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The Case for States Regulating Medicaid Managed Care Pharmacy Benefit Managers Claims Charges

Background

After the Affordable Care Act (ACA) ensured that state Medicaid Managed Care (MMC) prescription drug benefits programs receive the same drug rebates as Medicaid Fee For Service (FFS) Rx program, many state Medicaid agencies began moving pharmacy benefits into MMC programs (referred to as a "carve in") in the early 2010's based on the Medicaid Managed Care Organization (MCO) insurers' and their contracted Pharmacy Benefit Managers' (PBMs) assertions that states would see $ 11.1 Billion in Medicaid drug spending net savings over 10 years.

But after 13 years of the shift to Medicaid Managed Care prescription benefit "carve in" programs by many states – except for the handful of states that mandated as part of their carve in program the use of cost-based, transparent, and accountable MMC Rx claims reimbursement systems – "carve-in" states have discovered that Medicaid Managed Care Organization's (MCOs) and their PBMs overcharged their states billions of dollars through the following non-transparent methods:

- Excessive and often times deceptive administrative charges
- "Spread pricing" (charging Medicaid more for a Rx claim than paid to the pharmacy)
- Undisclosed self-dealing advantaged by PBMs which own their pharmacies (i.e., directing (steering) prescriptions & higher reimbursement rates to self-owned pharmacies), and
- Market manipulation (including undisclosed post-dispensing claim payment "claw backs")

Although the methods vary, these MCO PBMs' opaque practices have resulted in taxpayers being overcharged for Medicaid pharmacy claims and increased per capita payments for State Medicaid Programs while supplying excess profits for PBMs. Consequently, since June 2021, 18 states so far have settled Medicaid fraud cases against MCOs for nearly $1 Billion because of these practices. At the same time, these MMC PBMs frequently reimbursed pharmacies for less than their costs to dispense these MMC Rx claims, which restricted or even eliminated Medicaid recipients ready access to all their medication needs.

This paper explains:

- the status of Medicaid Managed Care Rx "carve-in" states approaches to end these MMC overcharges
- state legal actions taken against these abuses
- information needs by states to determine the extent of such MMC Rx overcharges, and
- how MMC Rx payment claw backs create undisclosed overcharges to State Medicaid programs

Every MMC Rx "carve in" state will benefit from this information and resources to develop cost-based, transparent and accountable "pass through" Medicaid prescription drug benefit programs that: 1) serve the taxpayers' interest; and 2) preserves and enhances Medicaid patients access to their prescription and pharmacy providers.

Some Medicaid Managed Care Rx "Carve In" States Created Access Protections & Accountability

After the ACA-mandated rebate provision went into effect, to preserve Medicaid access and ensure accountability to state Medicaid agencies for managing prescription benefits, **6** states - Kansas (2014), Iowa [2016], Louisiana and Mississippi (both in 2017), North Carolina (2022) and Oklahoma (2024) - mandated that their MMC PBMs utilize transparent systems where pharmacies were reimbursed equivalent to the FFS reimbursement formula and MCO's only charge the state that amount plus a negotiated administrative fee.

Because of these protections, these states have not experienced the phenomenon that occurred in the mid-2010's of MMC MCO Rx "spread pricing" or other overcharge practices.

States Approaches to Ending Medicaid Managed Care Prescription Claims Overcharges

But since 2010, the other states that followed implemented MMC Rx "carve in" programs without those protections eventually discovered that the PBM promised net drug spending savings were not being realized and changed course to either "carve back out" the Medicaid Rx benefit back to a FFS approach or investigate the reasons for the increased drug costs and institute MMC Rx benefit program management reforms.
Below is a description of the experience of states that post-2010 "carved in" the Medicaid Rx benefit into MMC from the FFS program and experienced higher drug spending costs than predicted by the MMCOs:

STATES THAT "CARVED BACK OUT" PRESCRIPTION DRUG BENEFIT FROM MEDICAID MANAGED CARE

West Virginia - After an analysis from Optum Actuarial Services predicted $30 million in savings for the West Virginia Medicaid program and an added injection of $34 Million into the pharmacy community in dispensing fees, West Virginia Medicaid elected to carve out the pharmacy benefit from their MCO's on July 1, 2017.

After 12 months, an actuarial analysis of actual results performed by another actuarial firm (chosen to avoid bias), Navigant, showed the West Virginia Medicaid Rx carve out produced actual savings of $54.5 Million for West Virginia taxpayers, even after paying an added $116 million to pharmacies in professional dispensing fees. (The pricing methodology and dispensing fee was mandated by CMS for Medicaid Fee for Service (FFS) programs). The average dispensing fee paid by pharmacy benefit managers (PBMs) on behalf of the managed care programs was $0.59. In contrast, the FFS program paid a dispensing fee of $10.49.

The method for determining the savings was:

1. Repriced both SFY17 managed care and SFY18 FFS experience to NADAC rates to set up baseline comparison of costs, adjusted for dispensing fees, and calculated the difference in expected claim costs in SFY2018. *(Encounter claims and FFS claims for the years to be compared were needed).*

2. Analyzed differences in administrative costs covered by the State under both managed care and FFS reimbursement arrangements.
   (FFS administrative costs included payments to vendors supplying prior authorization, preferred drug list services, and drug utilization review programs. Administrative costs included administrative capitation rates, taxes and fees such as Health Insurance Provider Fees (HIF), and pharmacy clinical management fees.)

At the time of this study, there were no fees assessed by PBMs from pharmacies after claims adjudication, so it was not necessary to set up an effective payment rate.

California - The State of California "carved out" their pharmacy benefit from the managed care program in January 2022. Medi-Cal assumed responsibility for their pharmacy program by contracting directly with a centralized PBM which supplies the functions of claim processing, drug utilization review, rebate administration, prior authorization, transactions, customer service, and health plan coordination activities. Medi-Cal is now reimbursing pharmacies for all Medicaid claims (previously had a partial carve-out) at the FFS rates. The move is projected to generate net savings for the Medi-Cal program of $150 Million and increase pharmacy access for Medi-Cal members. Medi-Cal is part of a large purchasing pool for all California public health insurance programs.

North Dakota - In response to concerns about the State Medicaid program being charged more than pharmacy claims reimbursement for prescriptions, North Dakota "carved out" the prescription drug benefit from its Medicaid managed care program into its Medicaid Fee-for-Service system in 2019. Pharmacies were reimbursed at the FFS rate, based on a federally mandated algorithm using NADAC and a survey based dispensing fee. The state saw savings of $17 million.

New York State - Following up on a New York Senate investigation that required PBMs to report rebates they negotiated with manufacturers and a New York Comptroller report that showed MMCO's Rx program management was costing New York over $800 million in higher drug costs including not obtaining all rebates, New York State enacted in April 2020 a carve out of the Medicaid Rx drug benefit from MMC by April 2023. New York Medicaid implemented this

program NYRx in April 2023 which is budgeted to save $410 million in just the first year while also paying pharmacies the full ingredient and service costs to dispense a Medicaid covered prescription.

States Mandating Transparent, Cost-Based "Pass-Through" MMC Rx Reimbursement Systems

Michigan - over the course of 4 years (2018-2021), 3 different studies documented MMC PBM spread pricing overcharges to the Michigan Medicaid program of up to $190 Million. In response, starting in SFY 2022, Michigan mandated in its last 2 state appropriation acts that a single MMC PBM reimburse MI independent pharmacies at the cost-based fee-for-service rates and only charge the state at these rates. Michigan Medicaid reports on reviews of the Michigan Medicaid managed care Rx program prior to these reform over a two-year period have delineated that over $745.5 million in Medicaid MMC Rx overbilling have been averted in the last 2 budget years.

Based on these savings, in the fall of 2023, Michigan enacted a law to make this "pass through" cost based MMC Rx reimbursement system permanent. It is expected that under this permanent state law, Michigan will save an additional $5 million - $12 million.

Kentucky - A study of PBM pricing and charges to Kentucky Medicaid started by the Kentucky Cabinet of Health and Family Services showed that PBMs made $86,730,868 in CY 2017 and $123,515,854 in CY 2018 in spread pricing alone. In 2021, Kentucky Medicaid implemented a transparent payment model by contracting directly with one PBM for all of their pharmacy services. An audit report on the savings results of this cost-based mandate is expected soon. In late fall of 2023, Kentucky Medicaid issued a report from its actuary, Milliman, documenting that the state had excessing its projected $200 million in savings and has saved nearly $283 million over the first 2 years of these reforms.

Ohio - The Ohio State Auditor in 2018 conducted an audit of Ohio's Medicaid Managed Care Prescription Claims practices where they discovered that MCO PBM's spread pricing cost the state $224.8 million in one year, plus an additional $20 Million of spread from one of the MCOs. To conduct the study, the Auditor needed data showing the difference between the payment from the health plan to the PBM and from the PBM to the pharmacy. *(One way to find the actual amount paid to the pharmacy is to examine the state's rebate files, since the amount paid to the pharmacy is a Federally mandated reporting field.)*

The Auditor recommended that the following be made available:
1) *Any transactions that occurred outside of claims adjudication (direct and indirect fees charged to the pharmacy)*
2) *Financial terms and payment arrangements between the MCOs and their PBMs*
3) *A timeframe specific Maximum Allowable Cost Analysis (MAC) & generic drug pricing lists were needed for this analysis.*

To end this MMC Rx overcharging, on October 1, 2022, the Ohio Department of Medicaid (ODM) started implementing a transparent payment model for their MMC pharmacy program. ODM contracted directly with a single PBM (instead of allowing each of their Managed Care Organizations to sub-contract with a PBM) with ODM Medicaid setting the pharmacy reimbursement rate in a "drug cost plus model".

Georgia - After conducting one study - and awaiting completion of another legislative mandated study of Medicaid MCO/PBM abuses (spread pricing, overbilling, etc.) – starting in 2023, the Georgia enacted in its annual budget a mandate for Georgia MCO PBMs to pay MMC network pharmacies at the Georgia Medicaid FFS COD PDF rate. Additionally, through contract changes, Georgia MCO's are now reimbursing the MMC network pharmacies at the NADAC prices for the Managed care covered drug ingredient costs. There is no data available yet from Georgia on the amount of savings these MMC prescription benefit reforms are providing to Georgia taxpayers.

New Mexico – Begun 2020, the New Mexico State Auditor reported in 2021 an investigation of New Mexico MMC's PBM's practices of over billing New Mexico for Medicaid prescription drug claims, along with a referral to the New Mexico Attorney General. After a settlement of one Medicaid fraud case for MMC PBM overbilling ($13.7 million), in 2024 New Mexico enacted legislation mandating New Mexico MCO PBMs to reimburse New Mexico MMC network pharmacies at a transparent, cost based "pass through" reimbursement rate of NADAC and a COD PDF. This new MMC prescription drug reimbursement reform started on July 1, 2024 so there has yet to be any data on the cost savings to New Mexico Medicaid's program.

Nebraska - In 2024, to address concerns about Nebraska Medicaid's patient access to prescription services, and a settlement of MMC PBM overbilling ($29.3 million), Nebraska enacted legislation, starting July 1, 2024, to mandate Nebraska MCO PBMs to pay MMC network pharmacies at the Nebraska Medicaid FFS COD PDF rate. Additionally, through contract changes, Nebraska MCO's are now reimbursing the MMC network pharmacies at the NADAC prices for the Managed care covered drug ingredient costs. There is no data available yet from Nebraska on the amount of savings these MMC prescription benefit reforms are providing to Nebraska taxpayers.

State Government Studies of MMC PBM Rx Spread Pricing & other Overcharge Practices

District of Columbia - As the federal seat, the U.S. Health and Human Services Office of Inspector General (HHS OIG) conducted a study of the District of Columbia's Medicaid managed care prescription drug program for 2016 -2019. The March 2023 HHS OIG Audit report determined that DC Medicaid office had insufficient oversight over their MMC Rx program and the **MCO PBMs were overbilling DC for MMC Rx claims by $23.3 million** these practices

Florida - A study was conducted by Milliman in 2020 that showed PBMs participating in Florida's Medicaid managed care prescription drug program made $90 Million in spread pricing overbilling. One PBM represented 40% of the program and accounted for the most prescriptions filled at its retail pharmacies, as well as the most prescriptions charged to the Medicaid program. That PBM paid themselves for 11,000,000 prescriptions almost twice as many as were paid to Walgreens, Publix, Walmart and Winn Dixie combined. Specialty pharmacies owned by PBMs paid themselves at the highest reimbursement rates, while independent pharmacies were reimbursed at the lowest rates.

All these practices reflect manipulation of the Medicaid pharmacy program for excessive profit.
To end this overcharge and to create transparency to the State of Florida for the costs of its Medicaid Managed Care Rx claims, in July 2022, the Governor issued an Executive Order mandating that Florida Medicaid revise its MCO contract (being bid for a new 5-year contract to be award at the end of 2023) to mandate that all MCO PBMs use a pharmacy cost-based reimbursement rate, which is also the only amount the MCO's may charge Florida's Medicaid program. To create further protections in May of 2023, Florida enacted a new PBM law to mandate such transparency on MMC PBM contracts by statute. Florida's new Medicaid managed care contracts that will be awarded in 2024 will require such a cost-based pass-through prescription reimbursement methodology be used in Florida MMC contracts.

Illinois - In May 2023, the Illinois Auditor General released a legislatively mandated performance audit of the Illinois Medicaid Managed Care PBMs that identified over **$200 Million over 2 years in spread pricing** overbilling to the Illinois Medicaid managed Care prescription program. Additionally, the audit identified that there was an undetermined about of MMC Rx overbilling where IL MMC PBM paid themselves more than were paid to non-PBM affiliated MMC network pharmacies. The report recommended several contract reforms for the IL Medicaid program to institute in its MCO contracts to eliminate these abuses

Indiana - In August, 2024, in response to a legislative mandate, the Indiana Attorney General's Office conducted an audit of Indiana' MMC PBM claims plus their handling of rebates. This audit was limited in its scope of review and noted its lack of complete information due to the non-cooperation from Indiana MCO PBMs. A second audit required by Indiana state statute will investigate Indiana MCO PBM's spead pricing practices.

Maryland – In 2018, the Maryland Medical Assistance Program (Medicaid) hired an independent auditor, Myers and Stauffer (MS), to conduct an audit of Maryland Medicaid MCO's PBMs, which identified $71.85 Million in spread pricing overbilling. *Pharmacy claims with records of payment from the MCO to its corresponding PBM and records of payment from the PBMs to their network pharmacies were analyzed. Fee for Service claims data was also analyzed as a comparator. In addition to claims data, the auditors required access to the contracts between the MCOs and PBMs and the PBMs and pharmacies.*

New Jersey – In 2020, the State Auditor of New Jersey audited the State's Medicaid pharmacy program to decide if adequate procedures and controls were in place to properly manage FFS and managed care pharmacy claims and to prevent improper payments. They found that the FFS program would have paid $84 million less than the MCO program for the same claims.

Oregon – After conducting a study requested by the State Legislature, the Oregon State Auditor released a findings report in August 2023 of its review of 4 years of Oregon MMC MCO PBM claims costs to determine if the State was receiving appropriate services for its Medicaid population and if the MMC Rx program was being well managed on behalf of Oregon taxpayers. The Report's review of MMC PBM payment to pharmacies for 13 drugs found:

"Pharmacy reimbursements vary significantly depending on the drugs, pharmacy type, & PBM. Pharmacies often lose money when filling certain prescriptions. We found that national chains, some of which are owned by PBMs or PBM parent companies, were reimbursed twice the amount independent pharmacies were for selected drugs". (pg. 20) "

The main conclusion of the report is:

"The State [of Oregon] should enact legislation that focuses on patient and pharmacy protections and increasing transparency in the prescription drug supply chain. Making these changes will help ensure the Medicaid program is getting good value for pharmacy benefits, people have access to the same medications, and Oregonians have access to community pharmacies". (Audit highlight page)

Pennsylvania - Two different Pennsylvania State Auditor Generals conducted audit investigations and produced Three (3) separate reports that concluded that Pennsylvania MCO PBMs were conducting financial abuses of the taxpayers through their opaque practices.

After a new law mandated the Pennsylvania Office of State Auditor General have access to all MMC PBM claims data, in late summer of 2024, the Pennsylvania State Auditor General issued a new state performance audit that documented at least $7 Million annually in MMC PBM prescription drug overbilling of the PA Medicaid program due to undisclosed practices of spread pricing, hidden post claim clawbacks, hidden fees that are not disclosed to either the MCOs or Pennsylvania's Medicaid program.

Other states - Texas Utah & Virginia have initiated audits & investigations of Medicaid MCO/PBM operations. All analyzed the amount of PBM profit resulting from spread pricing, PBM generated MAC prices, and Generic Effective Rates (GER). *Other sources of information needed were PBM policies and standard operating procedures to determine MAC prices, drug coverage & formularies, administrative fees, & reimbursement rates.* All these states found various degrees of MCO PBM prescription claims charges being higher than those of the FFS program, depending on the amount of information the MCO's and their PBMs provided to them on pharmacy reimbursements for each MMC claim.

STATES MEDICAID FRAUD LEGAL ACTIONS AGAINST MEDICAID MANAGED CARE PBM RX CLAIMS

Aside from State reviews and analysis of Medicaid managed care PBM spread pricing overcharges practices, State Attorney Generals have been taking separate legal action against MCO's Rx overcharges to publicly funded Medicaid prescription drug programs as Medicaid fraud claims. One of the largest MMCO's providing pharmacy "carve-in" services, Centene, has set aside $1.25 billion to settle state Medicaid fraud lawsuits for prescription overcharges. Eighteen (18) states have already received **$947.7 Million** in the following MMC Rx overcharge Medicaid fraud allegation legal settlements with Centene:

Arkansas -	$ 15.2 million	Nebraska -	$ 29.3 million
California -	$215 million	Nevada -	$ 11.3 million
Iowa -	$ 44.4 million	New Hampshire -	$ 21.1 million
Illinois -	$ 56.7 million (paid in two installments)	New Mexico -	$ 13.7 million
Indiana -	$ 66.5 million	Ohio -	$ 88.3 million
Louisiana -	$ 64.2 million	Oregon -	$ 17 million
Kansas -	$ 27.6 million	South Carolina -	$ 25.8 million
Massachusetts -	$ 14.2 million	Texas -	$165.6 million
Mississippi -	$ 55.5 million	Washington State -	$ 33.3 million

At least three more State Medicaid False Claims Act MMC Rx overcharges case settlements with Centene are reportedly pending. Centene expects to eventually reach Medicaid fraud claims settlements with all remaining 10 states (AZ, DE, FL, GA, KY, MI, NC, NJ, NY, PA) where it provides MMC Rx prescription benefits services.

State Medicaid Managed Care Prescription Benefit Overcharge Studies, Reforms and Medicaid Fraud Settlements Compel the Remaining MMC Rx Carve-In States to Enact Cost-Based, Transparent, Accountable Managed Care Prescription Reimbursement Mandates

In summary, since the wave in the early 2010's to "carve in" prescription drug benefits to Medicaid managed care raised the number of "carve in" states to 35, over the past 12 years, **sixteen (16) states have taken actions to protect taxpayers through accountability and transparency mandates of a "cost based", pass through Medicaid managed care Rx system**:

- **6 states** (**IA, KS, LA, MS, NC, OK**) mandated at the outset of a Medicaid managed care Rx "carve in" (or shortly thereafter) a "cost based" pass through reimbursement system for such covered prescription drug claims
- **4 states** (**CA, NY, ND, WV**) after having "carved in" their prescriptions benefit into Medicaid managed care saw Medicaid drug spend increase and access impact, reserved policy and **"carved out"** the Medicaid Rx benefit back to the Medicaid FFS program, **saving over $630 Million**
- **3 states** (**KY, MI, OH**), after **documenting over $1.27 Billion of MMC Rx PBMs overcharges**, implemented reforms to mandate a "cost-based" pass through reimbursement system for such covered prescription drug claims.
- **3 states** (**GA, NE, NM**) have implemented reforms to mandate a "cost-based" pass through reimbursement system for such covered prescription drug claims within the past 2 years that have yet to produce data on how much savings to state taxpayers these transparent, cost based "pass through" MMC Rx reimbursement methodology mandates are producing.

In response to the growing evidence of Medicaid managed care prescriptions overbilling through "spread pricing" and other undisclosed PBM practices, **14 states** (**GA, FL, KY, IL, MD, MI, NJ, NY, PA, OH, OR, TX, UT, VA**) and **DC** have conducted studies of their Medicaid managed care prescription benefit "carve in" program that have **documented over $1.3 billion in MMC PBM overbilling practices**.

Finally, **18 states** have **settled Medicaid fraud cases for $947.7 Million** against one MMC PBM.

- States with Medicaid prescription benefits carved into Medicaid managed care programs that have not enacted transparent cost based "pass through" mandates on MCO PBMs are under growing pressure to do so because of:

1. documented total to date of **$2.977 billion** in state level MMC Rx overbilling evidence;

2. two **HHS OIG reports identifying the poor track record of State Medicaid Agencies with Medicaid prescription drug benefits "carved in" to Medicaid managed care programs in identifying MMC Rx overbilling abuses by PBMs and providing recommendations for State Medicaid programs to reign in these MCO PBM overbilling abuses**; and

3. **the expected ten (10) additional state Medicaid fraud settlements** with Centene for Medicaid managed care prescription overbilling

The remaining 19 Medicaid prescription benefits "carve in" states that do not have cost-based systems need to take actions to mandate cost-based transparent and accountable "pass through" MMC Rx reimbursement system in order to protect taxpayers, the vulnerable Medicaid prescription benefit patients and their pharmacy providers upon which they depend for access to this vital Medicaid benefit.

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INDEPENDENT PHARMACY COOPERATIVE

ATTACHMENT 1

Glossary of Pharmacy Pricing Terms

AWP (Average Wholesale Price) - Price point published in pricing data bases but not used by Medicaid. In some commercial contracts, there are references to AWP-as a certain percentage discount calculation for reimbursement. It does not come close to identifying the true cost of a drug and is disparagingly referred to as "Ain't What's Paid".

CMS (Centers for Medicare and Medicaid) - The Federal agency that operates the Medicaid program. State Medicaid programs must give state plan amendments (SPAs) to CMS for approval. Federal matching funds for state Medicaid programs depend on adherence to State Plans.

Cost based reimbursement - Reimbursement to pharmacies is based on a published transparent pricing from public sources for both the drug ingredient cost (usually NADAC) and a dispensing fee (based on a COD PDF) that a PBM must pay to a pharmacy for full cost of a pharmacy fulfilling and dispensing a prescription.

COD PDF (Cost of Dispensing Professional Dispensing Fee) - Full cost of prescription dispensing incurred by a pharmacy including vials, bags, overhead, building and equipment depreciation, staffing & any other costs of a pharmacy doing business. Medicaid FFS programs pay this amount, determined by a COD Survey, plus the cost of the drug dispensed. This is often interchanged with the term "professional dispensing fee", which measures overhead cost.

Medicaid Fee for Service programs reimburse at the lower of NADAC, or WAC, when NADAC is not available, FUL, SMAC or the cost submitted by the pharmacy plus a **professional dispensing fee identified in a Cost of Dispensing Study.** If the Usual and Customary (U&C) charge submitted by the pharmacy is lower than the other price points, then that amount is paid, but no dispensing fee is attached.

FUL (Federal Upper Limit) - A drug reimbursement price point created in 1987 under the Social Security Act's Section 1927(e) to ensure that Medicaid was a prudent purchaser of drugs. The calculation was revised in the Affordable Care Act as no less than 175% of the most recently reported Average Manufacturer Price (AMP) reported. These prices are also reported on a file from CMS & uploaded into the Medicaid Fee for Service (FFS) claims processing system.

NADAC (National Average Drug Acquisition Cost) - Based on the retail price survey & focuses on the retail community pharmacy acquisition costs. CMS has mandated that Medicaid pharmacy programs reimburse at the Actual Acquisition Cost (AAC) of drugs plus a professional dispensing fee (PDF), which NADAC represents. NADAC prices are updated weekly & are loaded weekly into the Medicaid Fee for Service (FFS) claims processing systems.

PBM Claw backs – Any charges (described by many different terms (i.e., DIRs, GERs BERs, effective rates, performance measures, fees) from a PBM to a pharmacy for a prescription claim after the point of sale (usually months afterwards) when the patient receives the prescription. These claw backs are not reflected in the claims cost encounter data provided to Medicaid programs (or commercial benefits sponsors). (Explanation of PBM claw backs harmful impact in next section)

"Spread Pricing" – The practice where PBM's charge payers like Medicaid more than they pay the pharmacy for a medication and then the PBM keeps the "spread" or difference as profit.

SMAC (State Maximum Allowable Cost) -The maximum amount a state Medicaid program pays for a drug. This is based on a calculation involving prices from several generic drug manufacturers and are loaded into the Medicaid Fee for Service claims processing system.

Transparent "Pass Through" Pricing – Plan sponsors pay the same drug cost & dispensing fee that the PBM pays to the pharmacy. The PBM only collects an fully disclosed and agreed upon administrative fee for services provided to a benefit sponsor.

U&C (Usual and Customary Fee) - Price charged to a pharmacy customer who pays cash for their prescription. (Think about the 30-day supply for $4.00 list published by many mass retail chain pharmacies.)

WAC (Wholesale Acquisition Cost) - Estimate of the manufacturer's list price for a drug to wholesalers or direct purchasers but does not include discounts or rebates. Also is used by State Medicaid programs for single source drug reimbursement rates when there is not yet a NADAC price created by CMS. WAC is the preferred pricing reference tool versus AWP.

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INDEPENDENT PHARMACY COOPERATIVE

ATTACHMENT 2

PBM PHARMACY CLAW BACKS EXPLAINED – AND HOW THEY COST PAYERS, PATIENTS AND PHARMACIES

The ABC's Of PBM Claw backs

PBM Claw backs occur when a PBM charges DIR (direct and indirect remuneration) fees to a pharmacy after the point-of-sale claim adjudication. These fees often create a negative payment to the pharmacy and come months after a prescription is dispensed. Since they come long after the claim is adjudicated, they can cause tax issues for the pharmacy. Often, PBMs do not explain how the fees are calculated. The terms **claw back,** and DIR fee are often used interchangeably, since a **claw back** is one type of a DIR fee.

PBM Claw backs Origins

To understand the origin of claw backs, it is necessary to understand that the Medicare Part D law created Direct & Indirect Remuneration (DIR) Fees to offer incentives to pharmacies to provide covered Part D drugs at the lowest possible cost.[1] They include "discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, upfront payments, coupons, goods in kind, free or reduced-price, grants, or other price concessions or similar benefits from manufacturers, pharmacies or a similar entity". The Part D DIR rule's goal was to ensure these price concessions would bring the drug price down from the Part D contracted price & be fully reported to Medicare. DIR fees have become PBM fee charges to pharmacies, which have not lower Part D net drug prices, but have become an added profit source for PBMs. Part D DIR fees can be based on: (1) a reconciliation between a drug claim & the negotiated price; (2) a fee charged to the pharmacy by the PBM for being in their network; or (3) "performance" of the pharmacy (applies to Medicare Part D and their star ratings program).

Proliferation of PBM Claw back after Part D and their Impact on Medicaid Managed Care Claims

DIR fees have become a "kitchen sink" phrase and do not serve the purpose for which they were intended. PBMs have used this Federally mandated process for Medicare Part D to their advantage and applied it to other programs, including Medicaid managed care. There is no Federal legislation to support application of DIR fees to Medicaid managed care or any other prescription program. For Medicaid managed care, these claw back/DIR fees do not lower prescription costs for the Medicaid program, are not transparent at point of sale to the pharmacy or usually disclosed to the Medicaid program by the MCO's or their PBMs. They do not lower the cost of prescriptions for the Medicaid agency, the ultimate payer for the program.

DIR fees are generally flat dollar fees (retail pharmacy), but some are percentages (specialty pharmacy). Regardless of the calculation, they are often more than the cost of the drug dispensed. DIR fees most often apply to generic drugs and are sometimes related to the Maximum Allowable Cost (MAC) transparency laws in states. DIR fees are charged in addition to the administrative fees the pharmacies pay to PBMs.

Claw Backs Only Benefit the PBMs

Because of the lack of transparency in the calculation of claw backs, it is difficult to figure out the amount of profit made by PBMs on Medicaid managed care claims and to find potential overcharges to the Medicaid program.

To ensure that Medicaid Managed Care prescription program reform truly eliminate claims overpayments, State policy makers need to ensure in both statute and contract that MCO PBMs cannot charge post-adjudication DIR fees in the form of claw backs. Without this type of contract prohibition, MCO PBM claw backs become another form of undisclosed "spread pricing" by a different PBM practice.

[1] (42 CFR 423.308)

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ATTACHMENT 3

Prescription Claims Information Needed to Conduct MMC MCO PBM Claims Cost Evaluation Studies

The following lists are suggested data elements and general information needed to properly evaluate PBM charges to Medicaid Pharmacy Programs.

On a per claim basis

- Pharmacy payments made by the MCO's PBMs (both ingredient cost and dispensing fees) per claim
- PBM Rx encounter cost per claim gave to each MCO
- MCO Rx encounter data gave to Medicaid
- MCO rebate payment data gave to Medicaid
- PBM Administrative fees charged to an MMC network pharmacy
- Each fee (transmission, processing, credential, etc.) charged by a PBM to an MMC network pharmacy
- Any audit recoupment dollar amount of claims payment remitted back to Medicaid or retained by the MCOs & PBMs
- Any audit recoupment of Medicaid managed care Rx recipient co-pays remitted back to the patient, Medicaid or retained by the MCOs & PBMs

On an overall data level

- Number of Rx claims processed
- PBM administrative fees gave to each contracted MCO
- PBM administrative fees gave by each MCO to Medicaid as part of the capitation rate calculation
- MCO capitation rate
- MCO capitation rate part attributed to Rx benefit program
- Amount of PBM & MCO Rx audit recoupment dollars & amount remitted back to PA Medicaid
- Amount of PBM & MCO Rx audit recoupment dollars remitted back to Medicaid and Medicaid recipients
- Medicaid Drug Pricing File
- PBM and MCO contracts
- PBM and pharmacy contracts
- Any "claw back" payments to the PBM from network pharmacies
- State rebate quarterly files claims cost data for all Medicaid Managed Care claims submitted to CMS by the State Medicaid Office with all rebate-related data redacted

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ATTACHMENT 4

Catalog of State Statutes Mandating Medicaid Managed Care Prescription Drug Programs to Utilize Transparent, Cost Based "Pass Through" Prescription Drug Reimbursement Methodology

New Mexico

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Assistance Act, Section 27-2-12.34 NMSA 1978, is enacted to read:

"27-2-12.34. COMMUNITY-BASED PHARMACY REIMBURSEMENT.-

A. Each managed care organization that contracts with the department shall ensure that community-based pharmacy providers that provide services to medicaid recipients are reimbursed as follows:

(1) for the ingredient cost of a drug at a value that is at least equal to the national average drug acquisition cost for the prescription drug at the time that the drug is administered or dispensed, or if data for the national average drug acquisition is unavailable, the wholesale acquisition cost of the drug; and
(2) a professional dispensing fee.

B. The professional dispensing fee reimbursed to community-based pharmacy providers shall be no less than the professional dispensing fee reimbursed to community-based pharmacy providers for covered outpatient drugs in the medicaid fee-for-service program.

C. By January 1, 2025, and annually thereafter, the department shall compile a list of all community-based pharmacy providers in the state and publish the list on the department's website.

D. For the purposes of this section:
(1) "community-based pharmacy provider" means a pharmacy that is:
(a) open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written;
(b) located in the state or near the state border, if the border town is a primary source of prescription drugs for medicaid recipients residing in the border area; and
(c) not: 1) government-owned; 2) hospital-owned; 3) owned by a corporation that owns hospitals; 4) an extension of a medical practice or special facility; 5) owned by a corporate chain of pharmacies with stores outside of the state; or 6) a mail-order pharmacy;
(2) "ingredient cost" means the actual amount paid to a community-based pharmacy provider for a prescription drug, not including the professional dispensing fee or cost sharing;
(3) "managed care organization" means a person or entity eligible to enter into risk-based prepaid capitation agreements with the department to provide health care and related services;
(4) "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;
(5) "medicaid recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;
(6) "national average drug acquisition cost" means the national average of prices at which pharmacies purchase a prescription drug from manufacturers or wholesalers; and
(7) "wholesale acquisition cost" means a manufacturer's list price for a prescription drug sold to wholesalers in the United States, not including discounts, rebates or reductions in price."

SECTION 2. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2024

Kentucky

The department shall:

(a) Establish a single preferred drug list to be used by the state pharmacy benefit manager for each managed care organization with whom the department contracts for the delivery of Medicaid services; and benefit manager for each managed care organization with whom the department contracts for the delivery of Medicaid services; and

(b) Promulgate administrative regulations that establish:
1. Reimbursement Methodologies; and
2. Dispensing fees which may take into account applicable guidance by the Centers for Medicare and Medicaid Services and which may, to the extent permitted under federal law, vary by pharmacy type including rural and independently owned pharmacies, chain pharmacies and pharmacies owned or contracted by a health care facility that is registered as a covered entity pursuant to 42 U.S.C. sec. 256b.

Reimbursement methodologies established by administrative regulations shall not discriminate against pharmacies owned or contracted by a health care facility that is registered as a covered entity pursuant to 42 U.S.C. sec. 256b, to the extent allowable by the Centers for Medicare and Medicaid Services.

The reimbursement methodologies and dispensing fees established by the department pursuant to subsection (1) of this section shall be used by the state pharmacy benefit manager for each managed care organization with whom the department contract for the delivery of Medicaid services.

The state pharmacy benefit manager shall administer, adjudicate and reimburse pharmacy benefit claims submitted by pharmacies to the state pharmacy benefit manager in accordance with:

(a) The terms of any contract between a health care facility that is registered as a covered entity pursuant to 42 U.S.C. section 256b and a Medicaid managed care organization.

(b) The terms and conditions of the contract between the state pharmacy benefit manager and the Commonwealth; and

(c) The reimbursement methodologies and dispensing fees established by the department, pursuant to subsection (1) of this section.

Louisiana

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 46:460.36(D) is hereby amended and reenacted to read as follows:

§460.36. Pharmacy reimbursement by managed care organizations

* * *

D. No managed care organization shall pay a local pharmacy a per-prescription reimbursement at a rate less than the legacy Medicaid rate.

Section 2. R.S. 46:460.36(B), (C), and (E) are hereby repealed in their entirety.

Section 3. This Act shall become effective on October 1, 2017.

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