Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Managed care purchasing arrangements for prescription drugs

Engrossed Substitute House Bill 1109; Section 211(56); Chapter 415; Laws of 2019

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Executive summary

Prescription drug expenditures continue to rise year-over-year due to increases in drug pricing, increases in prescription drug use by patients, and new-to-market drugs launching at record prices. For Washington State, the Health Care Authority (HCA) works to create fair and equitable pharmacy programs that balance cost and access, but rising prescription drug costs continue to exert pressure on the state budget. Given the recent budget forecasts, there is renewed attention and urgency to explore innovative pharmacy management strategies that can significantly reduce costs while maintaining access to appropriate medications and adhering to federal requirements.

One recent strategy that has produced savings is the Washington Apple Health (Medicaid) Preferred Drug List (PDL). The Apple Health PDL aligns all Apple Health programs to preferred drugs that are the lowest net cost to the state and use consistent clinical criteria for utilization management. To supplement this strategy, the Washington State Legislature sought an analysis to evaluate the rates at which the Apple Health programs reimburse pharmacies for prescription drugs.

Pursuant to the budget proviso in Section 211(56) of Engrossed Substitute House Bill (ESHB) 1109, Chapter 415, Laws of 2019, HCA conducted a financial analysis that compared the costs of paid prescription drug claims from all Apple Health managed care organizations (MCOs) against the contracted rates for the Northwest Prescription Drug Consortium (Consortium) for state fiscal years (SFYs) 2017 and 2018.

The Consortium financial analysis included 32,480,489 prescription drug claims, and the total spend was $2,232,035,837. HCA recalculated the cost for each claim with the Consortium contracted rate, which determined that the same claims would cost $2,163,467,940, a difference of $68,567,897 less for the biennium, if the Consortium rates were used in place of the MCO reimbursement rates.

Although the results of the Consortium financial analysis suggest there might be opportunities to realize cost savings in prescription drug reimbursement, HCA identified several limitations with applying the results of the financial analysis for policy consideration. For example:

- Claims data from SFYs 2017 and 2018 are outdated and do not reflect current prescription drug utilization or prices.
- Beginning on January 1, 2020, HCA began disallowing MCOs from retaining the “spread” (or pharmacy claim cost difference) between the MCO, their pharmacy benefit manager (PBM), and pharmacies — which was still occurring during SFYs 2017 and 2018.
- Any changes to current MCOs’ prescription drug reimbursement methods would create a number of implementation challenges, which are outside the scope of this legislative report.
- Other prescription drug reimbursement methods are worthy of consideration — such as using the fee-for-service (FFS) reimbursement rates — in case they might be more advantageous than those the Consortium offers.

To illustrate the potential to use different prescription drug reimbursement methods, HCA performed a second financial analysis that evaluated the costs of paid prescription drug claims in the first quarter of 2020 from all MCOs against the FFS reimbursement rates. This financial analysis sought to address the limitations above by:

- Using more current claims that were billed after the practice of spread pricing was disallowed; and
- More advantageous reimbursement rates.

The FFS financial analysis repriced the MCO prescription drug claims using the FFS methodology, specifically around the National Average Drug Acquisition Cost (NADAC) rate. This financial analysis evaluated 4,137,412 MCO paid prescription drug claims from January 1, 2020, through March 31, 2020. The results of the analysis indicate that the FFS price method would have expended $10,821,763 less for Q1 2020. Assuming consistent utilization, the FFS price method could possibly realize approximately $86.5 million in cost avoidance per biennium. However, it is important to note that these analyses do not evaluate the timelines and resources necessary to implement such a strategy, especially since these options may require approval from the Centers for Medicare and Medicaid Services (CMS).

Background

Apple Health pharmacy programs

The Apple Health program offers pharmacy benefits to Apple Health enrollees through five contracted MCOs and through the state-run FFS program. Each MCO contracts with one of three unique PBMs to assist the MCO in administering its pharmacy programs, including negotiating reimbursement rates with pharmacies for prescription drugs dispensed to clients. As a result, different entities pay pharmacies different amounts for the same prescription drugs. This variation means that Apple Health is paying more than the optimal amount for some prescriptions, and that there may be an opportunity for savings, if all plans consistently paid using the most favorable method.

The Washington State Legislature sought alignment between the Apple Health programs by requiring the creation of a single preferred drug list (PDL). HCA began implementing the Apple Health PDL in 2018 and evaluated all drug classes for clinically appropriate drugs that could be managed to the lowest net cost to the state. Though the FFS program and MCOs now prefer drugs that have the lowest net cost to the state, variation in how the MCOs bill the state and reimburse pharmacies existed.

This variation in pricing between MCOs and pharmacies was evaluated recently. Effective January 1, 2020, HCA prohibits MCOs from retaining any “spread” between their PBM, the MCO, and the pharmacy. “Spread pricing” occurs when a PBM invoices a pharmacy claim to the MCO more than what is reimbursed to the pharmacy for dispensing that prescription. The practice of spread pricing

has been considered as a potential opportunity to reduce expenditure by ensuring transparency between what the MCOs pay the PBMs and what the PBMs pay to pharmacies. The calendar year 2021 managed care costs would have been approximately $156.8 million higher, if not for the elimination of spread pricing.

Prescription drug reimbursement methods

Payers reimburse pharmacies for dispensing prescriptions through a variety of different reimbursement methodologies that are calculated off drug prices. For brand name drugs and some generic drugs, the PBMs reimburse pharmacies based on either a percentage of the wholesale acquisition cost (WAC) or the average wholesale price (AWP).

The WAC is determined by pharmaceutical manufacturers when they sell drugs to wholesalers, whereas the AWP is a calculation of the WAC plus twenty percent. Both methods are older practices that attempt to estimate the cost at which pharmacies purchase drugs from wholesalers. Other generic drugs are reimbursed at maximum allowable cost (MAC) rates. MACs are used when multiple manufacturers sell interchangeable generics, and the rate is derived from the average cost of the lowest-priced manufacturers. For example, if there are ten manufacturers (each with their own wholesale acquisition cost for the drug), the plan may calculate the MAC price by averaging the lowest five WACs.

One of the known challenges with WAC and AWP methods is that they may overestimate or underestimate the pharmacies' actual acquisition cost of drugs, especially as these amounts change over time with price increases. As a result of constantly shifting drug pricing, MCOs either pay more than the optimal amount for prescriptions or underpay pharmacies by not adequately reimbursing them for the costs required to acquire and dispense the prescriptions.

Due to these challenges, Centers for Medicare & Medicaid Services (CMS) developed the national average drug acquisition cost (NADAC) method to estimate better the actual acquisition cost of drugs. CMS creates the NADAC from an analysis of weekly costs reported by pharmacies for acquiring the drug from wholesalers. Pharmacies earn their revenue from the professional dispensing fee, which is a separate payment to pharmacies for their work related to dispensing a prescription.

CMS, through the Covered Outpatient Drug final rule with comment,[1] requires all state-administered FFS programs to use the newly developed NADAC plus a professional dispensing fee method to reimburse pharmacies beginning April 1, 2016. CMS expects states to survey pharmacies periodically to determine the pharmacies' overhead costs for dispensing a prescription drug to clients. States would then use the survey results to establish the professional dispensing fee.

[1] 42 CFR Part 447 [CMS-2345-FC] Medicaid Program; Covered Outpatient Drugs; Final Rule, published in 81 FR 5170, from https://www.govinfo.gov/content/pkg/FR-2016-02-01/pdf/2016-01274.pdf, accessed on February 6, 2020.

Apple Health FFS and MCO plans are also able to pay using other pricing methods. For example:

- Federal Upper Limit (FUL) is the maximum reimbursement amount allowed for certain drugs pursuant to Section 1927(e) of the Social Security Act.
- Usual and Customary (U&C) is the "cash price" for patients as offered by pharmacies, which reflects the costs of the drugs to the consumer at the retail level without the use of insurance or other discounts.

Given the variation in drug pricing and reimbursement methods between the state, the MCOs, the PBMs, and the pharmacies, there are opportunities for HCA to study how different drug reimbursement methods may result in savings to the state.

Consortium prescription drug purchasing evaluation

Methods

To perform the analysis, HCA signed a data sharing agreement with Moda Health (Moda), the administrator for the Northwest Prescription Drug Consortium. HCA provided Moda with the MCO prescription drug encounter data from SFY 2017 and SFY 2018. The data included claim-level data from the ProviderOne Operational Data Store (ODS), including the date of service, the national drug code (NDC) number, the quantity dispensed, and whether the product was a generic drug or a brand drug. A brand drug can be a single source brand drug or multi-source branded drug (a brand drug with a generic equivalent).

Moda Health contracts with MedImpact, a PBM, to handle pharmacy claims adjudication. Pharmacy claims adjudication is the process for evaluating a pharmacy claim and determining whether it should be paid or rejected in accordance with the health plan's benefit design and clinical appropriateness. This process also determines the amount that the pharmacy will be reimbursed for the claim.

MedImpact used their systems to reprice the MCO paid prescription drug claims data using the Consortium reimbursement rates specific to the date of service and NDC for every claim. First, MedImpact identified the NDC, the amount of drug dispensed, and date of service. Then they calculated the amount that the Consortium would have paid for each individual claim using the reimbursement method that would have applied on that date for that specific claim. HCA's Financial Services Division then compared the paid amounts from the Apple Health MCOs' data to the paid amounts MedImpact reported for the Consortium.

Results

Table 1 below illustrates the total number of prescription claims paid and the total paid amounts by all MCOs in SFY 2017 and SFY 2018.

Table 1 — Apple Health managed care organizations' paid pharmacy claims in state fiscal years 2017 and 2018

SFY	Drug type	Count of paid claims	Percent of paid claims	MCO paid amount	Percent of total MCO paid amount
2017	Brand	1,716,642	10.6%	$717,439,963	68.0%
	Generic	14,522,089	89.4%	$338,362,428	32.0%
	All types	**16,238,731**	**100.0%**	**$1,055,802,390**	**100.0%**
2018	Brand	1,786,686	11.0%	$833,989,235	70.9%
	Generic	14,455,072	89.0%	$342,244,211	29.1%
	All types	**16,241,758**	**100.0%**	**$1,176,233,446**	**100.0%**
2017-18	Brand	3,503,328	10.8%	$1,551,429,198	69.5%
	Generic	28,977,161	89.2%	$680,606,639	30.5%
	All types	**32,480,489**	**100.00%**	**$2,232,035,837**	**100.00%**

Source: HCA Financial Services Division, November 2019.

Notes: SFY means state fiscal year. MCO means Apple Health managed care organization.

The two years of the biennium are shown separately to demonstrate the variation in prescription drug use between the years.

- **In SFY 2017**, the five Apple Health MCOs paid 16,238,731 claims. Of those paid claims, 89.4 percent were for generic drugs and 10.6 percent were for brand drugs. The generic drug claims accounted for 32.0 percent of the total Apple Health MCOs paid for all prescription drug claims in SFY 2017 ($1,055,802,390).
- **In SFY 2018**, the number of Apple Health MCO paid prescription drug claims increased by 3,027 claims (0.02 percent) relative to SFY 2017. The percent of generic drug claims decreased slightly by 267,017 claims (0.46 percent) relative to SFY 2017. Generic claims made up 89.0 percent of the total paid claims in SFY 2018 and accounted for 29.1 percent of the total Apple Health MCOs paid for all prescription drug claims in SFY 2018 ($1,176,233,446).

Table 2 below compares what the Apple Health MCOs paid for prescription drugs to what they would have paid had they been using the Consortium rates. The amount reimbursed to the pharmacy does not impact the amount of federal and supplemental rebates received for prescription drugs. Therefore, this analysis accounts for all federal and supplemental rebates Apple Health receives. Overall, the Consortium would have paid 3.1 percent less than what the Apple Health MCOs paid in SFY 2017 and SFY 2018. On average, the Consortium rates paid about 10.0 percent more for brand name drugs than the Apple Health MCOs, but 32.9 percent less for generic drugs.

Table 2 — Comparison between Apple Health managed care organizations' paid pharmacy claims and consortium paid amounts in state fiscal years 2017 and 2018

SFY	Drug type	Consortium paid amount	Percent of total consortium paid amount	Paid amount difference	Percent difference of paid amount
2017	Brand	$812,549,470	78.9%	$96,802,070	13.3%
	Generic	$217,809,924	21.1%	($120,552,504)	(35.6%)
	All types	**$1,030,359,394**	**100.0%**	**($25,442,997)**	**(2.4%)**
2018	Brand	$894,032,648	78.9%	$60,043,412	7.2%
	Generic	$239,075,899	21.1%	($103,168,313)	(30.1%)
	All types	**$1,133,108,546**	**100.0%**	**($43,124,900)**	**(3.7%)**
2017-18	Brand	$1,706,582,118	78.9%	$155,152,920	10.0%
	Generic	$456,885,822	21.1%	($223,720,817)	(32.9%)
	All types	**$2,163,467,940**	**100.0%**	**($68,567,897)**	**(3.1%)**

Source: HCA Financial Services Division, November 2019.

Notes: SFY means state fiscal year. Paid Amount Difference means Consortium Paid Amount minus MCO Paid Amount from Table 1. Percent Difference of Paid Amount uses the MCO Paid Amount from Table 1 as the denominator for the percentages.

Between SFY 2017 and SFY 2018, the Apple Health MCOs experienced an 11.4 percent increase in expenditure (from $1,055,802,390 in SFY2017 to $1,176,233,446 in SFY2018; see Table 1). However, the Consortium only experienced a 10.0 percent increase in expenditure (from $1,030,359,394 in SFY 2017 to $1,133,108,546 in SFY2018; see Table 2).

Discussion

Although the results of the Consortium financial analysis suggest there might be opportunities to realize cost savings in prescription drug reimbursement, HCA identified several limitations with applying the results of the financial analysis for policy consideration. For example:

- Claims data from SFYs 2017 and 2018 are outdated and do not reflect current prescription drug utilization or prices.
- Beginning on January 1, 2020, HCA began disallowing MCOs from retaining any "spread" between their PBM, the MCO, and the pharmacy, which was still occurring during SFYs 2017 and 2018.
- Any changes to current MCOs' prescription drug reimbursement methods would create a number of implementation challenges, which are outside the scope of this legislative report.
- Other prescription drug reimbursement methods are worthy of consideration, in case they might be more advantageous than those the Consortium offers.

To illustrate the potential to use different prescription drug reimbursement methods, HCA performed a second financial analysis that evaluated the use of FFS pricing. This financial analysis sought to address the limitations above by using more current claims that were billed after the practice of spread pricing was disallowed, and with more advantageous reimbursement rates.

FFS prescription drug purchasing evaluation

Methods

HCA designed a similar financial analysis to compare the MCO spent amount on prescription drug claims in the first quarter (Q1) of calendar year 2020 to the amount they would have spent using FFS price methods. Claims data from calendar year 2020 did not include any spread pricing, so this analysis would not include confounding from savings attributable to disallowing the retention of spread pricing. Whether using the MCO reimbursement methodology or the FFS methodology, the federal and supplemental rebates the state receives remain the same.

To determine what the MCOs paid in Q1, HCA collected all paid prescription drug claims from accepted MCO encounter data from the ProviderOne ODS for encounters that occurred from January 1, 2020, through March 31, 2020. In this analysis, HCA repriced every Apple Health MCO prescription dispensed during this period, because each claim in the dataset included the MCO paid amount.

HCA's Financial Services Division performed the analysis, using applicable FFS price methods. The analysis repriced most claims using NADAC plus the professional dispensing fee, based on the current FFS professional dispensing fee rates for Q1 2020. Other FFS price methods included FUL, MAC (i.e., MACSTATE, or Washington State Maximum Allowable Cost), U&C, and WAC cost types to produce a more realistic reprice estimate for these prescription drug claims.

Results

Table 3 below illustrates the differences between MCO paid amount and the amount from the FFS price method for Q1 2020.

Table 3 — Apple Health managed care organizations' paid amount versus fee-for-service price method for the first quarter of calendar year 2020

Drug type	Number of paid claims	MCO paid amount	FFS price method	Savings
Brand	541,844	$287,266,637	$287,767,789	($501,152)
Generic	3,595,568	$76,456,837	$65,133,922	$11,322,915
Total	**4,137,412**	**$363,723,474**	**$352,901,711**	**$10,821,763**

Source: HCA Financial Services Division, May 2020.

Notes: MCO means managed care organization. FFS means fee-for-service.

This analysis evaluated 4,137,412 MCO paid prescription drug claims, for which the FFS price method would have expended $10,821,763 less for Q1 2020. Assuming consistent utilization, the FFS price method could possibly result in approximately $86.5 million in cost avoidance per biennium. Table 4 below breaks down the totals from Table 3 by FFS cost type.

Table 4 — Comparison between Apple Health managed care organizations' paid amount and fee-for-service price method by cost type for the first quarter of calendar year 2020

Cost type	Count of paid claims	MCO paid amount	FFS price method	Savings
FUL	193,117	$4,221,294	$3,174,379	$1,046,915
MAC	971,010	$71,584,401	$65,312,292	$6,272,109
NADAC-brand	293,321	$175,987,977	$180,838,341	($4,850,364)
NADAC-generic	2,536,137	$57,101,893	$46,586,999	$10,514,894
U&C	18,612	$169,990	$169,990	$0
WAC	125,215	$54,657,919	$56,819,709	($2,161,790)
Total	**4,137,412**	**$363,723,474**	**$352,901,711**	**$10,821,762**

Source: HCA Financial Services Division, May 2020.

Notes: MCO means managed care organization. NADAC means National Average Drug Acquisition Cost. FUL means federal upper limit. MAC means maximum allowable cost; for this analysis, MAC is equivalent to MACSTATE, or Washington State maximum allowable cost. NADAC-Brand and NADAC-Generic mean the NADAC price type applied to brand name prescription drugs and generic prescription drugs, respectively. U&C means usual and customary. WAC means wholesale acquisition cost. HCA Financial Services Division applied the FUL, MAC, U&C, and WAC cost types to brand name drugs and generic drugs.

Conclusion

HCA performed a financial analysis that compared the Apple Health MCO's prescription drug expenditures for SFYs 2017 and 2018 with what Apple Health would have paid using the Consortium to process those prescription drug claims. After finding evidence of potential savings, HCA decided to conduct a second analysis comparing the MCO prescription drug expenditure with what the FFS program would have paid. This second analysis resulted in an even larger savings. HCA considered several options to take advantage of these savings, including the following:

1. Require MCOs to use the Consortium as their PBM for Apple Health and reimburse at the Consortium rate.
2. Request CMS approval to direct the MCOs (through contract) to use FFS rates for pharmacy payment as an Administrative Services Only (ASO) model. HCA would only reimburse the MCOs the amount that the FFS program would have paid to a pharmacy for the same claim.
3. Carve-out the entire pharmacy benefit from MCOs, contract with the Consortium to manage the pharmacy benefit, and reimburse using the FFS rates.
4. Carve the pharmacy risk back into the MCOs and adjust MCO pharmacy rates, according to the savings projected by using the best performing plans in 2019.

HCA eventually decided to go with option 4, because the other three options would likely take two years before savings would be realized. For example, option 1 would require transitioning from the MCOs' current PBMs to the Consortium; this usually takes at least 12 months. Option 2 requires a waiver from CMS. Option 3 would likely require both a procurement and CMS approval.

Any consideration for future prescription drug purchasing strategies would require updated financial analyses. Any policy consideration will also need to account for timelines and resources necessary to implement such a strategy, including whether HCA will need approval from CMS for any of these purchasing options.