Dave Yost • Auditor of State

Joint Medicaid Oversight Committee

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Analysis of Ohio's Medicaid Managed Care Pharmacy Services
August 16, 2018

Chairman Burke, Ranking Member Sykes, and members of Joint Medicaid Oversight Committee, thank you for allowing me to share some of our findings relative to pharmacy benefit management in Ohio's Medicaid Program.

In March of this year, the Speaker of the House and several State Representatives asked that my office perform an examination of Pharmacy Benefit Manager (PBM) services contracted with Ohio's Medicaid Managed Care Plans.

As far as we can surmise, this is the first report of its kind in the country. Only Virginia has run a similar report and it only looked at one quarter of data.

Specifically, legislators expressed the following concerns:

1) Lack of transparency in obtaining data on pharmacy services;
2) A discrepancy between pharmacy reimbursement and overall costs to the Medicaid program (spread pricing);
3) Potential conflict of interest related to a retail pharmacy chain that is affiliated with one of the Medicaid PBMs and reported reductions in pharmacy reimbursements; and
4) The impact of reductions in pharmacy reimbursement on access to care, particularly in rural communities.

But before delving into the micro, there are several things at the macro level worth pointing out. In 2011, when Ohio moved from a fee-for-service model on prescription drug benefits to a PBM model, the managed care plans, and by extension, Medicaid, hired out one of their core functions to a private entity. This happens all the time in government, and sometimes to great effect – improved efficiency, better service delivery, and ultimately cost-savings to taxpayers. But when the State hires out a public function to the private sector, the State deserves a window into that operation, at the very least to guard against anti-competitive practices and conflicts of interest.

Second, every Ohioan has the right to ask, in any transaction with the State, what are we getting for our money, what is the value proposition. In tracing the flow of public money across the cost chain – Taxpayer to ODM, ODM to managed care plans, managed care plans to PBMs, PBMs to pharmacies, and finally pharmacies delivering drugs to patients – one piece of that chain is clouded in secrecy – the PBM transaction.

We know PBMs provide a service to the State, and that Medicaid managed care PBMs save the State millions of dollars (over fee-for-service), but at what cost? That cost is the so-called black box. When administrative fees are hidden in the spread, it's impossible to tell what the state is really paying for, or whether the same service could be provided at a drastically lower rate. When the PBMs guarantee a low rate for the managed care plans, no one stops to think how they got there.

This report does not provide an exhaustive look at all parts of the Goldbergian PBM transaction some of which is hidden from view, such as rebates, fees, and drug costs. I would direct your attention to the areas for further study section of the report for a comprehensive list.

Our office reviewed pharmacy payment data related to the State's Medicaid managed care program and performed analyses of price spreading, the reimbursements to pharmacies and the amounts paid to PBMs. We reviewed contracts between the PBMs and the managed care plans. Finally, we obtained CVS Caremark's maximum allowable cost (MAC) lists for the period of one week; neither ODM nor HDS obtained these lists.

While the Department's announcement Tuesday that it will not use spread pricing next year relieves the immediate political pressure created by this committee's strong leadership on the issue, it leaves many of the larger questions unanswered. Is this proposed solution the best solution for Ohio, and will it serve to control costs? What has happened to the delivery system in Ohio during the past eight years, and have pharmacy closures left service gaps?

A pass-through model transfers the risk on cost fluctuations from PBMs back to the State. All the services PBMs currently provide for the managed care plans will still need to be provided, but now will take the form of a transaction fee tacked on to the actual charge for the drug. That transaction fee has the potential to be the new "black box" because you don't know what it represents, essentially the same problem we have now – what are we paying for?

We cannot be content to accept a "black box" in the delivery of public services, particularly a service ODM says it did not understand, and had insufficient data to assess either in its effectiveness or its unintended consequences in the marketplace. But for the General Assembly's work, it is not hard to imagine that the Administration might still today be content.

Spread-Pricing

Managed care plans reimburse PBMs on a pricing model that is based on the average wholesale price (AWP). PBMs reimburse pharmacies using different pricing models based on their contracts. As result, the amount reimbursed to a pharmacy by a PBM does not correlate to the amount paid to the PBM by the managed care plan for the same transaction.

PBMs provide a range of administrative functions on behalf of managed care plans and, in lieu of being paid a set fee for these functions; the PBM retains the difference between the managed care plan's payment and the amount paid to the pharmacy – the spread. The Auditor's office obtained and analyzed the difference between the payment from the managed care plan to the PBM and the PBM's payment to the pharmacy (the price spread data).

Average Spread by Quarter and by Drug Type from April 1, 2017 through March 31, 2018

	Average Spread			
Quarter	**Brand**	**Generic**	**Specialty**	**Total Average Spread for All Claims**
4/1/2017-6/30/2017	$2.11	$5.39	$30.12	$5.09
7/1/2017-9/30/2017	$2.03	$5.71	$31.91	$5.35
10/1/2017-12/31/2017	$1.57	$7.10	$31.24	$6.47
1/1/2018-3/31/2018	$1.62	$6.48	$46.04	$6.01
Yearly Total	**$1.85**	**$6.14**	**$33.49**	**$5.71**
	Brand	**Generic**	**Specialty**	**Totals**
Number of Prescriptions	**5,268,144**	**33,913,042**	**197,408**	**39,378,594**
Percentage of Claims	**13.4%**	**86.1%**	**0.50%**	**100%**
Amount Paid by Plans (millions)	**$1,246.1**	**$662.7**	**$617.6**	**$2,526.5**
Total Spread (millions)	**$9.8**	**$208.4**	**$6.6**	**$224.8**
Spread Relative to Total Paid Amount by Drug Type	**0.8%**	**31.4%**	**1.1%**	**8.9%**

Unlike the analysis performed by HDS (or at least the portion that has been released), our examination breaks down the spread by brand, generic, and specialty. As you can see, the average spread for all claims is $5.71 per claim, 8.9%, with a total spread of $224.8 million. The vast majority of the spread comes from generics - $208 million. Looking just at the generic spend, and calculating a spread relative to the total amount paid by drug type, the "generic spread" is 31.4%. As we know, the majority of the managed care plans' specialty are filled by

CVS Retail pharmacies, so those efficiencies, and the spread of $33.49, accrue to CVS Caremark. In other words, CVS is getting the full payment on these specialty drugs for four of the five managed care plans.

We also looked at the spread as it relates to CVS pharmacies compared to independents, then broke that down according to region.

Spread Analysis by Region and Pharmacy Type (for both PBMs - CVS and Optum)

	CVS Pharmacies			Independent Pharmacies		
	Brand	**Generic**	**Specialty**	**Brand**	**Generic**	**Specialty**
Combined Average Without Metro	**$2.37**	**$5.74**	**$53.42**	**$2.57**	**$5.80**	**$35.19**
Combined Average All	**$2.22**	**$5.63**	**$55.09**	**$2.10**	**$5.66**	**$39.08**

The data shows that the spread is similar for transactions between CVS Caremark and CVS pharmacies and between CVS Caremark and independents. On generics, the average spread for CVS pharmacies is $5.63, and the average for independents is $5.66. On specialty, the spread difference between CVS and independents is more pronounced, $55.09 for CVS pharmacies and $39.08 for independents.

But a cursory analysis here can be somewhat misleading. Even though a higher spread equates to a lower reimbursement to CVS pharmacies, CVS Caremark is still benefiting from the higher spread, and by extension, the parent company. In other words, even if the retail arm is receiving less, that's balanced out by the PBM arm receiving more -- the money is in different pockets, but the pockets are still in Caremark's pants.

Furthermore, the spread does not reflect all transactions between a pharmacy and PBM. For example, this spread analysis does not include fees paid back to the PBM by the pharmacy. Moreover, as mentioned earlier, many specialty drugs are filled by CVS Caremark's own specialty pharmacy – CVS Retail, both of which are owned by CVS Health. And we know significant rebates are offered to PBMs directly from the manufacturer, some of which are over and above the supplemental rebates we know about. In sum, the spread is just one component (and revenue stream) of the transaction between PBMs and pharmacies; the information needed to fully assess the flow of money is currently inaccessible.

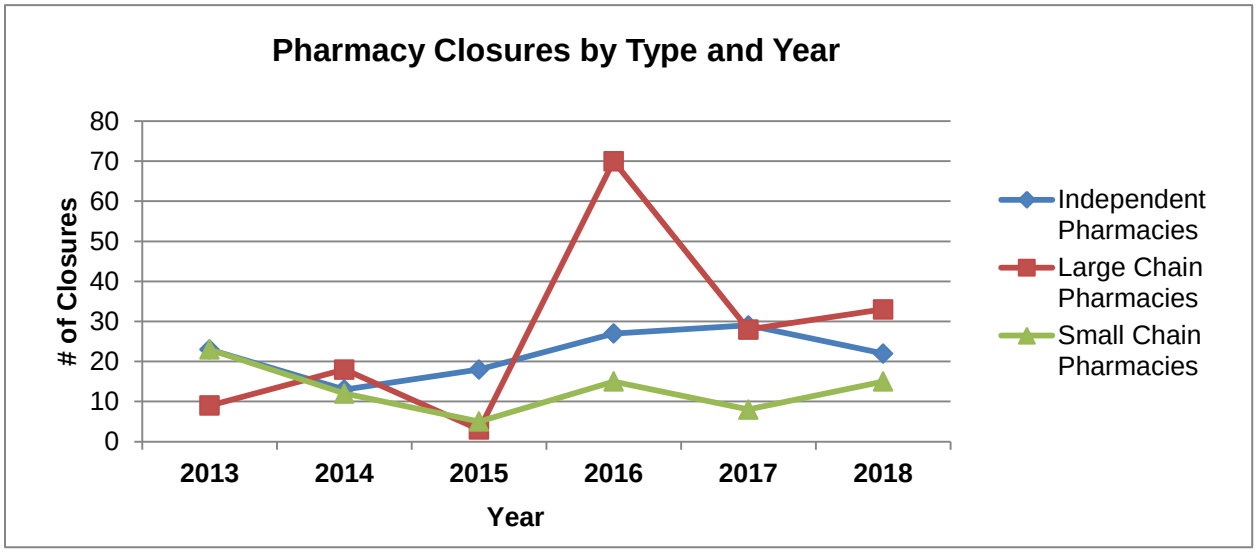
Regional Spread and Pharmacy Closure Data

Spread Analysis by Region and Pharmacy Type

	CVS Pharmacies			Independent Pharmacies		
Region	**Brand**	**Generic**	**Specialty**	**Brand**	**Generic**	**Specialty**
Metro	$2.04	$5.49	$57.02	$1.67	$5.50	$43.67
Central	$1.60	$5.83	$66.58	$1.80	$5.11	$24.21
Northeast	$2.51	$5.60	$50.68	$3.55	$6.71	$39.14
Northwest	$4.85	$7.13	$43.50	$3.71	$6.69	$25.32
Southeast	$1.91	$5.58	$62.92	$1.88	$4.90	$43.28
Southwest	$2.06	$5.57	$50.19	$1.77	$5.27	$31.32
Combined Average Without Metro	**$2.37**	**$5.74**	**$53.42**	**$2.57**	**$5.80**	**$35.19**
Combined Average All	**$2.22**	**$5.63**	**$55.09**	**$2.10**	**$5.66**	**$39.08**

Of particular note is the higher spread in northeast and northwest Ohio. The spread for independent community pharmacies in the northeast and northwest regions for this 12 month period was higher than other regions for both brand (69 and 77 percent, respectively) and generic (19 and 18 percent, respectively) drugs. Since higher spread typically correlates to lower reimbursement, this raises questions as to why reimbursement rates are lower in these regions of the state. The pharmacy closure data shows that 48 percent of Ohio independent pharmacies closed since 2013 were located in these two regions, however this data does not include information on pharmacy *openings*, nor does it necessarily show causality. Further research is necessary to determine the cause of these closures.

Since 2013, 210 independent community (132) and small chain pharmacies (78) have closed, as well as 161 large chain pharmacies.



As you can see, there has been an overall increase in closures for both small chain and independent pharmacies from 2015 on, with continuing increases for independent pharmacies in ’17. The spike in large chain closures in ’16 was likely caused by the closure and reopening of Target Corp. pharmacies. The data for 2018 only represents the first 5 months of 2018.

The Northeast region has the highest number of closures (133), followed by southwest (93), central (63), northwest (55), and southeast (27).

Department of Medicaid Oversight and HDS Report

For the most part, ODM has constrained its monitoring to the managed care plans, not the entities they contract with to perform their core functions. In April of this year, the Department amended its agreements with the plans to require increased pharmacy data reporting, including all financial terms and agreements with PBMs, encounter data, and the spread. You are well aware of the HealthPlan Data Solutions (HDS) report commissioned by ODM, which tracks very closely to our findings with regard to spread data.

The HDS report recommended that the MCPs move to a pass-through pricing model and estimated such a change would result in a “**net decrease** in prescription plan costs for the MCPs [of] **$16,154,557.17** while **increasing** the pharmacy reimbursement by **$191,038,145.91**”

Although the HDS report concluded moving PBM functions in-house would not accrue a cost-savings (as West Virginia has done), the methodology behind such a conclusion has not been made publicly available. This is another area worthy of further investigation.

Other State Initiatives

Several states have taken action in this area and we’d be wise to look to those efforts for guidance. I will not detail these initiatives now, but we have noted them in the text of our report.

Recommendations and Conclusion

In addition to the recommendations I’ve already mentioned, the state should do the following:

- Conduct independent periodic compliance audits of PBM contracts with managed-care plans.
- Obtain financial information to document transactions that occur outside of claims adjudication, including the financial terms between managed care plans, PBMs, drug manufacturers, and pharmacies, data sales fees, and other fees/rebates.
- Strengthen the internal control procedures over drug rebate contract monitoring.

These recommendations are not impacted by the Department's announcement on Tuesday, and represent simple good management -- practices that should have been in place well in advance of this year's hearings. They still should be implemented.

Our report does not directly address allegations of anti-competitive practices. It should be noted that of the PBMs operating in Ohio's Medicaid space, CVS Caremark is the only PBM that shares ownership with a pharmacy (CVS Health owns CVS Retail and CVS Caremark). Representatives of CVS Caremark interviewed as part of this report stated that a "firewall" is maintained between CVS Retail Pharmacies and CVS Caremark. During interviews with interested parties, it was suggested that CVS Retail pharmacy technicians are prompted as to which NDC to pick from a list to maximize the spread. CVS Caremark representative deny that this takes place. This report does not address this practice, nor did we have access to information to investigate such a practice.

We also inquired with representatives of CVS Caremark as to whether they sell data associated with PBM facilitated transactions, as another potential revenue stream. Officials were uncertain as to whether this takes place. Based on a review of contracts between PBMs and the Medicaid managed care plans, there are no provisions prohibiting the sale of data by a PBM to a third party.

Finally, I'd like to point out that this "black box" problem is not new or isolated to PBMs. It occurs with some regularity in the delivery of public services, and is a function of off-loading public services into subcontracts with private sector firms that are not transparent or accountable.

We turn to the private sector to provide public services for reasons of efficiency and cost control. No one would argue that the government could construct a building or run a janitorial service more efficiently than the private firms whose core business it is -- so we contract for those things.

This is because of the profit motive. A private business gets to keep what it does not spend, and so is highly motivated to find the most efficient way to do a thing, to innovate and adapt.

But we should recognize that when we in government use private sector contracts to bring in efficiency and cost control to public service, we invite the profits in, too.

And privately contracted or subcontracted services become more questionable the further we go into government's core functions. We would never accept a privatized police force, no matter the level of efficiency or savings.

It is time for us to think carefully about when we should be willing to use private contracts to obtain public goals, and what safeguards are necessary to preserve transparency, assess effectiveness, and understand collateral and often unintended consequences.

Thank you for allowing me to report to you on this important matter that deserves swift action. I'd be happy to address any questions you have at this time.

Regions and counties used in this report