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DEPARTMENT OF HUMAN SERVICES

Good morning Chairwoman Rapp, Chairman Frankel, members of the committee, and staff. I am pleased to be here today to provide testimony on the Pennsylvania Auditor General's report on the role of pharmacy benefit managers entitled *Bringing Transparency & Accountability to Drug Pricing*. I am Sally Kozak and I serve as the Deputy Secretary for the Office of Medical Assistance Programs (OMAP) for the Department of Human Services (DHS). Joining me today is Kristin Hoover, Clinical Pharmacy Manager also from OMAP.

Approximately 2.9 million Pennsylvanians receive their physical and behavioral health care under the Medical Assistance (MA) Program, which includes the coverage of outpatient drugs. The fee-for-service (FFS) delivery system covers 13 percent of those individuals. The remaining 87 percent of MA beneficiaries are enrolled in one of the nine managed care organizations (MCOs) that have entered into an agreement with DHS to provide MA-covered services.

The Auditor General's report includes ten recommendations concerning the role of pharmacy benefit managers (PBMs) in the MA Program. I am here today to share DHS' responses to those recommendations.

Recommendation 1: The General Assembly should immediately pass legislation banning all "gag rules" and allow pharmacists to tell all patients if they could be paying less for a medication.

Response: While the gag clause is a significant concern for other consumers in the commonwealth, it is not relevant to the MA Program. Gag clauses do not exist in the agreements that DHS holds with the MCOs. Gag clauses would be found in contracts between the PBM and their individual network pharmacies. Also, the issues of higher out-of-pocket costs for patients as a result of gag clauses do not apply to the MA

population. Federal and state regulations require that a MA beneficiary cannot be denied a covered service if they are unable to pay their copay. Pennsylvania's MA copays for prescription drugs are $1 for generics and $3 for brands. In addition, many MA-covered drugs are copay-exempt.

Recommendation 2: To ensure taxpayer dollars are being handled effectively and efficiently, the General Assembly should immediately pass legislation allowing the state to perform a full-scale annual review or audit of subcontracts with pharmacy benefit managers.

Response: DHS does not regulate PBMs directly but enters into agreements with MCOs to provide MA-covered services to eligible beneficiaries. The MCOs may choose to subcontract with PBMs and DHS reviews all MCO subcontracts. The PBM establishes the pharmacy provider network and the financial aspects of the contracts between the PBM and the pharmacies were not subject to DHS review. DHS reviews provider contracts to confirm the inclusion of mandated protections for MA beneficiaries and other DHS requirements. PBM product pricing and pharmacy reimbursement details have not previously been required elements for DHS review. However, in response to the need for greater transparency in payment for drugs and MCO accountability, DHS amended the 2019 MCO agreements. Pricing and rebate transparency, a second-level provider dispute resolution process, and audit requirements were added to increase transparency. These added transparency requirements became effective January 1, 2019.

Recommendation 3: To better control costs, Pennsylvania should consider directly managing its Medicaid prescription drug benefits instead of contracting with managed care organizations to do so.

Response: The Department is committed to the managed care comprehensive risk-based model allowing for the MCOs to assume the financial risk for furnishing the full range of health services covered under the MA Program to plan enrollees. If the MCOs pay more than the Department's actuary predicted in the rates, the MCOs are responsible to cover the excess expenses.

Recommendation 4: The General Assembly should pass legislation that increases transparency into PBM pricing practices.

Response: DHS is not opposed to this concept. However, DHS has achieved transparency within the MA Program through the amendments made to the 2019 MCO agreements that became effective January 1, 2019. As mentioned earlier, these amendments include pricing and rebate transparency, a second-level provider dispute resolution process, and audit requirements.

Recommendation 5: The General Assembly should pass legislation to use the federal Centers for Medicare & Medicaid Services' (CMS) National Average Drug Acquisition Cost (NADAC) for pricing prescription drugs filled through Medicaid.

Response: The NADAC is one of many methods for reimbursing pharmacies for the ingredient cost of the drugs that they dispense. CMS requires that the FFS MA Program makes payment for drugs using an actual acquisition cost for the drug plus a professional dispensing fee. CMS approved Pennsylvania's use of NADAC as the basis for payment of drugs. In addition to the NADAC for the actual drug dispensed, the FFS MA Program must also pay a $10 professional dispensing fee that was approved by CMS. Payers other than the FFS MA Program can pay pharmacies based on other drug pricing benchmarks and dispensing fees negotiated between the pharmacies in the network and the PBM or other payer. Mandating through legislation that the MA MCOs

pay drug ingredient costs using NADAC as the basis for payment without increasing the dispensing fees paid to the pharmacy may result in some pharmacies being paid less than what they are paid now. If the recommendation was intended to propose legislation that requires the MA MCOs to pay pharmacies using the FFS payment methodology (NADAC plus the $10 professional dispensing fee) then it forces DHS to stray from the comprehensive risk-based model that requires the MCOs to assume the financial risk for providing access to all MA-covered services. It could result in increased costs overall to DHS for the MA pharmacy benefit.

Recommendation 6: The General Assembly should grant state oversight of contracts signed between PBMs and pharmacies or pharmacy services administration organizations, which are currently shielded from oversight because they are subcontracts.

Response: DHS is not opposed to this concept. However, DHS has achieved transparency within the MA Program through the amendments made to the 2019 MCO agreements that became effective January 1, 2019. The amendments include pricing and rebate transparency, a second-level provider dispute resolution process, and audit requirements.

Recommendation 7: So the state pays only for services PBMs render, the General Assembly should pass legislation requiring a flat-fee pricing model for compensating PBMs.

Response: DHS believes that without more data documenting cost efficiency and cost effectiveness of each pricing model option mandating a model would be premature. We are not aware of any testing or studies that provide conclusive findings validating flat-fee pricing as more cost efficient than another (i.e. spread pricing). The 2019 MCO

agreement language requires the MCOs to report the amount the MCO pays the PBM, the amount the PBM pays the pharmacies, and all administrative payments made to the PBM. We expect that transparency in pricing will reveal the most cost-effective pricing model.

Recommendation 8: Pennsylvania's Department of Human Services should use Texas' Vendor Drug Program as a model to create Pennsylvania's own universal preferred drug list for Medicaid clients.

Response: DHS is currently analyzing the cost, risks, and benefits of a uniform Preferred Drug List (PDL) for Pennsylvania MA beneficiaries.

Recommendation 9: Pennsylvania's Department of Human Services should add "good steward" language to all Medicaid-related contracts.

Response: DHS is reviewing the MCO Agreements for opportunities to enhance "good steward" language.

Recommendation 10: The Federal Trade Commission (FTC) should investigate whether separation truly exists between the PBM and pharmacy acquisition segments of major companies that operate both. And, if the FTC does not investigate, then the General Assembly should consider legislation that prevents managed care organizations from using a PBM for Medicaid if the PBM is part of a larger company that also owns retail pharmacies.

Response: DHS supports this recommendation and is considering options to address this issue in the MCO agreements.

Thank you for the opportunity to provide testimony in response to the Auditor General's report on the role of pharmacy benefit managers. I welcome any questions the committee may have at this time for me or my staff.