House Finance & Facilities Subcommittee

Pharmacy Benefit Manager Pricing Practices in the Statewide Medicaid Managed Care Program

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Overview

Background on FL Medicaid pharmacy benefit

What is a Pharmacy Benefits Manager

Key results from Milliman report

The Florida Medicaid Program

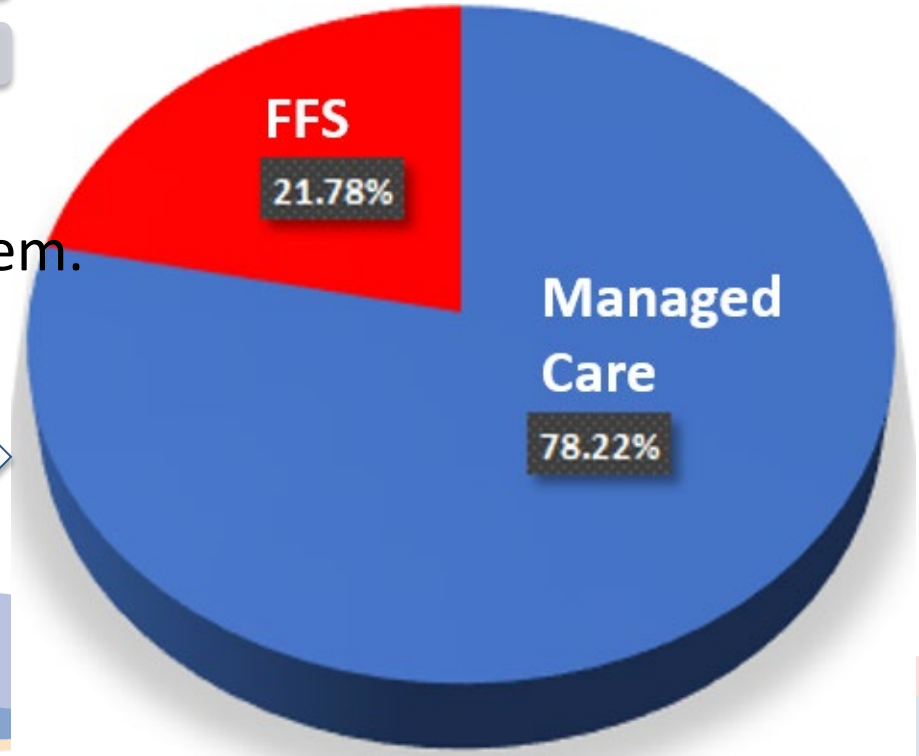
Medicaid serves about 4.5 million of the most vulnerable Floridians:

1.6 million	• Adults - parents, elderly, and disabled
48%	• Children in Florida
56%	• Birth deliveries in Florida
63%	• Nursing home days in Florida

A majority of Florida's Medicaid population receives Medicaid services through a managed care delivery system.

Statewide Medicaid Managed Care (SMMC) Program

- Implemented in 2013-2014



Florida Medicaid Pharmacy Benefits

- Medicaid covers all drugs approved by the Food and Drug Administration.
- The Agency maintains a Medicaid preferred drug list (PDL), which is a listing of cost-effective, safe and clinically efficient medications for each of the therapeutic classes on the list.
  - Drugs on the PDL generally do not require prior authorization.

Medicaid health plans must provide medically necessary prescription drugs to all their Medicaid members.

The same pharmacy benefit is available to all Florida Medicaid recipients, whether they are in the fee-for-service delivery system or the SMMC program.

Health plans must follow the Agency's PDL.

Florida Medicaid Pharmacy Benefit

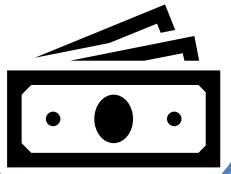
Statewide Medicaid Managed Care program (SMMC) plans are:

- Paid a capitated rate, which is a per-member, per-month amount that covers the cost of providing the required care and administering the contract.
- Responsible for maintaining a network of providers sufficient to meet the needs of their enrollees, based on network standard established by the Agency.

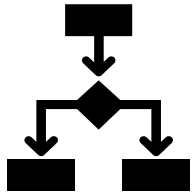
Required Pharmacy Network Standards for Health Plans			
	Maximum time (minutes)	Maximum distance (miles)	Providers per Enrollee
Pharmacy	15	10	1:2,500 enrollees
24-hour Pharmacy	60	45	N/A

What is a Pharmacy Benefits Manager (PBM)?

PBMs are central to the pharmacy supply chain across all lines of healthcare business—commercial, Medicare, and Medicaid



They work on behalf of insurers to negotiate better rates with pharmacy suppliers.



They administer pharmacy benefits according to the benefit structure dictated by the insurer.

<u>Duties can include:</u> Developing formularies, negotiating rebates with manufacturers, contracting with pharmacies, clinical authorization of drugs, paying claims

Pharmacy Benefits Manager Role in Medicaid

- The SMMC plans use seven different PBMs to provide services that include:
  - Developing and maintaining a network of contracted pharmacies
  - Performing prior authorization and utilization management of prescription drugs
  - Maintaining point of sale systems
  - Paying pharmacy claims
- PBMs can own pharmacies

Current SMMC Plan PBMs
CVS Caremark
Envolve Pharmacy Solutions
Humana Pharmacy Solutions
IngenioRx, Inc.
Magellan Rx
OptumRx
PerformRx

Manufacturer Rebates

- The State recoups a significant part of the retail cost of prescriptions reimbursed by Florida Medicaid through rebates paid by pharmaceutical manufacturers.
  - Rebates required by the federal government
  - State negotiated supplemental rebates

Florida Medicaid negotiates rebates on prescriptions paid for through both fee-for-service and SMMC.

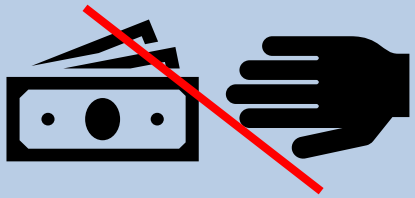
Plans are not permitted to negotiate or collect any drug rebates with pharmaceutical manufacturers.

The Agency is the sole negotiator of pharmaceutical rebates for all prescribed drugs, and all rebate payments for prescribed drugs are made to the Agency.

PBMs in Florida Medicaid Do NOT:

Create or maintain a formulary of drugs

The Agency maintains the Preferred Drug List, which is recommended by the Pharmaceutical and Therapeutics Committee.



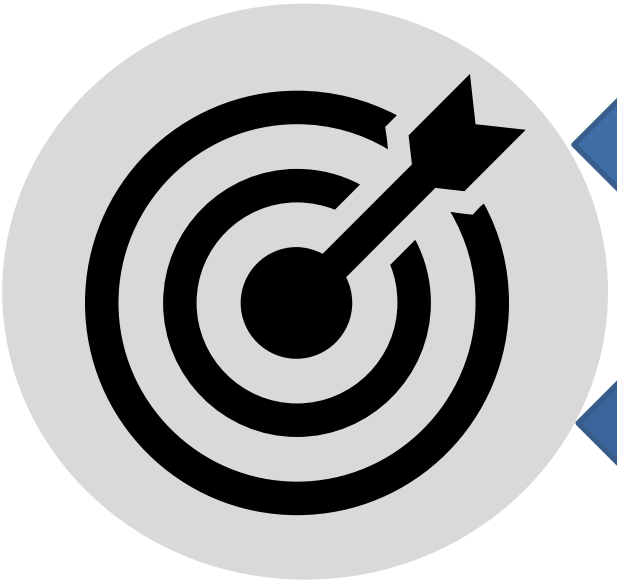
Negotiate or collect drug rebates from drug manufacturers

The Agency does this for all Medicaid-funded drugs.

The Milliman PBM Report

AHCA Retained Milliman to perform an independent analysis of PBM practices in the SMMC program.

GOALS:



- Provide a better understanding of the current landscape of Medicaid pricing practices
- Answer questions being asked by stakeholders and policymakers

The report is NOT intended to:	
✕	Make policy recommendations
✕	Identify savings opportunities
✕	Address lines of business other than Medicaid*

*Most provider contracts with PBM involve multiple lines of business (Medicaid, Medicare, Commercial, etc.)

Milliman's Analysis – Goals and Scope

Analysis Scope

- Analyzed 22.7 million claims for the most recent 12-month contract performance period for each SMMC plan
- 15 SMMC **plans paid $2.1378 billion** to 7 PBMs for the direct reimbursement of prescription claims
- Received both plan-to-PBM claims and PBM-to-pharmacy remittance claims
- Reviewed the plan-to-PBM contracts and reconciliation reports

Milliman Report Findings are Consistent with Other States

- The findings of the report show that PBM operations in FL Medicaid are consistent with operations in other states.
- Over 30 states have made some level of change in relation to PBMs.

Overview of Pharmacy Supply Chain and Reimbursement Flow

Types of Plan-to-PBM Pricing Methodologies

Spread Pricing

- The PBM charges the managed care plan an amount different (higher) than the amount the PBM reimburses the pharmacy for the covered drugs dispensed.

Pass-through Pricing

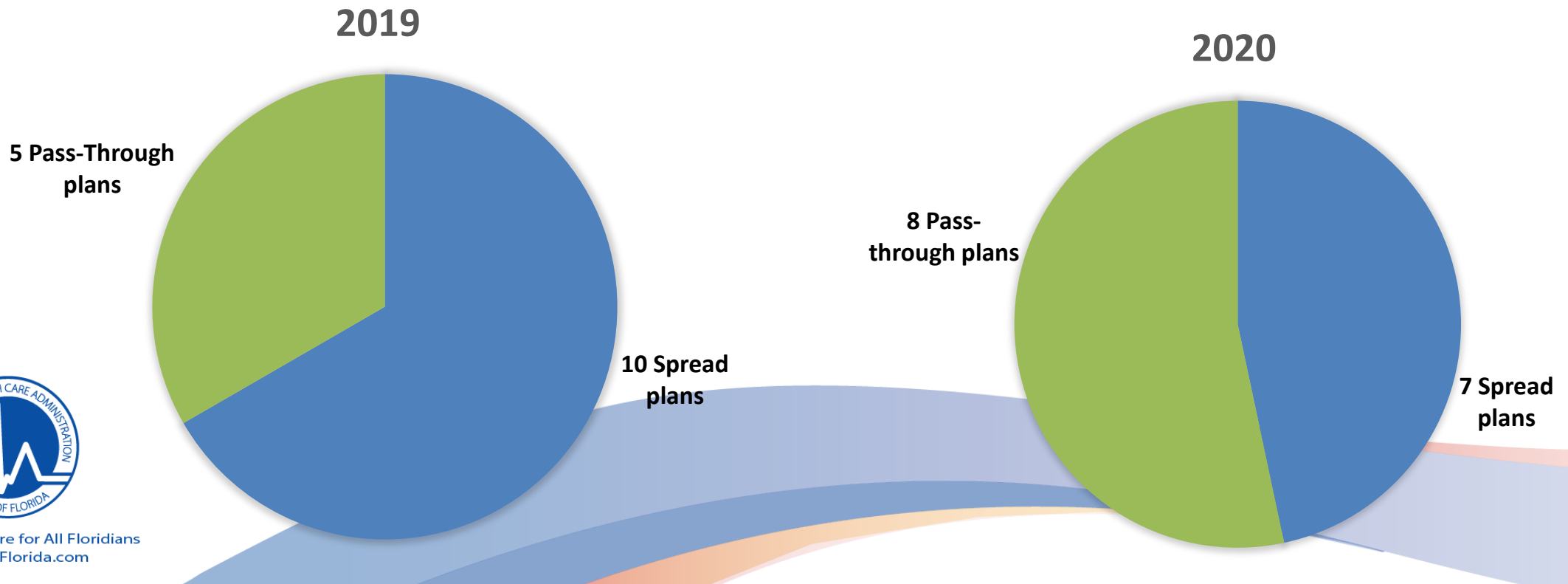
- The PBM reimburses the pharmacy the same amount the PBM collects from the managed care plan for the covered drugs dispensed.
- The PBM charges the managed care plan a separate administrative fee.

Fee-for-Service (FFS) Pricing

- Florida's Medicaid FFS pricing schedule is defined by setting pharmacy reimbursement to a cost-plus model with a $10.24 per claim professional dispensing fee where applicable.
- The PBM charges a separate administrative fee to implement FFS pricing.

Plans by PBM Contract Type: Spread vs. Pass-through

- Plans are moving away from spread pricing.
  - In 2019, 10 plans (45.8% of pharmacy claims) were in spread arrangements and 5 plans (54.2% of pharmacy claims) were in pass-through arrangements.
  - In 2020, 7 plans (17.9% of pharmacy claims) were in spread arrangements and 8 plans (82.1% of pharmacy claims) were in pass-through arrangements.



Milliman's Analysis – Results

PBM Payments: Total for SMMC Program

- Total claim payment difference between the plan-to-PBM and the PBM-to-pharmacy payments
  - $2.1378 billion paid to PBMs by plans
  - $2.0482 billion paid to pharmacies by PBMs
  - Difference of $89.6 million (4.1% of total plan-to-PBM claim payments)
- Plans paid PBMs $17.9 million in administrative fees in pass-through payment arrangements

Milliman's Analysis – Results

PBM Payments: Spread Arrangements

- Plans in spread arrangements pay PBMs $91.20 per claim and PBMs reimburse pharmacies $82.56 per claim
  - $946.1 million paid to PBMs by plans
  - $856.5 million paid to pharmacies by PBMs
  - Difference of $89.6 million (9.5% of plan-to-PBM claim payments)
- Spread is mostly identified in retail generic prescriptions
  - $67.2 million of the $89.6 million in observed spread

Milliman's Analysis – Results

PBM Payments: Pass-through Arrangements

- Plans in pass-through arrangements pay PBMs $96.92 per claim and PBMs reimburse pharmacies the same amount resulting in zero spread
  - $1.1917 billion paid to PBMs by plans
  - $1.1917 billion paid to pharmacies by PBMs
- Plans also pay an administrative fee to the PBMs equal to $1.45 per claim
  - $17.9 million (1.5% of plan-to-PBM claim payments)

Milliman's Analysis – Results

Other Types of Fees Paid to PBMs by Pharmacies

- **Transaction fees paid by pharmacies to PBMs are commonly found within PBM-to-pharmacy contracts. For the SMMC contracts plans reported their respective PBMs collected approximately:**
  - **$5.8 million in transaction fees per year**
  - **$0.13 per claim**
  - **0.3% of PBM-to-pharmacy payments**
- **Plans attested that there were no other network fees (e.g., DIR) charged to the pharmacies for SMMC utilization.**

Milliman's Analysis – Results

PBM Revenues

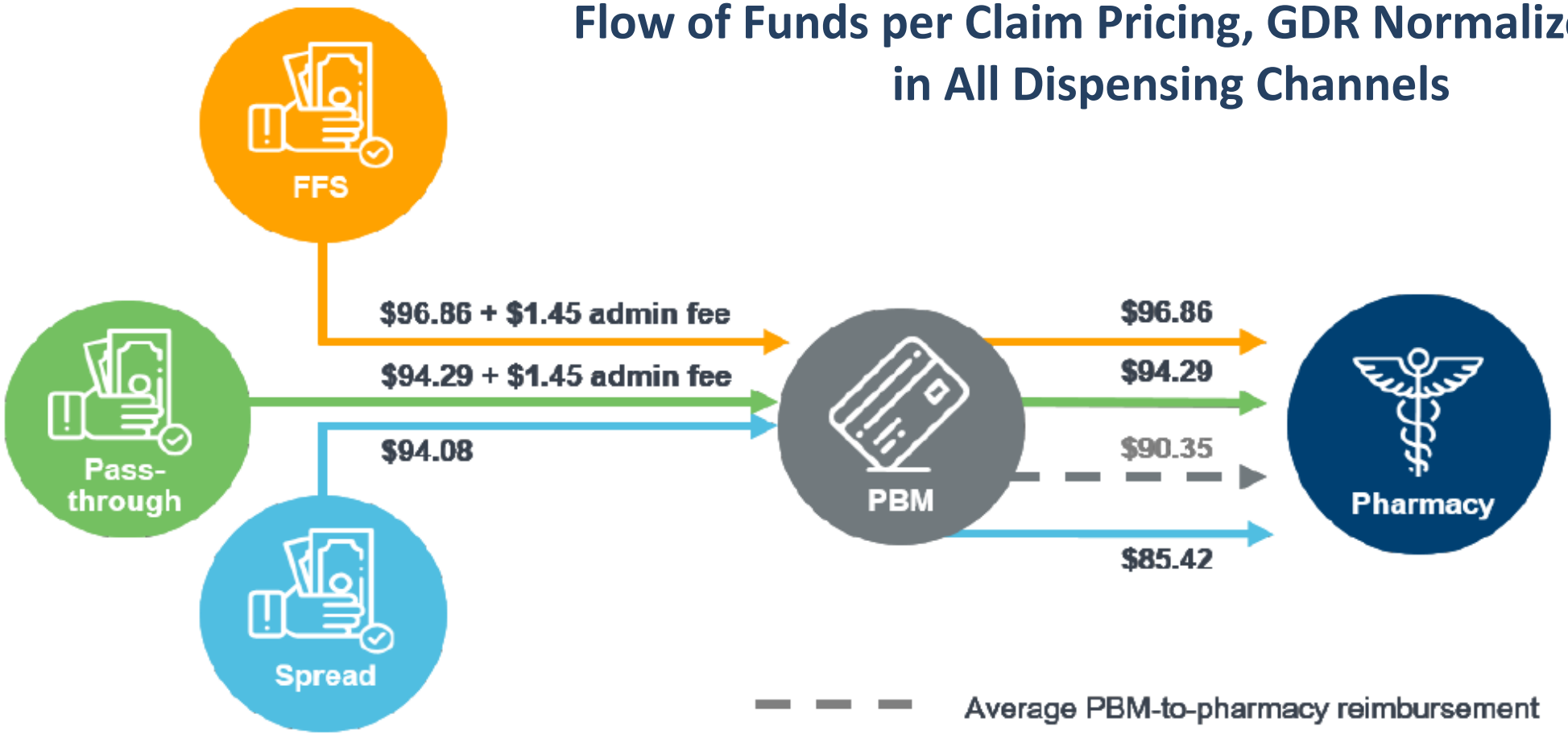
- PBMs retained $113.3 million in revenue:
  - $89.6 million spread pricing retention
  - $17.9 million in pass-through administrative fees
  - $5.8 million in transaction fees

Milliman's Analysis – Results

Additional Cost to Implement Florida's FFS Fee Schedule

- Repriced all SMMC pharmacy claims using the ingredient costs and professional dispensing fees paid to pharmacies under Florida's Medicaid FFS program
- If claims had been paid using the FFS methodology, it would result in the following differences compared to the current SMMC pricing arrangements
  - $171.5 million increase to pharmacy payments, driven by the FFS professional dispensing fee of $10.24 per claim
  - $72.7 million decrease to PBM payments
- Net impact is a $98.8 million increase to the cost of the SMMC program (4.6% of plan paid)

Flow of Funds per Claim Pricing, GDR Normalized Claims in All Dispensing Channels



	CALCULATED SPREAD USING SPECIFIC PAYMENT AMOUNT	CALCULATED SPREAD USING PBM-TO-PHARMACY AVERAGE PAYMENT
Plans with Spread	$94.08 - $85.42 = $8.66 (9.2%)	$94.08 - $90.35 = $3.73 (4.0%)
Plans with Pass-through	$94.29 - $94.29 = $0 (0%)	$94.29 - $90.35 = $3.94 (4.2%)

Note: It is not possible to discern which PBM pricing arrangement provides the lowest pharmacy costs to a managed care plan through a direct comparison of the spread and pass-through results above.

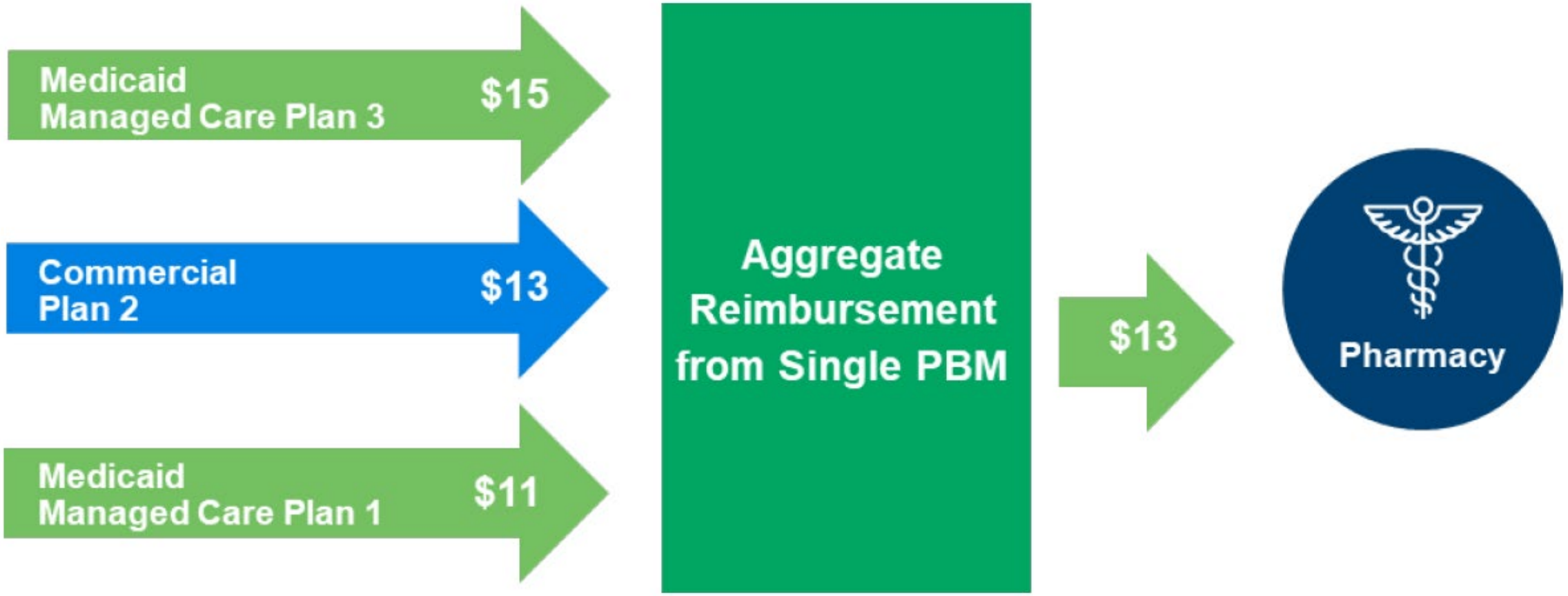
PBM-to-Pharmacy Contract Structures

Typical Contract Arrangements: OGER

- PBMs contract directly with pharmacies or with pharmacies through pharmacy services administration organizations (PSAOs).
- Overall guarantee effective rate (OGER) contracts are when the PBM negotiates an aggregate payment amount to the pharmacy over the contract period.
- For any individual claim payment, the amount paid to the participating pharmacy may not equal the total amount due the pharmacy because the typical OGER contract reconciles the guarantee payments in the aggregate across all commercial and Medicaid contracts.
- For example, an OGER contract may guarantee:
  - A discount rate of 87% off average wholesale price (AWP) for all generics.
  - A typical 30-day generic prescription with $100 AWP will equate to a $13 reimbursement to the pharmacy under an OGER contract.

PBM-to-Pharmacy Contracts and Payments

Using a $13 generic drug example, the PBM has the ability to pay more than the OGER to the pharmacy for claims where they have a pass-through pricing contract with a managed care plan and pay less than the OGER to the pharmacy for claims where they have a spread pricing contract with a different managed care plan as long as the guarantee is met in aggregate across all commercial and Medicaid contracts.



PBM-to-Pharmacy Contract Structures

Typical Contract Arrangements: Non-OGER

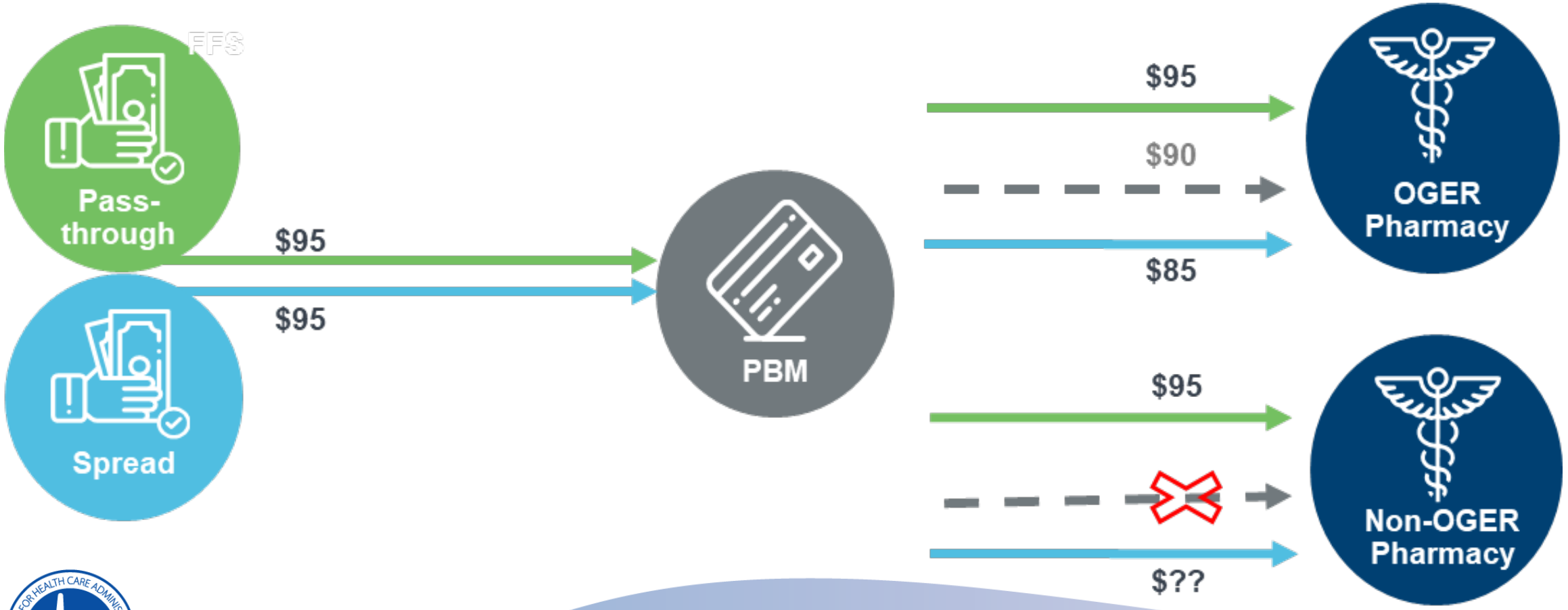
- Non-OGER contracts are when the PBM's contract with the pharmacy does not include a contractually required payment amount, although there is a drug-specific pricing floor that the PBM is unable to price below.
- This means every generic prescription could be paid to the pharmacy at what the PBM estimates is the actual acquisition cost to the pharmacy.
- It is common for independent and community pharmacies (non-national chain pharmacies) to be in these types of contracts.
- For example, a non-OGER arrangement typically reimburses pharmacies:
  - The pass-through amount under pass-through arrangements
  - A lower amount under spread arrangements, subject to some minimum floors
  - No reconciliation since there is no payment guarantee provision

How Pricing Models Affect Chain and Large-scale Pharmacies vs. Independent Pharmacies

Pharmacies without guaranteed contracts with the PBMs (non-overall guarantee effective rate (OGER) – typically independent pharmacies) will receive higher levels of payment for claims from plans with pass-through arrangements and receive lower payments for claims from plans with spread arrangements, but these two separate payment streams do not balance to an overall guarantee.

- **This means the non-OGER pharmacies can be financially affected if they dispense a disproportionate number of claims from plans in spread arrangements.**

How Pricing Models Affect Chain and Large-scale Pharmacies vs. Independent Pharmacies



Pharmacy Location Claims Distribution by Pharmacy Type

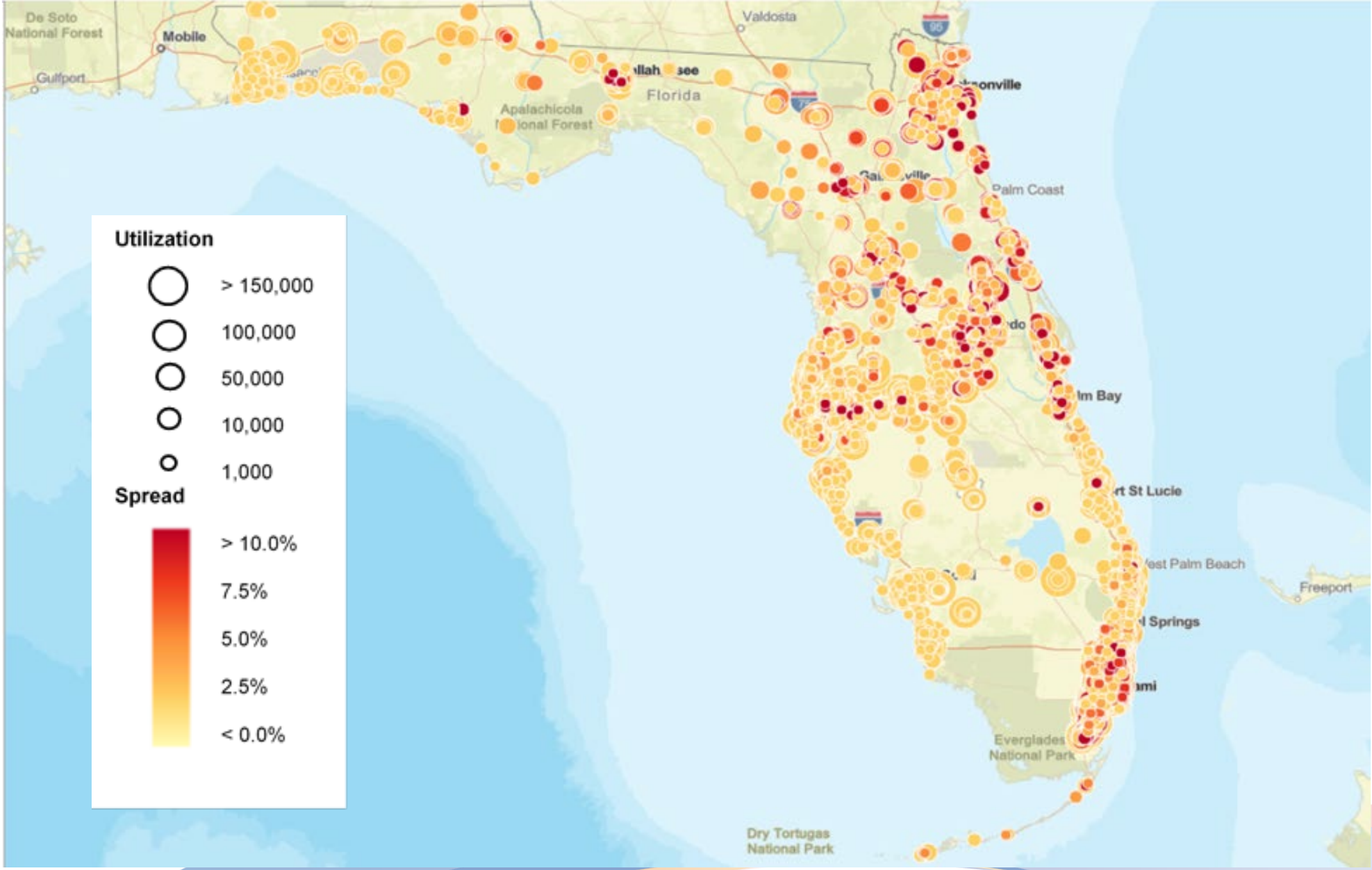
Chains are more common in urban areas; independents and chains are about equal in rural areas; and in "super-rural" areas, >50% are independents

Pharmacy Location	Independent	Chain	PBM Owned	Other	TOTAL
Urban	16.5%	56.9%	26.1%	0.5%	100.0%
Rural	36.2%	40.8%	23.0%	0.0%	100.0%
Super Rural	54.5%	21.9%	23.6%	0.0%	100.0%

Geographical Considerations

A single pharmacy could receive a disproportionate number of Medicaid claims in higher per-claim reimbursement pass-through arrangements and benefit from not having corresponding lower per-claim reimbursement from spread. The inverse of this scenario is also possible.

Another consideration is independent pharmacies in a pharmacy services administrative organization (PSAO) contract with a contracted guaranteed payment rate. Independent pharmacies in a geographical area with plans that have pass-through arrangements may receive higher reimbursement relative to independent pharmacies that are located in areas with plans that have spread arrangements.


Utilization
> 150,000
100,000
50,000
10,000
1,000
Spread
> 10.0%
7.5%
5.0%
2.5%
< 0.0%
De Soto National Forest
Mobile
Gulfport
Valdosta
Florida
Apalachicola National Forest
Palm Coast
Freeport
Everglades National Park
Dry Tortugas National Park

Milliman's Analysis – Recap of Results

High-Level Results

1. Total claim payment difference between the plan-to-PBM and the PBM-to-pharmacy payments was $89.6 million (4.1% of total plan-to-PBM claim payments). Plans paid PBMs $17.9 million in administrative fees in pass-through payment arrangements.
2. Plans in spread arrangements pay PBMs $91.20 per claim and PBMs reimburse pharmacies $82.56 per claim, generating a 9.5% spread. Spread is mostly identified in the retail generic prescriptions.
3. Plans in pass-through arrangements pay PBMs $96.92 per claim and PBMs reimburse pharmacies the same amount resulting in zero spread, but the plan also pays an administrative fee to the PBMs equal to $1.45 per claim (1.5% of plan-to-PBM claim payments).

Milliman's Analysis – Recap of Results

High-Level Results, cont'd

4. Plans reported their respective PBMs collected approximately $5.8 million in transaction fees per year from participating pharmacies. These are commonly found within PBM-to-pharmacy contracts.
5. Plans attested that there were no other network fees (e.g. DIR) charged to the pharmacies for SMMC utilization.
6. Repricing all SMMC pharmacy claims using the Florida FFS fee schedule resulted in an increased cost to the SMMC program of approximately $98.8 million compared to current pricing arrangements (4.6% of plan paid).

Caveats

The following items were not part of this analysis:

1. **SMMC program cost changes if claims were to move from spread to pass-through and vice versa**
2. **Analysis of manufacturer federal and supplemental rebates**
3. **PBM pricing practices for the Commercial and Medicare lines of business**
4. **PBM profitability and financial audits**

Questions