy Pricing and Audit Consultant (PPAC)." *Ohio Medicaid Managed Care*, Ohio Department of Medicaid, https://managedcare.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager. Accessed September 1, 2022.

Ohio Auditor General, Dave Yost, observed the need for reform in a 2018 report entitled *Ohio's Medicaid Managed Care Pharmacy Services*.[98] The Ohio General Assembly tasked the Auditor General and his office with analyzing data transparency, disparities between pharmacy reimbursement rates and overall costs to the state's Medicaid program, potential conflicts of interest because of PBM vertical integration, and the impact, if any, of reduced pharmacy reimbursements on access to services in rural communities.[99]

Yost found that from 2016 to 2017, the number of Medicaid prescriptions in Ohio increased by almost five times the national average. During this same period, the average increase in drug spending reported by all states to CMS was 4.4 percent. In Ohio, the total amount paid increased by 12 percent.[100] Ohio's Department of Medicaid also reported a two percent decrease in eligible Medicaid recipients between December 2016 and December 2017.[101] To summarize, Ohio was experiencing an increase in the volume of Medicaid prescriptions, an increase in prescription costs, and a decrease in Medicaid-eligible enrollees.

According to the Ohio Department of Medicaid, the combination of these factors creates an unsustainable system, requiring immediate intervention for cost control. Ohio's lack of internal controls to strengthen existing procedures and monitor program improvements compounded this issue.[102]

The new SPBM model, according to ODM, will transform the state's Medicaid Managed Care program. The SPBM will be responsible for processing pharmacy claims and will allow pharmacists to streamline inventory based on a Unified Preferred Drug List (UPDL).[103] The ODM expects the creation of the SPBM will lead to a single set of transparent guidelines, ensuring greater consistency of outcomes. This provision aims to improve the efficiency of reimbursements and the pharmaceutical supply chain.[104]

Before October 1st, the Ohio Department of Medicaid required various stakeholders in the pharmaceutical supply chain to fill out as many as seven separate forms to verify their qualifications for Medicaid reimbursement. Validating the information from seven different documents

[98] Ohio, Auditor of State. Yost, Dave. *Ohio's Medicaid Managed Care Pharmacy Services*, 16 Aug. 2018. https://ohioauditor.gov/auditsearch/Reports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf. Accessed July 20, 2022.
[99] Ibid.
[100] Ibid.
[101] Ibid.
[102] Ibid.
[103] Ohio Department of Medicaid, 2022, *Ohio Medicaid Next Generation Pharmacy Program*, https://managed-care.medicaid.ohio.gov/managed-care/single-pharmacy-benefit-manager. Accessed September 1, 2022.
[104] "Single Pharmacy Benefit Manager (SPBM) Overview." Ohio Department of Medicaid, 13 Sept. 2021, https://www.youtube.com/watch?v=8oPq2wB9QSk. Accessed September 1, 2022.

is a process that often takes months to complete, and Ohio's revamped Medicaid managed care system requires one standardized form to be completed. Under the traditional multi-PBM model, it is difficult for regulators to ensure compliance because PBMs are not subject to a universal industry-wide standard. Ohio's State Auditor report notes the reason exact terms of financial agreements for pharmacy services are kept confidential is primarily due to the sheer number of entities involved in each transaction.

In January 2021, Ohio announced the selection of Gainwell Technologies as the Department of Medicaid's SPBM vendor, agreeing to a contract worth a reported $158 million over a 7.5-year duration. Ohio has included provisions within the agreement to nullify and exit the deal if Gainwell does not meet the state's expectations.

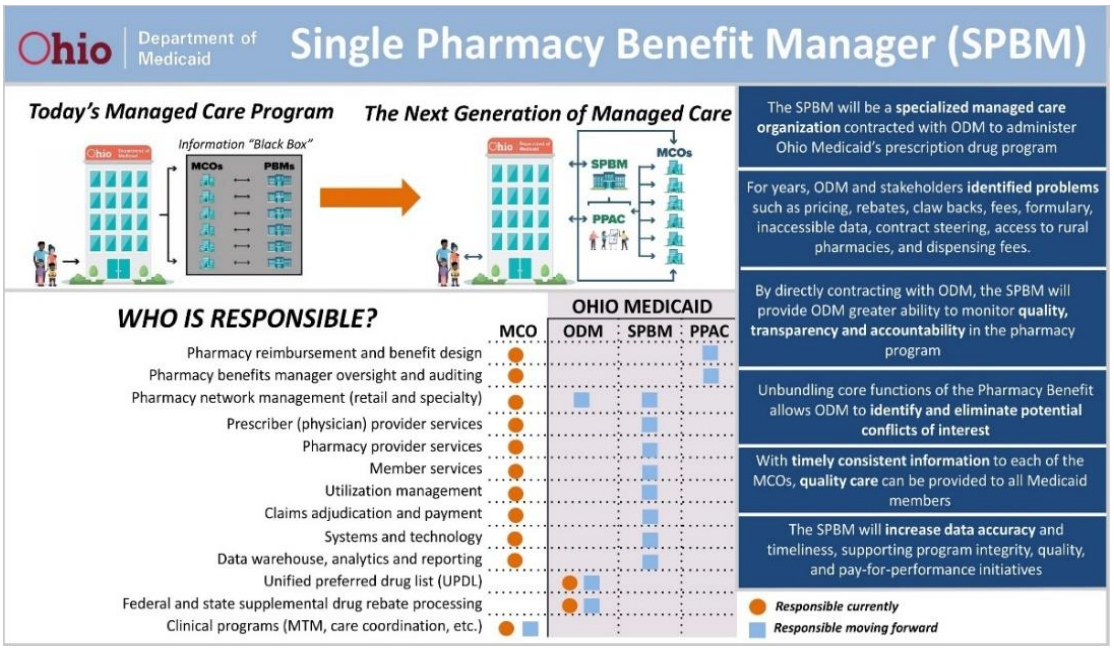
The primary responsibilities of Gainwell, in addition to providing pharmacy services, include developing utilization management strategies, adjudicating claims and payment, and supporting various information technology processes to ensure program success. The SPBM can also provide incentivized member-valued services and benefits such as home delivery, ninety-day refills, and adherence programs. Previously, when Medicaid recipients changed managed care plans, they had to make sure their new plan covered their preferred pharmacy, and recipients also had to check whether the new plan would still cover their prescription drugs. In theory, by establishing centralized credentialing of the new SPBM system, Ohio's Medicaid recipients will experience no difference in coverage policy.

ODM and Gainwell will coordinate with the Pharmacy Pricing and Audit Consultant (PPAC), who will provide operational assistance, oversight, and liaison support across the program.

By maintaining accurate and up to date AAC rates, the PPAC anticipates the ability to oversee all program functions and implement fair value-based reimbursements reliably. In April 2021, ODM officially announced the exclusive PPAC vendor would be Myers and Stauffer. Exhibit Exhibit 34 shows how ODM, the SPBM, and the PPAC divide roles and responsibilities within Ohio's Medicaid program.

Exhibit 34

Transition of Ohio's Medicaid Program Responsibilities



Source: Ohio Department of Medicaid.

Ohio's Medicaid Director estimated that by transitioning to an SPBM model, the state would save roughly $150 million to $200 million annually.[105] However, the Columbus Dispatch reported this figure represents a gross amount and does not factor in lost revenue from a tax on health insurance corporations that Ohio would no longer collect.[106] The lost revenue from this tax totals around $23 million. The cost-saving figure cited by the Medicaid Director also does not account for additional staff to handle the duties the agency would be taking over from managed care organizations.

California. California issued an RFP for a carve-out of its pharmacy benefit effective January 1, 2021, opting to adopt an SPBM model and delegate control of its Medicaid drug program to Magellan Health. The administration estimated the new SPBM would save the state $414 million in the 2022-23 budget year as the state's Medicaid managed care

[105] Rowland, Darrel. "After Federal OK, Ohio Names One State PBM to Replace Others, Save Money." *The Columbus Dispatch*, 11 Jan. 2021, https://www.dispatch.com/story/news/healthcare/2021/01/11/pharmacy-benefit-managers-ohio-medicaid-saving-pbm/6556793002/. Accessed September 2, 2002.
[106] Ibid.

program would receive more significant drug discounts than managed-care insurance plans.[107]

Before this, California's Department of Health Care Services contracted with about two dozen managed-care plans to administer services to the nearly fourteen million Medicaid recipients in the state. In the months before the transition, the Department told patients and doctors the system would grandfather medications for 180 days. As reported in the LA Times, however, the change has not been smooth. Since its inception, California's SPBM has been overwhelmed by the state's volume of Medicaid recipients. Patients have experienced long customer service wait times, delayed prescription dispensing, and improper claim denials.[108]

C. Reverse Auction PBMs

In traditional PBM procurement models, competitive bids are primarily kept confidential. The reverse auction model is designed to promote cost transparency by utilizing an online bidding process where PBMs compete for a state's contract by allowing bidders to counteroffer a lower price until a bid is accepted.

New Jersey was the first state to enact legislation to create a PBM reverse auction. In 2016, New Jersey enacted a law (L. 2016, c. 67) requiring the state to conduct an automated reverse auction to procure a PBM for the state health benefits plan and school employees' health benefits plan.[109] The state benefit plan covers roughly 800,000 public employees, and the New Jersey Department of the Treasury's Division of Pensions and Benefits Office manages the program. While performance data is currently unavailable, the state projected savings of $2.5 billion in reduced prescription drug spending by the end of 2022.[110]

[107] Young, Samantha. "'Somebody Is Gonna Die': Omicron Hobbles California's New Medicaid Prescription System." *Los Angeles Times*, 9 Feb. 2022, https://www.latimes.com/california/story/2022-02-09/california-medicaid- patients-struggle-prescriptions-pandemic. Accessed September 12, 2022.
[108] Ibid.
[109] N.J.L. 2016, c.67 Accessed September 12, 2022.
[110] Deacon, Christin, and Alysha Fluno. The National Academy for State Health Policy, *How States Can Control Pharmacy Benefit Manager Contract Costs through Reverse Auctions*, https://www.nashp.org/webinar-how-states-can-control-pharmacy-benefit-manager-contract-costs-through-reverse-auctions/. Accessed August 25, 2022.

The law requires all prospective PBMs to agree to the terms of the proposed state drug benefit plan if the PBM wishes to participate in the reverse auction. These include offering uniform contracting terms, including formulary control, plan design, and member cost sharing. Furthermore, participating PBMs must disclose requested administrative fees, rebates, and other financial requirements as requested by New Jersey's request for proposal. According to the State Treasury's Pension and Benefits Office, disclosing this information promotes market competition and allows state agencies to perform granular analysis for every claim.[111]

As stated above, the first step of the reverse auction procurement process involves PBMs fully agreeing to the contract's exact terms. Terminology and definitions are also set and agreed upon upfront. Subsequent auction phases preclude prospective bidders who do not accept this requirement. This pre-qualification step ensures that any prospective PBM operates within the program design guidelines established by the state. During this step, PBMs must also show how they will discount designated brand and generic drugs towards the pricing guarantees established within the contract terms.[112]

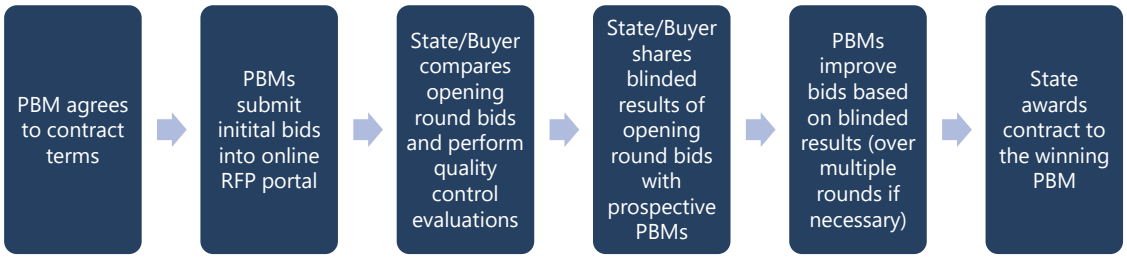
PBMs then submit their opening round bids via New Jersey's online portal. The portal allows the state to conduct side-by-side comparisons of each bid. This technology expedites the review process without compromising accuracy. Whereas a third-party consultant would typically require four to six weeks to evaluate bids manually, the reverse auction platform allows the state to conduct this step within a typical timeframe of one week.[113]

After the first round of bids has been evaluated and compared, the state shares summary-level results with participating PBMs. Crucially, these results are blind, meaning that bidders will not know who the leading candidates are but will be able to see how their offer compares to their competition. At this point, PBMs can improve their bids based on the blinded results submitted directly onto the platform from the first round. PBMs can adjust the pricing provisions in their counteroffer, but their benefit design may not change. Most reverse auctions go through at least three rounds of bidding. Once the bidding process has concluded, the state awards the winning PBM the contract. Please see Exhibit 35 for a visualization of the reverse auction process.

[111] Deacon, Christin, and Alysha Fluno. The National Academy for State Health Policy, *How States Can Control Pharmacy Benefit Manager Contract Costs through Reverse Auctions*, https://www.nashp.org/webinar-how-states-can-control-pharmacy-benefit-manager-contract-costs-through-reverse-auctions/. Accessed August 25, 2022.
[112] Ibid.
[113] Ibid.

Exhibit 35

New Jersey PBM Reverse Auction Procurement Process



Source: Developed by LBFC staff from information provided by the New Jersey Department of Treasury, Divisions of Pensions and Benefits.

Other states have already started to adopt New Jersey's approach. Maryland established a reverse auction by amending the Maryland State Personnel and Pensions Code (Md. Code Ann., State Personnel and Pensions Code § 2-502.2 (2021). The amendment formally directed the Department of Budget and Management to utilize the reverse auction model for various state health plans.[114] Either individually or collectively as a joint purchasing group with the State Employee and Retiree Health and Welfare Benefits Program, Maryland will allow self-funded county, municipal, public school, and public institutions of higher education employee health plans to be included in the reverse auction process. Maryland is procuring a vendor to implement an operational technology platform to conduct the reverse auction.

Other states continue to maintain interest in adopting this model. Louisiana, Colorado, and Minnesota enacted laws in 2021, enabling them to implement reverse auctions to procure a PBM for their state employee health plans. Louisiana and Minnesota have issued their technology vendor RFPs, while Colorado is currently in the developmental phase. In Pennsylvania, Senate Bill 1231, introduced in 2022, seeks to amend the Pharmacy Audit Integrity and Transparency Act, and create an online RFP vendor platform to manage the Commonwealth's Medicaid program.[115]

[114] Maryland, Department of Budget and Management, Health and Government Operations and Appropriations. *Maryland Comprehensive Pharmacy Benefits Manager Marketplace Act*, 27 Feb. 2020. https://mgaleg.maryland.gov/cmte_testimony/2020/hgo/4071_02272020_93227-901.pdf. Accessed August 29, 2022.
[115] Pennsylvania Senate Bill 2022-1231

SECTION VI
BACKGROUND INFORMATION

Fast Facts…

- *The Centers of Medicare & Medicaid Services (CMS) report Medicaid spending reached $671.2 billion in 2020, accounting for 16 percent of total National Health Expenditures.*
- *The Kaiser Family Foundation found that payments made to MCOs in federal fiscal year 2020 accounted for about 49% of total Medicaid spending.*
- *Currently, the three largest PBM companies (Express Scripts, CVS Caremark, and OptumRx) control roughly 89% of the marketplace.*

A. Introduction

Act 2020-120 amends the Pennsylvania Human Services Code by adding a section (449.1) directing the Legislative Budget and Finance Committee to prepare a report analyzing prescription drug pricing under the medical assistance managed care program.

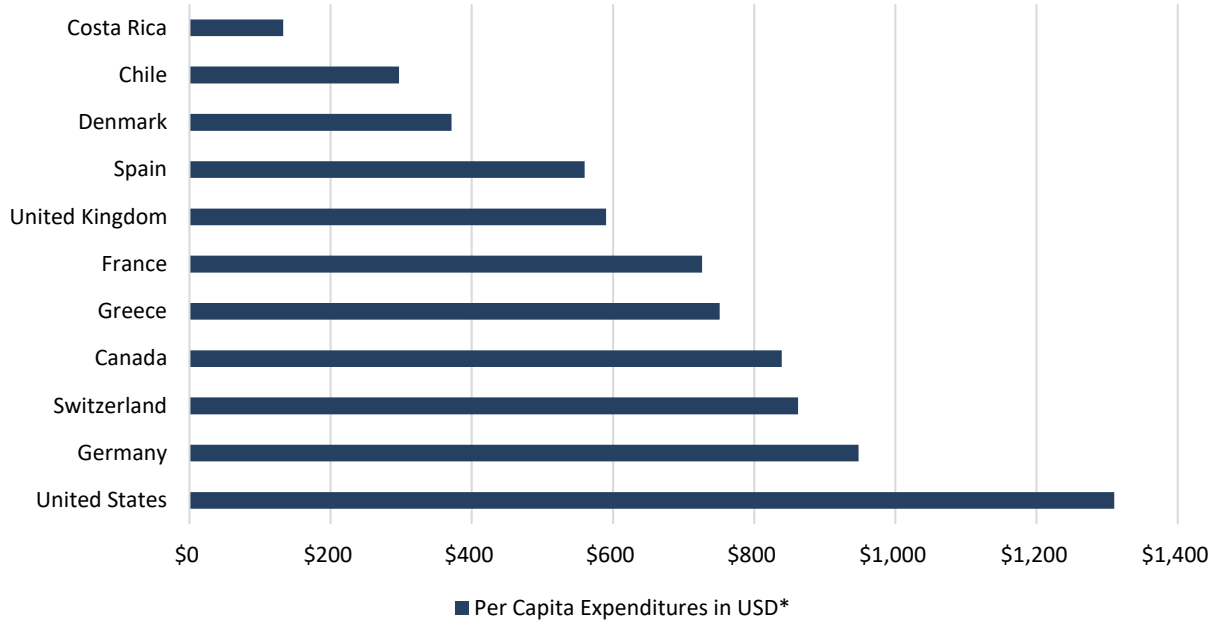
B. Overview of Prescription Drug and Medicaid Spending

The most recent data from the Organization for Economic Cooperation and Development (OECD) revealed that in 2020, Americans spent an average of $1,310 per capita on prescription medications as shown in Exhibit 36. As detailed by Exhibit 35 below, America's yearly per capita spending on pharmaceuticals was $362 more than Germany, the next highest country on the list.[116] The rising cost of prescription drugs is becoming an increasing financial hardship for many Americans, regardless of their insurance status. A study by the Brookings Institution observed that 79 percent of Americans consider U.S. prescription drug prices unreasonable, with almost 3 in 10 reporting they go without prescribed medications because they cannot afford the cost.[117]

[116] OECD. "Pharmaceutical Spending, Total, US Dollars/Capita." 2020. https://data.oecd.org/healthres/pharmaceutical-spending.htm#indicator-chart. Accessed on September 26, 2022.
[117] Ginsburg, P. B., & Steven, L. M. (2021). *Government Regulated or Negotiated Drug Prices: Key Design Considerations*. Brookings Institution. Retrieved from https://www.brookings.edu/essay/government-regulated-or-negotiated-drug-prices-key-design-considerations/. Accessed on February 8, 2022.

Exhibit 36

Per Capita Pharmaceutical Spending by Country (2020) *



*/ Figures include insurance spending and out-of-pocket patient costs for prescription and over-the-counter drugs. Additionally, they exclude any drugs that would be consumed in a hospital or other healthcare setting.

Source: Developed by LBFC staff with data from OECD 2020 Health Expenditure and Financing Report.

As Medicaid is responsible for covering a disproportionate share of some high-cost drugs for at-risk populations, program expenditures are burdened by the rising cost of drug prices and a growing enrollment pool. Gross Medicaid spending on prescription drugs, which refers to total expenditures before rebates, equaled $73.4 billion in 2020. This figure increased from $69.1 billion in the previous year's gross Medicaid spending on prescription drugs.[118] Overall, the Centers for Medicare & Medicaid Services (CMS) notes that all program expenditures for Medicaid tallied $671.2 billion in 2020.[119]

Experts project that Medicaid spending will continue to trend upward in the immediate future. In March 2022, the CMS Office of the Actuary

[118] Williams, E. (2021, December 14). *Medicaid Outpatient Prescription Drug Trends During the COVID-19 Pandemic* [Review of *Medicaid Outpatient Prescription Drug Trends During the COVID-19 Pandemic*]. Kff.org; Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-outpatient-prescription-drug-trends-during-the-covid-19-pandemic/#:~:text=Gross%20Spending%20Trends&text=Overall%2C%20Medicaid%20paid%20%2473.4%20billion,in%202019%20(Figure%203). Accessed May 18, 2022.
[119] Centers for Medicare and Medicaid Services. (2021, December 15). *National Health Expenditure Fact Sheet*.CMS.Gov. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet. Accessed September 19, 2022.

released the National Health Expenditure report, which provides detailed assessments and projections for Medicaid program expenditures by the end of the decade. The report notes that Medicaid enrollment experienced significant increases in 2021, and as a result, overall spending growth accelerated to 10.4 percent for the year.[120] The National Health Expenditure report also projects total Medicaid spending will increase by an average of 5.6 percent annually between 2021 and 2030.[121] As of May 2022, roughly 82 million Americans are enrolled in Medicaid.[122]

C. Historical Context of Medicaid Managed Care and Prescription Drug Pricing Legislation

The Medicaid program was created during the 1960s when the institutional infrastructure of American healthcare saw profound changes. Historical data from the United States Census reveals that from 1950 to 1963, the population of elderly Americans grew from 12 million to 17.3 million. Furthermore, two-thirds of America's elderly demographic earned an annual income of less than $1,000, and only one in eight had health insurance.[123] On July 30, 1965, President Lyndon B. Johnson signed the Social Security Act Amendments into law as part of his ongoing War on Poverty initiative.[124,125]

The Social Security Act established Medicaid, a health insurance program for the poor. Under the Act, the Federal Government sets general guidelines, requirements, and oversight. Still, Medicaid-managed care programs are delegated to the agencies of individual states to administer and determine means testing standards and allocation of funds. Delegating management allows states to identify and triage different

[120] Centers for Medicare & Medicaid Services. (2022, March 18). "CMS Office of the Actuary Releases 2021-2030 Projections of National Health Expenditures." *CMS.gov*, https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures. Accessed September 19, 2022.
[121] Ibid.
[122] (2022, May). *Medicaid*. Medicaid.gov; Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/index.html. Accessed September 19, 2022.
[123] United States National Archives and Records Administration. (2022, August 2). *Medicare and Medicaid Act*. Archives.gov; United States National Archives and Records Administration. https://www.archives.gov/milestone-documents/medicare-and-medicaid-act. Accessed on September 27, 2022.
[124] Ibid.
[125] Matthews, D. (2014, January 8). Everything you need to know about the war on poverty. *The Washington Post*. https://www.washingtonpost.com/news/wonk/wp/2014/01/08/everything-you-need-to-know-about-the-war-on-poverty/. Accessed on September 27, 2022.

priorities based on their respective conditions. The program is funded jointly by the states and the federal government.[126]

Various participants are involved in the manufacture, distribution, and sale of pharmaceutical medications, and understanding their roles and interactions provides insight into the marketplace for prescription drugs. State Medicaid agencies contract with Managed Care Organizations (MCOs) to assist them with delivering healthcare benefits and other services. An MCO is an entity that manages the purchase and provision of physical or behavioral health services for eligible Medical Assistance recipients. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), states increasingly rely on MCOs to deliver Medicaid services. The share of Medicaid beneficiaries enrolled in an MCO grew from about 15 percent in 1995 to about 50 percent by 2011 and is currently around 90 percent. In Pennsylvania, this figure has increased from 81 percent in 2016 to 92 percent in 2020.[127]

Payments to providers are issued through fee-for-service (FFS) or capitation. With FFS, providers bill and are paid for each service they deliver. Capitation refers to a payment model where MCOs are paid, per enrollee, in fixed upfront installments for expected utilization of covered benefits, administrative costs, and profit. The Kaiser Family Foundation found that in the federal Fiscal Year 2020, payments made to MCOs accounted for about 49 percent of total Medicaid spending.[128]

MCO Capitation Rates

When healthcare costs began to rise sharply in the 1970s and 1980s, Congress enacted new provisions for MCOs and state Medicaid agencies through the Omnibus Budget Reconciliation Acts of 1981 and 1990. In 1981, federal Medicaid law was amended to require all managed care capitation rates to be set on an actuarially sound basis. At the time, capitation rates were based on upper payment limits equal to the cost of providing the same services under FFS Medicaid. However, as states increasingly began to rely on managed care programs, the basis of setting capitation rates using FFS became unreliable.

[126] MACPAC. (2018). Federal Requirements and State Options: How states exercise flexibility under a Medicaid state plan. *MACPAC.gov*. Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Medicaid-Requirements-and-State-Options-How-States-Exercise-Flexibility-Under-a-State-Plan.pdf. Accessed September 27, 2022.

[127] Kaiser Family Foundation. (2020). Total Medicaid MCO Enrollment. *State Health Facts - Medicaid Managed Care Tracker*. kff.org. Retrieved from https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22pennsylvania%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed September 27, 2022

[128] Hinton, E., & Stolyar, L. (2022, February 23). 10 Things to Know About Medicaid Managed Care [Review of *10 Things to Know About Medicaid Managed Care*]. In *kff.org*. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/. Accessed on September 21, 2022.

In 2002, CMS abandoned the FFS methodology and established a new standard to define actuarial soundness. States, through their actuaries, were allowed to determine their payment rates to MCOs using available demographic and economic data. CMS strengthened these provisions in 2016 by requiring states to document and submit the data they used to calculate capitation rates to CMS for review. States seeking Federal reimbursement for the capitated payments to MCOs must receive prior approval from CMS for their contracts with MCOs.

Although state Medicaid agencies are required to follow generally accepted actuarial practices and federal rules, the methodology for developing their capitation rates is complex and involves several factors and metrics. There is a base capitation rate, the methodology for which does not rely on a single data source but rather a combination of aggregated prospective trend data. Pennsylvania's Department of Human Services (DHS) works with Mercer, a government and human services consulting firm, to gather data and develop capitation payment methodologies. DHS' 2021 Physical HealthChoices report reported the metrics used to set capitation rates are encounter data and financial information submitted by Physical Health-MCOs (PH-MCO), changes to the HealthChoices (HC) market, economic indices (such as the Consumer Price Index), and appropriate comparative benchmarks of neighboring states (FFS rates or managed care trends).

Encounter data refers to providers submitting claims or services for payment to MCOs. This base capitation rate is then adjusted for subgroups of the enrolled population known as rate cells with similar demographic, geographic, or cost characteristics. In adjusting for rate cells, state Medicaid agencies consider factors such as historical risk management data.

Within the Commonwealth, the Physical HealthChoices program is separated into five geographic zones: Northwest, Northeast, Southeast, Lehigh/Capital, and Southwest. Capitation rates are independently developed for each HC zone/region. The state pays different capitation rates to different MCOs based on historical encounter data for each geographic area.

Pennsylvania's Community HealthChoices (CHC) managed care plan was introduced in 2018 and phased implementation over three years. CHC emphasizes community services over facility services. The program covers Pennsylvanians 21 or older who have both Medicare and Medicaid or receive long-term support through Medicaid because they need help with daily personal tasks. DHS works with Mercer on developing CHC capitation rates and methodologies as well. While CHC utilizes the same five geographic zones as Physical HealthChoices, capitation rates are divided further within the Southeast and Southwest to account for cost differentials within Philadelphia and Allegheny County, respectively. Additionally, the Northeast and Northwest zones are aggregated to a single

rate region due to the membership volume within each zone. CHC capitation rates are developed through a similar methodology as PH plans; however, different historical data is utilized for rate cells as the demographic and risk management data for members under each plan varies.

Medicaid Drug Rebate Program

The Omnibus Budget Reconciliation Act of 1990 contained several provisions seeking to combat the costs associated with public programs. Among these provisions was the creation of the Medicaid Drug Rebate Program (MDRP), which intended to ease the cost burden for low-income patients. Manufacturers that want to have their drugs covered under the rebate program must enter into a national rebate agreement with the Department of Health and Human Services (HHS) in exchange for state Medicaid programs agreeing to cover all the manufacturer's outpatient drugs.

The law sets the required rebate to ensure the drug's net price is either equal to the best price available to anyone in the private market or equal to a certain percentage of the drug's average manufacturer price (AMP). A drug's AMP is the average price paid to a drug manufacturer by wholesalers or pharmacies purchasing directly from the manufacturer. Rebates and discounts provided to pharmacy benefit managers (PBMs), or other entities are not deducted from a drug's AMP calculation. The exact percentage set for rebates varies by the type of drug, with brand-name drugs generally requiring the largest rebates.

MDRP also includes a provision subjecting brand name and generic drugs to an inflationary penalty in addition to the primary rebate. The purpose of an inflationary rebate penalty is to provide a disincentive for drug manufacturers to raise the price of their drugs at a rate greater than inflation. Should a manufacturer violate this provision, the law mandates they must pay an additional rebate equal to the amount the price increase exceeds the rate of inflation.

MDRP remains a vital element of the American healthcare infrastructure. MACPAC reported the program's rebates for outpatient prescription drugs saved Medicaid $31.2 billion in gross expenditures for federal Fiscal Year 2016. For federal Fiscal Year 2018, MACPAC reported drug rebates, most of which occurred under managed care, reduced Medicaid gross expenditures by almost 60 percent.[129] While rebates significantly impact reducing Medicaid expenditures for prescription drugs, overall Medicaid expenditures continue to increase due to the growing number of Medicaid enrollees.

[129] (2019, December). MACStats: Medicaid and CHIP Data Book [Review of *MACStats: Medicaid and CHIP Data Book*]. *MACPAC.gov*. Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf

The core tenets of the Medicaid Drug Rebate Program have primarily remained intact since it was first created. While Congress has made minor changes throughout the years, the most significant reforms of the program did not occur until the passage of the Patient Protection and Affordable Care Act, more commonly referred to as the Affordable Care Act (ACA), in 2010.[130,131]

The Patient Protection and Affordable Care Act

The Affordable Care Act reformed the American healthcare system and expanded Medicaid. Under §2001 of the ACA, Medicaid eligibility was widened to include nearly all individuals under age 65 with incomes up to 133 percent of the Federal Poverty Level based on modified adjusted gross income.[132] The ACA also introduced significant changes to the established rebate rates under MDRP. At the time of MDRP's enactment, Congress set the minimum basic rebate for brand-name drugs at 12.5 percent of AMP. In 1996, the rate was increased to 15.1 percent, where it would remain until the passage of the ACA.[133] The Affordable Care Act changed the minimum basic rebate rate to its current level of 23.1 percent of AMP.

Unlike brand-name drugs, generic drug prices do not typically vary substantially from one payer to the next. Therefore, generic drugs had a fixed rebate amount, set initially at 10 percent of the AMP, and the Affordable Care Act increased the fixed rate to 13 percent of the AMP in 2010.[134]

Another key managed care provision the Affordable Care Act addressed included pharmacy reimbursement rates. Section 2503 of the Act establishes a nationwide calculation for Federal upper reimbursement limits of pharmaceutically and therapeutically equivalent multiple-source drugs that are available for purchase by retail community pharmacies.[135] The ACA also included statutory language regulating the practices of PBMs.

[130] (2022, April). *Federal Legislative Milestones in Medicaid and CHIP*. MACPAC.gov; Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/reference-materials/federal-legislative-milestones-in-medicaid-and-chip/. Accessed on September 20, 2022.
[131] 42 USC Ch. 157.
[132] 42 USC Ch. 157§2001.
[133] Ibid.
[134] Ibid.
[135] 42 USC Ch. 157 § 2503. *Under §2503, the calculation must be* no less than 175 percent of the weighted average of the most recently reported monthly AMP.

D. Legislative History of PBM Regulation

MCOs contract with PBMs to manage the pharmacy benefits portion of their services. Pharmacy Benefit Managers are third-party entities that function as administrative intermediaries between insurance providers and pharmaceutical manufacturers. PBMs create formularies, negotiate rebates (discounts paid by a drug manufacturer to a PBM) with manufacturers, process claims, create pharmacy networks, review drug utilization, and occasionally manage mail-order specialty pharmacies.[136] Pharmaceutical manufacturers work with wholesalers to sell their products to pharmacies. PBMs also contract with pharmacies directly to deliver and supply prescription drugs for patients.

PBMs were first introduced in the 1960s when private insurers began offering prescription drug coverage in their health plans. Their primary role was to help insurers control expenditures for drug coverage benefits.

The efficacy of PBMs came into question during the 1990s when drug manufacturers began purchasing them. According to the Federal Trade Commission (FTC), which enforces federal consumer protection laws, these acquisitions created a conflict of interest within the pharmaceutical industry.[137] The FTC intervened and challenged the acquisitions of Medco by Merck and PCS Health Systems by Eli Lilly and Company.[138] The FTC's intervention led to manufacturers selling their ownership interests in PBMs. Shortly thereafter, PBMs began consolidating when large chain pharmacies began acquiring them.

The Affordable Care Act included requirements for PBMs to act more transparently. Under §1150 of the Act, PBMs must disclose a drug's generic dispensing rate (by pharmacy type), the aggregate amount of rebates, and discounts or price concessions involved in a transaction to the Secretary of Health and Human Services for review.[139] PBMs must also disclose the total number of prescriptions dispensed and any difference between the amount the health benefits plan pays the PBM and the amount the PBM pays retail and mail-order pharmacies.[140] Finally, PBMs must provide the percentage of all prescriptions provided through retail pharmacies compared to mail-order pharmacies and the percentage of

[136] National Association of Insurance Commissioners. (2022, April 11). *Pharmacy Benefit Managers*. Center for Insurance Policy and Research. Retrieved from https://content.naic.org/cipr-topics/pharmacy-benefit-managers. Accessed April 21, 2022.
[137] Federal Trade Commission. (1998, August). *Merck Settles FTC Charges that Its Acquisition of Medco Could Cause Higher Prices and Reduced Quality for Prescription Drugs*. https://www.ftc.gov/news-events/news/press-releases/1998/08/merck-settles-ftc-charges-its-acquisition-medco-could-cause-higher-prices-reduced-quality. Accessed April 21, 2022.
[138] Ibid.
[139] 42 USC Ch. 157 §1150.
[140] Ibid.

medications for which a generic drug was available and dispensed.[141] While this information must be shared with the Secretary of HHS, the Department is prohibited from disclosing confidential, proprietary data.

Beyond these regulations at the federal level, the ACA also established new CMS guidelines to support state pilot programs for innovative payment and delivery arrangements in Medicaid. This provision has empowered states to develop and adopt policies and methodologies to regulate PBMs and Medicaid-managed care plans.

Arkansas Act 900 and Impact of *Rutledge v PCMA*

In 2015, Arkansas passed Act 900, which required PBMs to reimburse Arkansas pharmacies at a price equal to or greater than the pharmacy's wholesale cost.[142] The Act imposed requirements on PBMs pertaining to cost transparency and contained three fundamental enforcement mechanisms. First, PBMs are required to update their Maximum Allowable Cost (MAC) list within seven calendar days in the event of a 10 percent or more increase in the pharmacy acquisition cost, a 60 percent or more increase in any Arkansas-based wholesaler acquisition cost, or any change in the methodology on which the MAC list is based. Additionally, the Act created a streamlined appeals process for pharmacies to challenge MAC reimbursement rates. Finally, Arkansas pharmacies were granted the ability to refuse the sale of any drug with a reimbursement rate lower than its acquisition cost.[143]

In response, the Pharmaceutical Care Management Association (PCMA) sued Arkansas claiming Act 900 is pre-empted by the federal Employee Retirement Income Security Act of 1974 (ERISA).[144] PCMA is a national trade association representing 11 of the largest PBMs in the United States.[145] The association argued that 29 U. S. C. §1144(a) declares ERISA pre-empts all state laws relating to a covered employer-sponsored health benefits plan. Since Act 900 contains specific provisions on the management of Arkansas' Medicaid program and Employee Benefits Division, PCMA challenged the law's constitutionality arguing it should be overturned.[146]

[141] Ibid.
[142] Ark. Code Ann. § 17-92-507. Accessed on February 9, 2022.
[143] Ibid.
[144] Ravega, K., & Dunlap, S. (2020, December 11). *Arkansas' PBM Law Upheld by Supreme Court*. Quarles.com; Quarles & Brady LLP. https://www.quarles.com/publications/arkansas-pbm-law-upheld-by-supreme-court/. Accessed on February 9, 2022.
[145] *Rutledge v. PCMA*, 18–540, U.S. (2020). Accessed on February 9, 2022.
[146] *Rutledge v. PCMA*, 18–540, U.S. (2020). Accessed on February 9, 2022.

The Eighth Circuit Court of Appeals affirmed the District Court's decision that ERISA pre-empts Act 900. Arkansas appealed the case to the United States Supreme Court. On December 10, 2020, the Supreme Court ruled in an 8-0 decision that ERISA did not pre-empt Arkansas state law.[147, 148] Since Act 900 amounts to cost regulation, and there was nothing within the statutory language of the Act that specifically referenced ERISA, the court determined there was no impermissible connection between the state and federal laws.[149]

The Supreme Court's decision in *Rutledge v PCMA* set a precedent that reinforced the ability of states to regulate PBMs with greater authority. Since then, many states have adopted policies regulating PBMs.

E. Overview of the Current PBM Marketplace

Today, there are 66 PBM companies in the United States. The PBM industry is highly consolidated, with the three largest companies, Express Scripts, CVS Caremark, and OptumRx (UnitedHealth), controlling roughly 89 percent of the market.[150] The rest of the market is serviced by small independent PBMs that work with non-chain community pharmacies. The National Community Pharmacies Association estimates that about 22,000 community pharmacies operate nationwide. Eighty percent of community pharmacies are in underserved or rural areas with populations under 50,000.

Congress passed the Patient Right to Know Drug Prices Act at the federal level in 2018, which banned gag order clauses in contracts between PBMs and pharmacies.[151, 152] Such clauses prevented pharmacists from telling patients that a drug's cash price was less than the insurance copay price. Congress also passed the Know the Lowest Price Act to promote patient transparency further.[153] Section II of the law amends the Social

[147] Groom Law Group. "The Supreme Court Narrows ERISA Preemption in Rutledge v. PCMA." *Groom Law Group*, 5 Jan. 2021, https://www.groom.com/resources/the-supreme-court-narrows-erisa-preemption-in-rutledge-v-pcma/#:~:text=In%20the%20recently-decided%20Rutledge%20v.%20Pharmaceutical%20Care%20Management,pharmacy%20benefit%20managers%E2%80%99%20%28%E2%80%9CPBMs%E2%80%9D%29%20payments%20to%20network%20pharmacies. Accessed on April 21, 2022.
[148] *Rutledge v. PCMA*, 18–540, U.S. (2020)
[149] Ibid.
[150] National Association of Insurance Commissioners. (2022, April 11). *Pharmacy Benefit Managers*. Center for Insurance Policy and Research. Retrieved from https://content.naic.org/cipr-topics/pharmacy-benefit-managers. Accessed on May 3, 2022.
[151] S. 2554 – Patient Right to Know Drug Prices Act. *United States Senate Republican Policy Committee*. (2018, September 13). https://www.rpc.senate.gov/legislative-notices/s-2554_patient-right-to-know-drug-prices-act. Accessed on February 9, 2022.
[152] Public Law 115-263.
[153] Public Law 115-262.

Security Act to require pharmacies to inform individuals regarding prices for certain drugs and biologicals.[154]

In Pennsylvania, the Pharmacy Audit Integrity and Transparency Act (Act 2016-169) establishes procedures for pharmacy audits. It requires PBMs and entities conducting pharmacy audits to register with the Pennsylvania Insurance Department beginning February 19, 2017.[155]

Act 2020-120, which required this report, attempts to build on the transparency measures brought forth by the Pharmacy Audit Integrity and Transparency Act and provide more cost-efficient medical assistance pharmacy services.

[154] Ibid.
[155] P.L. 1318, No. 169 §301-304.

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APPENDICES

Appendix A – Act 2020-120

HUMAN SERVICES CODE - MEDICAL ASSISTANCE PHARMACY SERVICES AND PRESCRIPTION DRUG PRICING STUDY
Act of Nov. 25, 2020, P.L. 1208, No. 120 Cl. 67
Session of 2020
No. 2020-120

HB 941

AN ACT

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," in public assistance, further providing for medical assistance pharmacy services and providing for prescription drug pricing study.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 449 of the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code, is amended to read:

Section 449. Medical Assistance Pharmacy Services.--**(a)** Any managed care [entity] **organization** under contract to the department, **or an entity with which the managed care organization contracts**, must contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance Program that is willing to comply with the managed care [entity's] **organization's or entity's** pharmacy payment rates and terms and to adhere to quality standards established by the managed care [entity] **organization or entity**.

(b) The following shall apply:

(1) The department may conduct an audit or review of an entity for the purpose of determining compliance with this section.

(2) In the course of an audit or review under paragraph (1), an entity shall provide medical assistance-specific information from a pharmacy contract or agreement to the department.

(c) A contract or agreement between an entity and a pharmacy may not include any of the following:

(1) A confidentiality provision that prohibits the disclosure of information to the department.

(2) Any provision that restricts the disclosure of information to or communication with a managed care organization or the department.

(d) An entity shall maintain records regarding pharmacy services eligible for payment by the Medical Assistance Program and shall disclose the information to the department upon its request.

(e) Information disclosed or produced by an entity to the department under this section shall not be subject to public access under the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

(f) The following shall apply:

(1) If an entity approves a claim for payment under the Medical Assistance Program, the entity may not retroactively deny or modify the adjudicated claim unless any of the following apply:

(i) The claim was fraudulent.

(ii) The claim was duplicative of a previously paid claim.

(iii) The pharmacy did not dispense the pharmacy service on the claim.

(2) Nothing in this subsection shall be construed to prohibit the recovery of an adjudicated claim that was determined to be an overpayment or underpayment resulting from audit, review or investigation by a Federal or State agency or managed care organization.

(g) A managed care organization or pharmacy benefit manager may not mandate that a medical assistance recipient use a specific pharmacy unless it is consistent with subsection (a) and is preapproved by the department.

(h) A pharmacy benefit manager or pharmacy services administration organization may not do any of the following:

(1) Require that a pharmacist or pharmacy participate in a network managed by the pharmacy benefit manager or pharmacy services administration organization as a condition for the pharmacist or pharmacy to participate in another network managed by the same pharmacy benefit manager or pharmacy services administration organization.

(2) Automatically enroll or disenroll a pharmacist or pharmacy without cause.

(3) Charge or retain a differential between what is billed to a managed care organization as a reimbursement for a pharmacy service and what is paid to pharmacies by the pharmacy benefit manager or pharmacy services administration organization for the pharmacy service.

(4) Charge pharmacy transmission fees unless the amount of the fee is disclosed and applied at the time of claim adjudication.

(i) A managed care organization shall submit its policies and procedures, and any revisions, for development of network pharmacy payment methodology to the department. The department shall review all changes to pharmacy payment methodology prior to implementation.

(j) A managed care organization utilizing a pharmacy benefit manager shall report to the department information related to each outpatient drug encounter, including the following:

(1) The amount paid to the pharmacy benefit manager by the managed care organization.

(2) The amount paid by the pharmacy benefit manager to the pharmacy.

(3) Any differences between the amount paid in paragraph (1) and the amount paid in paragraph (2).

(4) Other information as requested by the department.

(k) A pharmacy shall, upon request by the department, submit the actual acquisition cost of prescriptions dispensed to medical assistance beneficiaries.

(l) As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Adjudicated claim" means a claim that has been processed to payment or denial.

"Entity" means a pharmacy, pharmacy benefit manager, pharmacy services administration organization or other entity that manages, processes or influences the payment for or dispenses pharmacy services to medical assistance recipients in the managed care delivery system.

"Pharmacy benefit management" means any of the following:

(1) The procurement of prescription drugs at a negotiated contracted rate for distribution within this Commonwealth.

(2) The administration or management of prescription drug benefits provided by a managed care organization.

(3) The administration of pharmacy benefits, including any of the following:

(i) Operating a mail-service pharmacy.

(ii) Processing claims.

(iii) Managing a retail pharmacy network.

(iv) Paying claims to pharmacies, including retail, specialty or mail-order pharmacies, for prescription drugs dispensed to medical assistance recipients receiving services in the managed care delivery system via a retail or mail-order pharmacy.

(v) Developing and managing a clinical formulary or preferred drug list, utilization management or quality assurance programs.

(vi) Rebate contracting and administration.

(vii) Managing a patient compliance, therapeutic intervention and generic substitution program.

(viii) Operating a disease management program.

(ix) Setting pharmacy payment pricing and methodologies, including maximum allowable cost and determining single or multiple source drugs.

"Pharmacy benefit manager" means a business that performs pharmacy benefit management. The term does not include a business that holds a valid license from the Insurance Department with accident and health authority to issue a health insurance policy and governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Pharmacy services administration organization" means an organization comprised of pharmacy members that performs any of the following:

(1) Negotiates or contracts with a managed care organization or pharmacy benefit manager on behalf of its pharmacy members.

(2) Negotiates payment rates, payments or audit terms on behalf of its pharmacy members.

(3) Collects or reconciles payments on behalf of its pharmacy members.

Section 2. The act is amended by adding a section to read:

Section 449.1. Prescription Drug Pricing Study.--(a) The Legislative Budget and Finance Committee shall conduct a study analyzing prescription drug pricing under the medical assistance managed care program. The committee shall do all of the following as it relates to the medical assistance managed care program only:

(1) Provide an overview of the distribution of and payment for pharmaceuticals in the medical assistance managed care program.

(2) Review the reimbursement practices of pharmacy benefit managers to pharmacies within this Commonwealth.

(3) Review the reimbursement practices of managed care organizations to pharmacy benefit managers.

(4) Investigate and compare the reimbursement rates paid by pharmacy benefit managers to independent pharmacies and to chain pharmacies.

(5) Study the best practices and laws adopted by other states to address concerns with pharmacy reimbursement practices of pharmacy benefit managers.

(b) The Legislative Budget and Finance Committee shall review and utilize data from the most recent twelve-month period.

(c) The department shall provide the following data for the medical assistance managed care program to the Legislative Budget and Finance Committee:

(1) The amount paid to a pharmacy provider per claim, including ingredient cost and the amount of any copayment deducted from the payment.

(2) The transmission fees charged by a pharmacy benefit manager to a pharmacy provider.

(3) The amount charged by the pharmacy benefit manager to the medical assistance managed care organization per claim, including all administrative fees and processing charges associated with the claim.

(4) Rebates paid by the pharmacy benefit manager to the managed care organization.

(5) Any other data the Legislative Budget and Finance Committee deems necessary.

(d) Pharmacy benefit managers and medical assistance managed care organizations shall provide the required data under subsection (c) to the department within forty-five days of the effective date of this section for distribution to the Legislative Budget and Finance Committee. The providing of data by the pharmacy benefit managers and medical assistance managed care organizations to the department or by the department to the Legislative Budget and Finance Committee shall not constitute a waiver of any applicable privilege or claim of confidentiality. All data shall be given confidential treatment, shall not be subject to subpoena by a third-party entity and may not be made public or otherwise shared by the department, the Legislative Budget and Finance Committee or any other person except to the extent allowed under this subsection.

(e) All data provided under subsection (b) for purposes of conducting the study shall be in a form that is de-identified of personal health information.

(f) The Legislative Budget and Finance Committee shall publish only aggregate data in the report. Any information disclosed or produced by a pharmacy benefit manager or a medical assistance managed care organization for the purposes of this study shall be confidential and not be subject to the act of February 14, 2008 (P.L.6, No.3), known as the "Right-to-Know Law."

(g) The Legislative Budget and Finance Committee shall submit a report of its findings and recommendations for legislative action to the General Assembly and the department within twelve months of the receipt of the data from the department under subsection (c).

(h) As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Adjudicated claim" shall have the same meaning as the term does in section 449.

"Entity" shall have the same meaning as the term does in section 449.

"Pharmacy benefit management" shall have the same meaning as the term does in section 449.

"Pharmacy benefit manager" shall have the same meaning as the term does in section 449.

"Pharmacy services administration organization" shall have the same meaning as the term does in section 449.

Section 3. The amendment of section 449 of the act shall apply to any agreement or contract relating to pharmacy services to medical assistance recipients in the managed care delivery system entered into or amended on or after the effective date of this section.

Section 4. This act shall take effect in 60 days.

APPROVED--The 25th day of November, A.D. 2020.

TOM WOLF

Appendix B – Response from the Pennsylvania Department of Human Services

Note: A portion of the Department's response required us to provide additional clarification. Those areas are footnoted at the bottom of the Department's response.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

January 18, 2023

Ms. Patricia A. Berger
Executive Director
Legislative Budget and Finance Committee
P.O. Box 8737
Harrisburg, Pennsylvania 17105-8737

Dear Ms. Berger:

Thank you for providing a draft copy of the Legislative Budget and Finance Committee's (LBFC) report titled Prescription Drug Pricing Under the Medical Assistance Managed Care Program and allowing the Department of Human Services (Department) to submit comments.

The Department is responsible for ensuring Medical Assistance (MA) beneficiaries have access to all covered services, including pharmacy. Since the beginning of managed care in the MA Program, the Department contracts, through the competitive bidding process, with qualified managed care organizations (MCOs). The Department pays the MCOs fixed per member per month (PMPM) payments for assuming the financial risk for furnishing the full range of health services, including pharmacy services, covered under the MA Program. The Department holds the MCOs accountable for ensuring access to all MA covered services for MA beneficiaries. The MCOs may choose to subcontract with Pharmacy Benefits Managers (PBMs). The pharmacies participating in the MCOs' networks have entered into agreements with the MCOs' designated PBMs. The MCOs or their subcontractors must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the MCO's payment rates and terms and to adhere to quality standards established by the MCOs.

The Department receives every MCO paid claim and uses this information to develop the capitation rates. However, the Department does not know from the claim records when providers, such as pharmacies, profit. The Department has taken multiple steps to promote transparency in prescription drug pricing in the MA Program.

Since 2018, the Department has met regularly with leaders from the Pennsylvania Pharmacist Association (PPA), Philadelphia Association of Retail Druggists, and representatives of independent pharmacies regarding pharmacy payment issues related to the MCOs and the PBMs they contract with to administer the pharmacy benefit to MA beneficiaries. The Department greatly values the relationship we have developed with the associations and the pharmacy provider community, and the information and perspective they have shared with us. We recognize the pharmacies' commitment to ensuring access to needed medications and quality services to the vulnerable MA beneficiaries across the state and have endeavored to address their concerns where it is appropriate and possible to do so. Issues presented by PPA that have been addressed by the Department include:

- Reimbursement rates that were less than the pharmacy's acquisition cost for the drug;
- Lack of transparency in contracts between the MCOs, PBMs, and pharmacies, and;
- Utilization management practices that could potentially disadvantage independent pharmacies over chain or PBM-owned/affiliated pharmacies.

In 2018, "spread pricing" became a nationwide buzz word associated with MCO and PBM contracting practices. Spread pricing occurs when the MCO payment made to the PBM is higher than the amount paid by the PBM to the pharmacy for dispensing the prescription. The "spread" is the amount retained by the PBM. In response, the Department added PBM transparency language to the 2019 MCO Agreements which require the MCOs to disclose to the Department the amount paid to the PBM, and the amount paid to the dispensing pharmacy. The Department developed transparency reports with input from PPA and the independent pharmacies. The MCOs have been compliant with the PBM transparency requirements.

In 2019, the Department added first level and second level drug pricing dispute requirements to the MCO Agreements. As a result, pharmacies have a process to appeal first to the PBM when there is a pricing discrepancy and second to the MCO if the PBM does not resolve the pricing discrepancy to the satisfaction of the pharmacy. Pharmacies are aware of the processes to dispute drug pricing and are utilizing them.

Prior to the introduction of House Bill 941, which became Act 120 of 2020, the Department had been meeting with PPA to discuss the concerns being raised by the pharmacies. PPA had the opportunity to review the draft MCO agreement language and provide comments.

The MCOs demonstrated in their submitted policies and procedures that they develop, implement, and maintain a process that ensures the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary. The Department staff review each policy and procedure carefully and meet with the individual MCOs in order to fully understand their approach to meeting the requirements. The MCO payment, in the aggregate, includes the cost of the drug ingredient as well as the professional dispensing services. For this reason and in response to page 55 of the report, the dispensing fee should not be evaluated by itself. As a result of the reviews, three of the eight MCOs amended their payment methodologies and adjusted claims paid to pharmacies with dates of service January 1, 2020, forward.

Over the time period that the Department made these changes to the MCO Agreements, and as the MCOs have implemented their Department approved polices, there has been a significant reduction in complaints by pharmacies to the Department. The Department maintains a collaborative working relationship with PPA and remains committed to working with both the pharmacy providers and our MCO partners to ensure access to quality care across the Commonwealth.

The Department offers the following comments on the recommendations in the report.

Recommendation 1. PBMs, MCOs, and/or Pharmacy Services Administrative Organizations (PSAOs) should ensure MAC reimbursement practices are transparent to pharmacies prior to claim adjudication.

Comment: The Department agrees with this recommendation.

Recommendation 2. The General Assembly should require contracts between PBMs and pharmacies to be submitted to DHS and released to oversight organizations, e.g., the LBFC and the Auditor General, when conducting a study of the PBMs and/or pharmacies.

Comment: The Agreements held between the Department and the MCOs requires the MCO and its subcontractor(s) to make all contracts available for audit, review, evaluation or inspection by the Commonwealth. The Department will amend the MCO Agreements to specify that the PBM and participating network pharmacy agreements are included in this requirement.

Recommendation 3. The General Assembly should require all pharmacies participating in the Pennsylvania managed care program to comply with any DHS request for information on pharmacy acquisition costs for purposes of comparing to actual reimbursement amounts.

Comment: The Department has the authority to request actual acquisition costs from pharmacies participating in the MA Program.
Act 120 of 2020 [Section 449(b)(k) of the Human Services Code] states the following:

> *"(k) A pharmacy shall, upon request by the department, submit the actual acquisition cost of prescriptions dispensed to medical assistance beneficiaries."* [1/]

Thank you for collaborating with the Department on this study. We appreciate that both organizations are dedicated to fiscal responsibility and providing access to quality care for vulnerable Pennsylvanians.

Sincerely,

Valerie A. Arkoosh, MD, MPH
Acting Secretary

LBFC Comment Concerning the Department of Human Services' Response:

[1/] In response to this comment, we amended the recommendation to add clarifying language that is not currently in Act 120-2020 to define actual acquisition cost (pages S-3 and 26).