



# Prying *open the* *black box*

**With 2019 state legislative sessions looming, here's how to fix Medicaid's pharmacy payment model.**

By Jayne Cannon and Scott Brunner

It's easy to understand why PBMs are referred to as a black box.

For years, their business practices have been sealed away, impenetrable and impervious to scrutiny — even scrutiny by the health plan to which they are contracted, even if that payer might happen to be the local or state or federal government. That secrecy has allowed them to extract profits from contracts in ways that sunlight and transparency might have called into question.

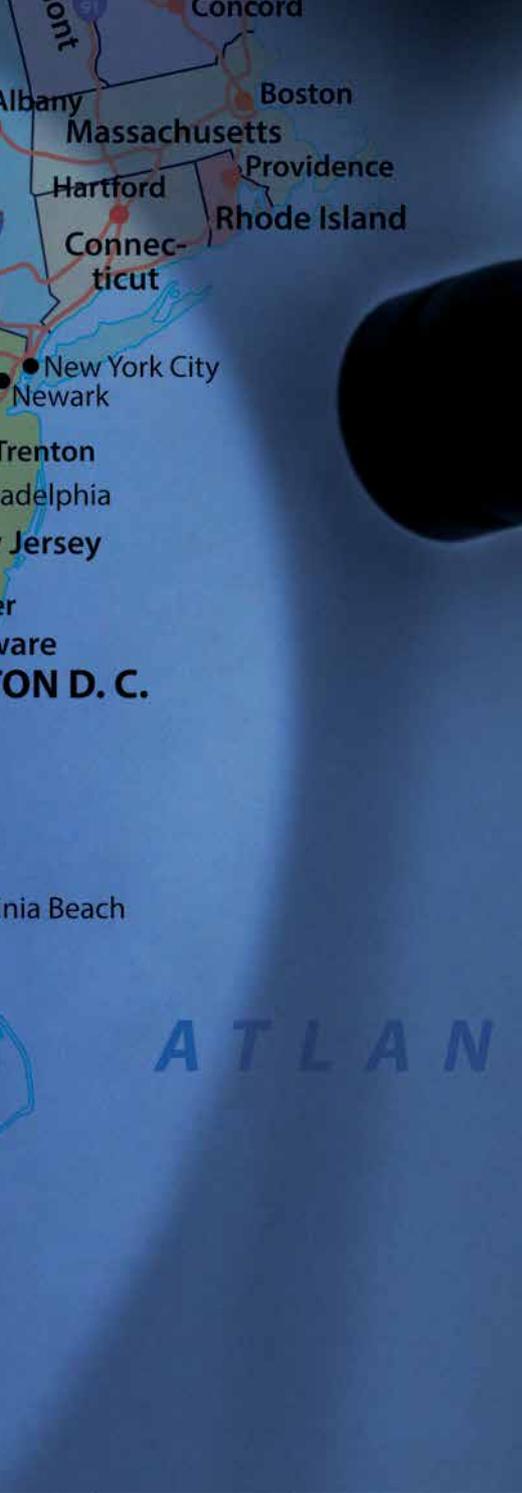


But recently, in a handful of states, community pharmacists have presented policymakers and media with hard data about Medicaid managed care reimbursements and billings. The lid of the black box has been pried open — at least a little — to reveal what we've suspected for years: PBMs are reimbursing pharmacies low, charging Medicaid programs high, and keeping the difference for themselves. That difference is not insignificant.

In Ohio, spurred by the Ohio Pharmacists Association, a state audit report this past summer found that PBMs contracted to managed care organizations in that state's Medicaid managed care program paid themselves \$223.7 million more than they reimbursed Ohio pharmacies, and that PBMs often paid themselves up to six times more per claim processed than was normal. As a result of that report — and relentless investigative

reporting by the *Columbus Dispatch* on PBMs' role in Ohio Medicaid — the state Medicaid agency terminated contracts with PBMs in its managed care program and in January will move to a pass-through model of PBM reimbursement.

"Extracting nearly \$224 million of taxpayer dollars from Medicaid contracts by paying yourself three-to-six times more per prescription than you should



## Good plan, good relationships are keys to changing Medicaid



Here are some tips for successful advocacy:

There's strength in numbers. You'll see greater impact if you work with your state association, NCPA, buying groups that are talking to state officials, and other pharmacy groups so that everyone is singing from the same sheet of music. Share your concerns and make sure the issues are understood by these groups to ensure effective and accurate advocacy.

Quantify your value. "Tell them what you do that's important and different," Ohio Pharmacist Association governmental affairs director Antonio Ciaccia says. "You deliver? Well, a lot of people deliver. Mail order is delivered. But if you deliver same-day and go in and do at-home consultation, that's something else. If you don't quantify your value, you're just another small business."

Complain constructively. You don't do that by complaining on Twitter; you do it by building a relationship with your representatives. "Advocacy is relationship-building," Ciaccia says. People don't tend to want to help you if they only see you when you have a problem.

Keep in touch. Make sure you're inviting lawmakers and regulators to your pharmacy, keeping in regular contact, and visiting their offices, even when things aren't dire. "Fair or not, they're more likely to listen to someone they've gotten to know over a cup of coffee," he says. "And you better know that PBM lobbyists are in their office every week."

Data, data, data. A single anecdote is not enough. Make sure you can show lawmakers and regulators on paper what's happening in your business, and why it's a persistent problem. Don't depend on a lawmaker's staff to do the research. They won't. Use data from NCPA, your state association, and CMS to prove your point. Data is powerful. Facts don't lie.

Keep it simple. Try explaining MAC or NADAC to a non-pharmacist lawmaker and her eyes might glaze over. Find ways to simply your message. Use metaphors to tell your story, not technical jargon.



sounds an awful lot like profiteering," NCPA CEO Douglas Hoey says.

"There are plenty of uses for those wasted dollars

that could have benefited taxpayers, and it raises concerns about whether state Medicaid agencies really know what's in those contracts they're signing with MCOs and whether they're properly holding MCOs accountable for overseeing the contracted PBMs."

"Ohio may be just the tip of the iceberg," Hoey adds. "What PBMs have been doing there is almost certainly what they're doing in some other states' Medicaid programs, but those other states may not yet be wise to the problem."

### HELPING STATES GET WISE

That's where you come in — and your state association, NCPA, and other supportive pharmacy partners

willing to work together on unified and coordinated action.

Together, armed with hard data, we can help state Medicaid officials, legislators, governors, and — if necessary — the news media get wise to PBM abuses in state Medicaid contracts that are harming patients, taxpayers, and yes, locally owned pharmacies.

When it comes to administration of the prescription drug benefit, there are alternatives to the current Medicaid managed care model. For instance, last year, West Virginia Medicaid carved out the prescription drug benefit from its Medicaid managed care program. As you'll read here, the cost savings have been extraordinary.

But even if carve-out is not politically feasible in your state, there are several common-sense actions states can take to assure not only transparency and accountability for taxpayer dollars allocated to the Medicaid program, but also that local pharmacies are fairly reimbursed and local patients have convenient access to medications.

As the 2019 state legislative sessions approach, the time is now to work with your state pharmacy association and other partners in developing strategies for raising this issue with policymakers and in crafting legislative solutions that will rectify the problems.

## **SOME SOLUTIONS**

What Medicaid reforms will work in your state? The following are a few ideas. But remember: Not every reform translates immediately into fair reimbursement for pharmacists. Some do, but that's really not the only goal. What is sorely needed in the Medicaid space is transparency in pricing and wise use of taxpayer dollars. Those, in turn, are likely to result in better treatment of community pharmacies such as yours.

**“Carving out” the prescription drug benefit.** In July 2017, the West Virginia Medicaid agency started managing the Medicaid prescription drug benefit directly, effectively carving it out of managed care. An actuarial study showed that the state could save money and pump money

back into local economies with reasonable pharmacy reimbursements. Going into the carve-out, West Virginia Medicaid officials forecast a \$30 million savings for the state. After the first year, West Virginia is expected to announce actual savings far greater than that forecast.

**Why it works:** It's been a big win for the state and community pharmacy. All pharmacies, both community and chain, now receive NADAC plus a \$10.46 dispensing fee on generics. With the carve-out, West Virginia was able to save money and preserve access to community pharmacies in medically underserved areas, where a local pharmacist is often the most accessible health care provider. And according to West Virginia Department of Health and Human Resources Director of Pharmacy Vicki Cunningham, the state only added one staff person as a result of the carve-out.

**Establish fee-for-service as a reimbursement floor in Medicaid managed care.** It's not always the standard. It should be, NCPA's State Government Affairs Director Matt Magner says. “Fee-for-service is more accurate now,” he says. “The rates are spelled out in the contract. They're much clearer. The PBM can't play games.” With the fee-for-service model, the state only pays for services actually used, and that usually results in savings. Pharmacies are paid for ingredient cost plus dispensing fee. FFS as a floor is working well in Iowa and Kansas, for instance.

**Why it works:** PBMs are ratcheting down reimbursements but charging states more. Using fee-for-service takes away the PBM's ability to arbitrarily increase its spread.

**Require states to have greater oversight of PBM contracts and reimbursements.** Earlier this year, Kentucky enacted one of the most

comprehensive PBM Medicaid managed care contract oversight laws in the nation. At the heart of it: PBMs are now required to disclose certain information concerning the use of tax dollars, such as the PBM spread and direct and indirect fees imposed on network pharmacies. The Medicaid department is allowed to review the PBM's reimbursement rates to ensure the state is getting a fair deal. “States have contracts with MCOs, but little oversight of PBMs,” Magner says. “That is one reform we'd like to see right away.”

**Why it works:** It's all about transparency. This gives the state greater control over how its tax dollars are spent. In Kentucky, a PBM's accountability is directly to the state via insurance commissioner oversight, not buried deep in an inaccessible MCO contract.

## **Make sure state contracts give Medicaid a right of action against PBMs.**

In managed care, the contract is usually between the MCO and the PBM, not between the PBM and the state. When there is no contract between a PBM and the state, the state often may have obstacles to pursuing an action against a PBM or subcontractor if there's a claim of wrongdoing.

**Why it works:** It gives the state greater ability to hold PBMs accountable.

## **Require a pass-through pricing model for compensating PBMs.**

Paying PBMs via a pass-through model gives them a flat administrative fee — no secretive rebates or deals and no spread pricing. “It's hard to get information on PBM revenues,” Magner says. “A pass-through model keeps everything above board.” In a pass-through model, he says, the state pays the actual contracted discounted pharmacy price and dispensing fee that the PBM has negotiated with the retail pharmacy network.



### Spelunking for data

A chorus of complaints about under-reimbursements sent Antonio Ciaccia scrambling for numbers. Ciaccia, director of government and public affairs at the Ohio Pharmacists Association, needed to show lawmakers the problem, not just tell them. Here's how he started his "bread-crumb trail" of facts and figures:

He filed public records requests with the state board of pharmacy to find out exactly how many pharma-

cies had closed over a two-year period. Exact numbers make a stronger case than "a lot of pharmacies have closed."

He poked around on [cms.gov](http://cms.gov) and found two essential reports. The Centers for Medicare & Medicaid Services publishes detailed Medicaid spending data. Using the State Utilization Database (published quarterly) and the National Average Drug Acquisition Cost database (updated weekly), he calculated the average invoice prices pharmacies pay for

every medication and compared it to what the state was charged.

You can do something similar: Take the publicly available CMS data and compare it with your own pharmacy's data to demonstrate what PBMs are paying you versus what they're billing health plans on average. If there's a considerable difference, you have a case to make to policymakers.



**Why it works:** Pass-through pricing better assures transparency and accountability, though it still requires plenty of due diligence to verify the veracity of the costs being “passed through.” The states know what they’re paying for. Pharmacies potentially get a fairer reimbursement and PBMs get a predictable administration fee. Arkansas has implemented this model; it starts Jan. 1 in Ohio.

**Require that only the amount paid to pharmacies count toward Medical Loss Ratio.** The Centers for Medicare & Medicaid Services says that insurers must spend at least 85 percent of their revenue on direct patient medical care and activities that improve quality. That should not include spread, but often does in some states. Any amount that remains with the PBM is not money spent on medical care. “It’s a bit of a shell game,” Wagner says. “It makes

it look like much more money is going toward patient care, when in actuality, a lot of it is going into PBM pockets.”

**Why it works:** This ensures that the right percentage of Medicaid dollars is spent on patients and that tax dollars help patients get healthier, not make PBMs richer. Virginia delegate and NCPA member Keith Hodges, RPh, is championing this strategy in his state. A bill to implement this rule failed in 2018 but is expected to be reintroduced in 2019.

**Require that state MAC transparency laws apply to PBMs in the Medicaid managed care space.**

**Why it works:** Applying state maximum allowable cost laws to Medicaid brings a base level of transparency to drug pricing so pharmacies have some idea of what they’ll be paid. This also gives pharmacists a method to appeal under-reimbursements.

**Mail-order houses should not be counted toward network adequacy.** Network adequacy means that patients must have access to a sufficient number of in-network providers, including pharmacies, as well as other health care services. It’s hard to quantify that, but when a patient doesn’t have same-day access to maintenance medications because maintenance meds are limited to mail order, the patient loses the personal care and counseling a pharmacist provides.

**Why it works:** Patients should have the ability to choose their pharmacist and choose where they obtain refills. After all, a personal connection to a pharmacist is a key predictor for adherence.

**Enforce “any willing provider” provisions.** If community pharmacies agree to match network pricing and terms, there’s no reason to deny their participation in PBM networks.

Many state laws assure this, but often they are not being enforced.

**Why it works:** A significant number of pharmacies are out-of-network for some patients. Any willing provider allows a patient to choose the best pharmacy for their needs. The decision is made by the patient, not based on an arbitrary network configured by the PBM.

### **ACTUAL RESULTS MAY VARY**

Medicaid managed care was created as a way for health care providers to control costs and assure quality of care. The Medicaid agency agrees to pay a contract MCO a fixed amount per patient, in return for which the MCO will manage that patient's health care and prescription drug benefit.

In most cases, managed care is to a PBM's advantage. It allows them to create preferred networks, and increasingly, the in-network pharmacies include ones in which the PBM has a financial stake. So, chalk up a win for PBMs, but a big loss for patients, who may lose their ability to use a pharmacy of their choice. Taxpayers lose too, because there's no way to comparison-shop. And community pharmacies lose, because they often are not part of the preferred network.

Because Medicaid is jointly funded with federal and state money, the program isn't run the same way in every state. Congress and CMS set the general rules, but each state operates its own program, so how it works in one state might not be how it works in another.

So it will be with the solutions we've suggested here. Some, maybe even several, may not be right for your state because of the way its Medicaid program is structured. That's why careful investigation now – laying the groundwork – is essential

if you want to effect change in your state and for your pharmacy.

### **MOVING THE NEEDLE**

There are ways to fix the Medicaid pharmacy payment model, and who better than your state's most accessible health care provider (that's you) to do it?

The current model, controlled by large PBM corporations, is not sustainable. Taxpayers and patients alike are being taken advantage of. Real accountability and stewardship are needed. Otherwise, the Medicaid tab is likely to keep going up, patient care won't be optimized, and your reimbursements will keep going down.

The time is right and the data is there to show policymakers how PBMs are enriching themselves at taxpayer expense. And thanks to states like West Virginia, Kentucky and Ohio, there are proven examples of transparency and fairness in prescription drug payments that will lead to savings.

What moves a lawmaker? Tax dollars and constituents, NCPA's Magner says. Show them how each is impacted by the current state of Medicaid and suggest proven fixes.

Collect documentation. Build a plan. Make a strong case for change.

Let's tear the lid off that black box. ■

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### **Call us maybe?**

NCPA's state governmental affairs team works with our state partners to create proposed pharmacy-related law and regulation that will withstand scrutiny and accomplish what it's meant to accomplish. This year NCPA has helped more than 35 states by reviewing, supporting, drafting, and testifying on state legislation. Got questions or ideas? Contact us.



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# As MCOs proliferate, will federal government provide Medicaid guardrails?

By Chris Linville

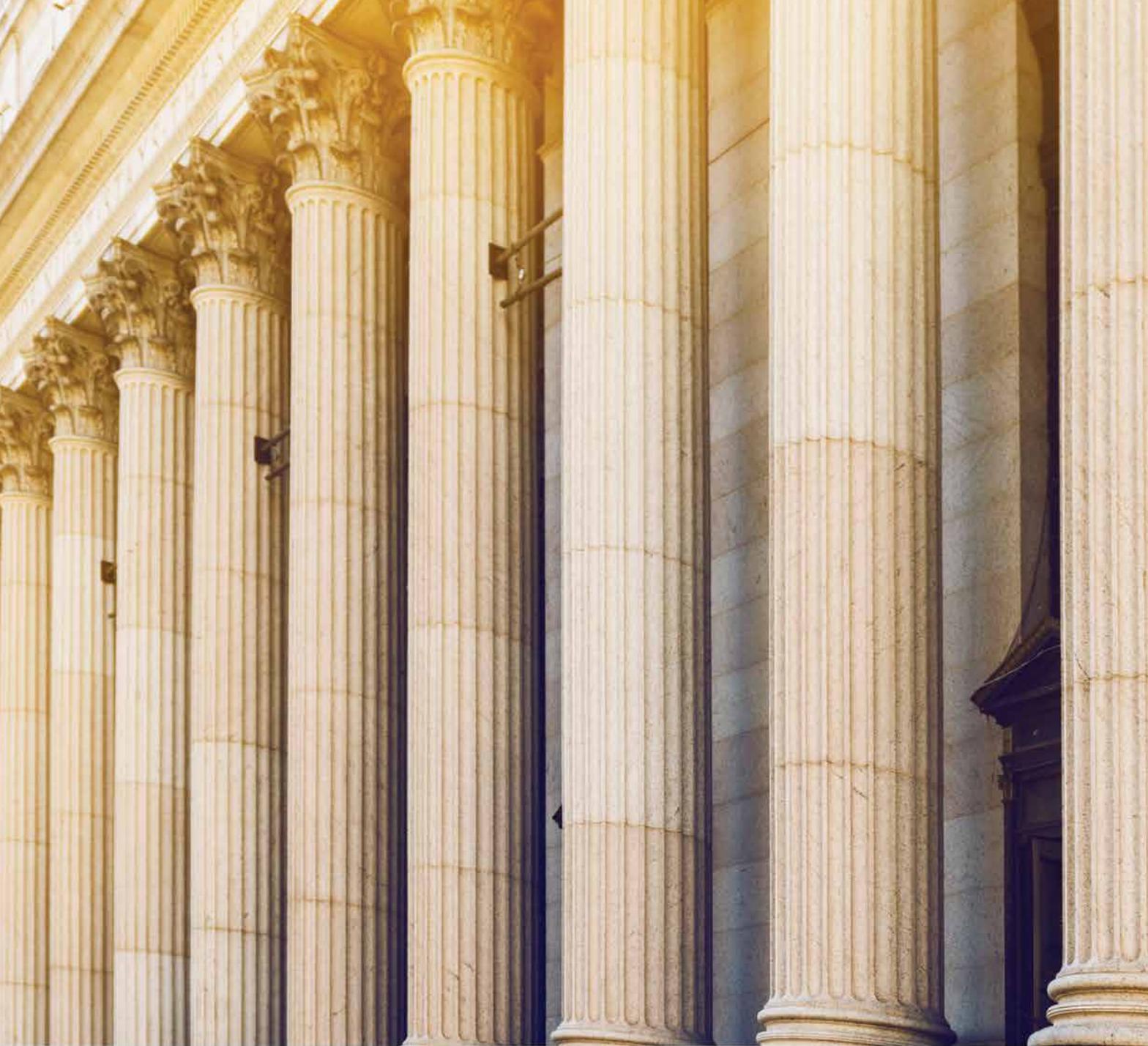
As a number of states are taking a critical look at their managed care programs, the federal government is signaling a potential federal overhaul, including proposing changes to the overview of MCO programs. A majority of states have gradually ceded power over their Medicaid programs away from traditional fee-for-service and toward MCOs. Some 75 percent of state Medicaid programs are now run by MCOs.

Medicaid is a federal program jointly funded by federal and state governments, but administered by the states. Under current federal Medicaid rules, providers in Medicaid fee-for-service programs must meet minimum requirements to contract with the state. Further, federal law requires that services provided under Medicaid fee-for-service be reimbursed in a manner “sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.”

However, these requirements are not necessarily in effect for pharmacy services provided under MCOs. In fact, in the absence of any official regulatory “guardrail,” the federal government has remained mostly silent on how managed care programs are administered at the state level, including provider reimbursement and enforcing provider network requirements.

States do have to set up network adequacy standards for managed care, but most states have not been vigorously enforcing those standards. Without a protective federal guardrail, it’s PBMs will continue to ratchet





down reimbursement rates, which are already dramatically impacting pharmacy providers, along with the vulnerable Medicaid beneficiaries that they serve.

With a large influx of new beneficiaries into Medicaid programs, states and MCOs will need to secure the participation of additional pharmacy providers to ensure that all patients have sufficient access to pharmacy services.

### **CMS REVIEW?**

On April 25, 2016, the Centers for Medicare & Medicaid Services put on display at the Federal Register the Medicaid and Children's Health Insurance Program Managed Care Final Rule. In 2017 after President Trump took office, CMS Administrator Seema Verma reviewed the 2016 rule but took no action. In a letter to Verma, NCPA pointed out that

for the average retail pharmacy, 17 percent of all prescription revenues come from Medicaid; and offered suggestions for provisions that are considered critical for community pharmacy, including:

- Urging retention of the provision in the 2016 Final Rule that requires states to develop and enforce network adequacy standards (time and distance requirements) for critical provider types, including pharmacy.
- Urging retention of provision in final rule that requires MCOs to meet Medicaid fee-for service standards regarding availability and prior authorization of covered outpatient prescription drugs.
- Urging that states be informed that MCOs must use fee-for-service Medicaid pharmacy

provider reimbursement rates as a minimum reimbursement "floor" when contracting with pharmacies. MCOs and pharmacies are free to contract for reimbursement rates greater than the state's fee-for-service reimbursement rate.

As of this writing, it is unclear what, if any, action CMS might take and how it might alter or adjust the 2016 Final Rule. Speculation is that it could go in either direction – either tightening the reins and creating more federal oversight, or taking a hands-off approach that allows states to implement their own policies. NCPA will continue to monitor the issue and engage with CMS and other policy makers to advocate for our members' best interests. ■

[Chris Linville is America's Pharmacist managing editor.](#)