Ohio | Department of Medicaid

**Mike DeWine,** Governor
**Jon Husted,** Lt. Governor

**Maureen M. Corcoran,** Director

# Executive Summary: Assessing the Impact of Pass-Through Pricing

Executive Summary prepared by the Ohio Department of Medicaid
Reports prepared by HealthPlan Data Solutions and the Ohio Department of Medicaid

September 2019

## Introduction

Approximately 1.2 million individuals served by Medicaid in Ohio's managed care programs require at least one prescription, at a cost of approximately $800 million per quarter, among all Medicaid Managed Care Plans (MCPs or "Plans"). Given the impact on individuals' care and the fiscal impact for the state, effective management of the pharmacy benefit is one of the single most important areas for state oversight. The discussion and recommendations that arose during the state budget, and amendments adopted, serve to emphasize the legislative and public concerns about the growing cost of prescription drugs.

In June 2018, the Ohio Department of Medicaid (ODM) identified two key gaps affecting how the MCPs were reporting pharmacy related information:

- Data reported the amount paid to the Pharmacy Benefit Managers (PBM) rather than the amount paid directly to the pharmacy.
- ODM managed care provider agreement requirements specifying the relationship between ODM and the MCPs did not contain explicit authority for ODM to review and oversee the PBM contracts and related data.

The impact of these two gaps related to data reporting was highlighted by the first HealthPlan Data Solutions Inc. (HDS) report released publicly in August 2018. The first problem was the result of incorrect data element mapping of the MCP encounter data into the ODM system. This mismatch contributed to a lack of visibility into a PBM billing practice known as "spread pricing". The implication of the second gap meant that ODM could not immediately obtain all the data required from the MCPs to fully understand and appropriately oversee the administration of the pharmacy benefit at a detail level.

In July 2018, at ODM's direction, the Plans began sending supplemental data files which allowed ODM to see the amount PBMs paid to pharmacies. Combined with claims data, ODM was able to calculate the spread between the amount MCPs paid the PBM and in turn the amount the PBM paid to pharmacies. These supplemental data files were received in August 2018 through Dec 2018. Prior to

the end of the evaluation ODM determined that a change in the PBM payment model and how data were reported by the Plans was necessary. ODM directed the MCPs to abandon spread pricing and change to a **transparent** "pass-through" pricing model. Effective January 1, 2019, all Plans were required to implement "pass-through" pricing and report to ODM through MITS what was reimbursed to the pharmacies for medication ingredient costs and dispensing fees. Transparency was the goal.

In addition to addressing spread pricing concerns, ODM also determined it was critical to determine the full cost of providing pharmaceuticals to members, including all administrative costs. When Ohio Medicaid Director Maureen Corcoran provided budget testimony to the General Assembly in April 2019, she indicated that ODM's efforts to "modernize the prescription drug program would drive toward greater transparency throughout the supply chain while increasing clinical efficiencies[i]". To begin to address concerns about administrative costs, the Plans were also required to provide quarterly reports detailing how much was spent internally to administer their pharmacy benefits, as well as how much they paid the PBMs for administrative functions (excluding ingredient and dispensing fees paid to pharmacies). Plans contract with PBMs for a multitude of services, so some variation from Plan to Plan for administrative costs is to be expected. The combined PBM/Plan administrative cost, along with their continued reporting of supplemental rebate data and total costs allows ODM to evaluate the efficiencies of the pharmacy benefit by Plan.

ODM subsequently contracted with HDS to provide an independent evaluation of the implementation of pass-through pricing and to provide additional insights into improving the administration of the pharmacy benefit. Three areas were analyzed, and recommendations were provided to ODM in the form of a report issued in September 2019. Some of these recommendations have already been implemented or were already included in the 2020 budget. The three primary components of the report prepared by HDS include:

- An evaluation of implementation of the pass-through model;
- test for anti-competitive practices between PBMs, Plans and pharmacies; and
- recommendations on how to improve the administration of the pharmacy benefit.

Contracts, pricing, and related data are sometimes considered proprietary, as the release of such information could have an impact on the data owner's competitive advantage or market position. To avoid exposing potentially proprietary information while also providing greater transparency into the administration of the pharmacy benefit, data in the report have been aggregated **only to the degree necessary to not reveal proprietary information**. As such, the report has been released without any redactions and is considered public record. A summary of each of the report components is included below. Please refer to the full HDS report for descriptions of methodology used in each area.

## Key Facts and Findings from the HDS Report

1. Verify that a pass-through pricing model has been implemented and adhered to by the PBMs contracted by the MCPs since 01/01/2019.
    a. HDS confirms that the pass-through model was successfully implemented in the 1st quarter of 2019 (CY Q1 2019).

2. Compare payments to pharmacy providers between fourth quarter of 2018 (CY Q4 2018) and Q1 2019. The comparison assesses the change in payments by drug category and the overall change in payment by aggregate average wholesale price (AWP) discount.
    a. In Q1 2019, reimbursement to the pharmacists increased by 5.74% when compared to Q4 2018, an increase of $38.3 million for the three-month period.
3. Identify any variance in payments by pharmacy provider type (mail vs. retail) and by ownership, identifying any potential anti-competitive pricing methodologies being used by the PBMs.
    a. HDS found that since pass-through was implemented each dispensing channel experienced a neutral (mail), or improvement (retail, specialty), in reimbursement to pharmacists.
4. Compare ingredient costs by generic product indicator (GPI) and national drug code (NDC), identifying any significant differences by MCP in the Q1 2019, including variances in average unit ingredient cost and average unit price paid by GPI code.
    a. Variances were identified. HDS indicated that "while not considered anti-competitive, over and under payments can create market instability and should be monitored and minimized".
5. Identify any mis-categorization of medications and subsequent overpricing for the first quarter of 2019.
    a. Some drugs were misclassified as specialty drugs, which may lead to over payments and raise concerns about conflicts of interest.
6. Report on the percentage of specialty drug prescription claims dispensed at PBM-owned specialty pharmacies in Q1 2019.
    a. About 35-46% of specialty drugs were dispensed by commonly owned entities. While HDS did not find any clear evidence of anti-competitive steering to commonly owned entities for specialty drug dispensing, the potential exists.
    b. ODM is examining specialty drugs in more depth to assess whether any patterns of concern are identified, with particular emphasis on the 35-46% fulfilled by commonly owned entities.
7. By MCP, calculate the aggregate Average Wholesale Price (AWP) discount for each prescription category, and the PBM performance against the contract terms for Q1 2019.
    a. As indicated, HDS was unable to identify any preferential or anti-competitive pricing by the PBMs. There was increased payment to all pharmacy groups.
8. Compare MCP pricing for the first quarter of 2019 to the HDS BenchMarket price, which is a proprietary survey-based market competitive price for multisource generic medications.
    a. While not expressly anti-competitive, unnecessary or excessive price fluctuations can create instability to pharmacies and raises concerns about the lack of transparency with PBM practices.
9. Provide recommendations for correcting drug mis-categorization and pricing issues.

a. HDS provided several recommendations that align with action ODM is taking and analytic tools ODM is deploying to enable more robust monitoring and oversight of the administration of the pharmacy benefit by the Plans and PBMs.

## Conclusions from the HealthCare Data Solutions Report and additional ODM findings

1. **HDS provided independent verification that the pass-through pricing model was effectively implemented.**
    a. By comparing claims from Q4 2018 and the Q1 2019, HDS was able to confirm that pass-through occurred as anticipated in 98.5% of the claims. Mismatches in third party liability was the most common cause of discrepancy.
    b. HDS found that the implementation of pass-through was associated with a 5.74% increase of amounts paid to pharmacies between Q4 2018 and Q1 2019. This is an increase of $38.4M in payment to pharmacies.
    c. Both ingredient costs and dispensing fees increased between Q4 2018 and Q1 2019. Seasonal variation and market fluctuations may explain some of these changes, however, HDS also found evidence that the MCPs made additional efforts to ensure fair payments were made to the pharmacies by their PBMs; "HDS calculated that 92.15% of this increase is due to an improvement in the reimbursement for traditional generic drugs."
    d. The improvement in payments was distributed as follows:
        i. Retail: 95.4%
        ii. Mail order: -0.03%
        iii. Specialty: 4.09%

2. **HDS was unable to identify any preferential or anti-competitive pricing that may have been implemented between Q4 2018 and Q1 2019 by the PBMs that serviced the five MCPs contracted with Ohio Medicaid.**[ii]
    a. Grouping pharmacy providers by "like" or common ownership and assessing payments for ingredient cost demonstrated less discounting in the Q1 2019 and higher payments to pharmacies, indicating that PBMs were not influencing where members could obtain pharmaceuticals.
    b. While the HDS report did not identify anti-competitive pricing by PBMs, there is evidence that some of the drugs themselves may have been overpaid and some drugs underpaid.
    c. Specialty drug orders fulfilled by pharmacies owned by the PBM/Plan were examined. While a significant number of claims were filled by PBM/MCP owned pharmacies (35-46%), there was much less exclusivity than expected. However, this alone does not address the full scope of ODM's concerns about specialty drugs, so additional work will be done to assess this area of the market.

3. **"Over" and "underpayment" of drugs was examined in the aggregate by ODM.**
    a. Table 8 in the HDS report identified "overpriced" drugs, using HDS's proprietary analytic engine. Overpriced drugs were calculated as $4.8m above HDS's determination of benchmark.
    b. Similarly, Table 9 identifies "underpriced" drugs. Underpriced drugs were calculated as $19m below HDS's determination of benchmark.
    c. Neither ODM nor the Plans want to overpay for drugs; nor do they want to underpay, negatively impacting consumer access and pharmacies. It is important to note that prices for drugs vary from month to month, if not more frequently. So, this point-in-time, aggregate calculation indicates a net variance of $14.2m. With a total quarterly spend of approximately $800m, the variance represents 2%. ODM has contracted with MediSpan to receive accurate pricing details on every drug covered by Medicaid. By the end of 2019, ODM will be able to monitor for outliers on a weekly basis and provide feedback and guidance to the Plans.

## Findings from the ODM Analysis of Administrative Costs

The total cost of providing medications and the pharmacy benefit to individuals served by Ohio Medicaid includes, what is

- Paid to pharmacies, including ingredient costs and dispensing fees
- Paid to PBMs, including payment for contracted PBM services and PBM administrative cost
- Paid to MCOs to administer the PBM contract and services and other administrative cost associated with administering the pharmacy benefit.

**ODM has created a dashboard describing these administrative costs to enable a variety of analysis. This aggregate data is now available, providing unprecedented visibility to the general public.**

**CLICK TO VIEW DASHBOARD**[1]

Administrative data has been combined with claims-related information to construct the dashboard on the efficiency of each Plan's pharmacy program. Variation between Plans and drugs can now be monitored on a quarterly basis, and the data can be used to evaluate the detailed impact of any further requirements or changes. These data will allow ODM to help manage an appropriate balance between the MCPs, PBMs, and pharmacies while maintaining the highest standards of access for all individuals served by Medicaid.

Current data shows Plans and their PBMs spend approximately $50 million per quarter administering the pharmacy benefit for the Ohio Medicaid managed care plans. The Plans, through their PBMs, reimburse pharmacies approximately $800 million dollars in ingredient costs and dispensing fees. The

[1] https://analytics.das.ohio.gov/#/site/ODMPUB/views/PBMRxDashboard/Dictionary?

administration of the pharmacy benefit for the first quarter of 2019 was about 6% of the total pharmacy reimbursement rate.

Administration of the pharmacy benefit involves a complex interchange between manufacturers, wholesalers, labelers, retailers, PBMs, MCOs, third party payers and regulators. Spending additional funds at any portion of the supply chain can have both positive and negative impacts on the final drug price. For instance, a Plan may choose to spend more on administrative oversight, and this additional cost could result better negotiated rates resulting in net savings to the system. Higher administrative costs may have positive outcomes, such as improving outcomes, improving quality, and/ or access for consumers. For example, a PBM program to increase adherence to medications, while costing more money and increasing utilization of medications, improves health and outcomes. Another example, if Plans and PBMs reimburse pharmacists at a higher rate (while not increasing their own profits), this could create additional access within the system even though total expenditures may be slightly higher.

## HDS Recommendations and Other ODM Actions

1. Additional analysis of specialty drugs is being conducted by ODM
    a. ODM requested that HDS provide a list of all drugs categorized as specialty drugs by any of the Plans. This data is being assessed now and will provide a basis for further analysis and monitoring and will help inform the work of implementing the Unified Preferred Drug List (UPDL) in January 2020. (Unified Preferred Drug List white paper) In addition, ODM will be monitoring the Plans' specialty drug lists regularly.

Additional recommendations by HDS regarding specialty drugs, followed by ODM action, include:

2. Decisions regarding drug categorizations, formularies and Maximum Allowable Cost (MAC) pricing would be better managed by a third-party vendor without ownership associated with the PBM or Plans
3. MCPs and ODM could benefit from a more effective and balanced generic price management process
    a. Pilot program for real-time MAC benchmarking
    b. Considering reference-based pricing
    c. Implementation of a single PBM
4. Change contract language allowing MCPs control over specialty drug list
    a. The current ODM-Plan provider agreement contains several important requirements related to managing specialty drugs. (Strengthening Managed Care Contracts white paper) Additional changes to the January 2020 agreement are being considered. Targeted data analysis and monitoring is being implemented.
    b. To put additional guardrails around the categorization of specialty drugs by MCPs or PBMs, ODM is considering various options for consistent identification and management of specialty drugs
5. Require a PBM that owns a specialty pharmacy to allow any willing provider to fill specialty prescriptions available to them with no associated penalties
    a. While ODM does not agree with the recommendation to require "any willing provider", some current requirements are in place and additional changes for January 2020 are

being considered in order to provide more competition. For example, ODM's July 2019 contract prohibits steering toward commonly owned entities. Finally, the potential for abuse exists, filling prescriptions at a PBM's commonly owned specialty pharmacy may be associated with lower cost because there is more control over the supply chain. ODM is monitoring these practices with the new dashboard and will adjust the provider agreement accordingly as additional evidence warrants changes.

6. Contract language allowing MCP input on the pricing of generic specialty drugs and requiring the inclusion of generic specialty drugs on the MAC list.
    a. The pricing of specialty drugs, and particularly generic specialty drugs, is a universal concern. The implementation of a single PBM will address this concern in the future. In the meantime, other options are being considered, additional changes will be made to the ODM-Plan provider agreement, and additional data analysis and monitoring will be completed. The pilot program for real-time MAC benchmarking may also address this concern.
7. Aggregate pricing discount guarantee on brand specialty drugs.
    a. The suggestion that rather than a pricing structure that combines price guarantees for all drugs, PBMs should be required to separate the specialty drug pricing structure from the other drugs.
    b. The pilot program for real-time benchmarking is intended to address this concern, by providing additional transparency in the pricing process.
    c. Action related to specialty drugs described in recommendation four above also addresses this concern.
    d. As noted above in recommendation number six, the implementation of a single PBM will be designed to address this concern, and others, in the future. In the meantime, other options are being considered, additional changes will be made to the ODM-Plan provider agreement, and additional data analysis and monitoring will be completed.

## Conclusion

The goal of implementing the pass-through pricing model was transparency. The results indicate that the transparent pass-through pricing model has been successfully implemented for the first quarter of 2019. The analysis conducted by HDS will be continued by ODM going forward, to assure continued integrity to the approach. This Executive Summary enumerates many important changes that have already been implemented and more that is to come, to improve the overall performance of Ohio's Medicaid pharmaceutical benefit and to continue to lead the nation in transparency and innovation.

---

[i] Corcoran, Maureen. Director, Ohio Department of Medicaid. April 25, 2019. State of Ohio Senate Finance Committee Testimony. Pages 12-13. https://medicaid.ohio.gov/Portals/0/Resources/Budget/OhioSenateFinance04252019.pdf

[ii] ODM contracts with the following managed care plans: Buckeye Health Plan, Caresource, Molina Healthcare, Paramount Advantage and UnitedHealthcare Community Plan. MyCare is not included in this analysis.