Pharmacy Benefit Management Reporting Task Force Meeting
December 4, 2019
Meeting Notes

Task Force Members Present:
Shane Desselle, RPh, PhD, FAPhA, President, Applied Pharmacy Solutions
Lisa Ghotbi, PharmD, Director of Pharmacy Services, San Francisco Health Plan
Clint Hopkins, PharmD, Owner and CEO, Pucci's Pharmacy
Patrick Robinson, RPh, MBA, Pharmacy Manager, Sutter Health Plus
Neeraj Sood, PhD, Professor and Vice Dean for Research at the USC Price School of Public Policy
John Stenerson, Deputy Executive Officer, Self-Insured Schools of California
Nicole Thibeau, PharmD, AAHIVP, Director, Pharmacy Services, Los Angeles LGBT Center

Department of Managed Health Care Staff Present:
Shelley Rouillard, Director
Sara Durston, Acting Deputy Director, Health Policy and Stakeholder Relations
Pritika Dutt, Deputy Director, Office of Financial Review

Facilitator:
Yolanda Richardson, CEO, Teloiv Consulting

1. Welcome and Introductions – Agenda

Yolanda Richardson opened the meeting by welcoming the Task Force members and members of the public. She asked the Task Force members to introduce themselves. Ms. Richardson then introduced Shelley Rouillard, Director of the Department of Managed Health Care (DMHC).

2. Opening Remarks

Ms. Rouillard opened the meeting by thanking the Task Force members for the expertise they brought to the process, which will inform the report due to the Legislature in February. Ms. Rouillard acknowledged the Task Force members recommended the DMHC gather many data elements that are outside the scope of this process, but there have been copious notes taken at all of the meetings that will help inform the DMHC's future policy considerations.

3. Review of Recommended Data Elements

Ms. Richardson introduced the PBM Reporting Task Force: Additional Data Elements chart and highlighted the importance of clearly defining each data element and the value, or how the data element will further the goals of Assembly Bill (AB) 315 (Chapter 905, Statutes of 2018). Ms. Richardson noted the chart includes not only the Task Force's recommended data elements, which was based on discussions from previous meetings, but also the data elements Neeraj Sood recommended when he presented.

Throughout the discussion, the Task Force decided not to discuss some recommended data elements included in the chart, as they deemed them to be unnecessary or duplicative. As a result of the discussion, the Task Force recommended the following:

Data Element #1 – "Spend by PBM by drug."

- Drugs should be reported at the National Drug Code -11 (NDC-11) level consistent with definitions in Senate Bill (SB) 17 (Chapter 603, Statutes of 2017) and as recommended by the Office of Statewide Health Planning and Development (OSHPD).
- "Spend" should be defined consistent with SB 17, which is the allowed amount for the drug. Lisa Ghotbi clarified that this means the Wholesale Acquisition Cost (WAC) reference price and the allowed amount for the drug.
- Reporting should be on the top 100 drugs by cost and volume (by number of prescriptions normalized to 30 days) for generic, brand, specialty, and other.
    - "Specialty" means the Centers for Medicare and Medicaid Services (CMS) definition.
    - Instructions should be clear that drugs must not be reported in multiple categories.
- Reporting should include both the PBM cost and member cost.

Data Element #2 – "Annual PBM revenue by PBM line of business." This should be reported by member months and include the following:

- Manufacturer rebates, administrative fees, and other.
- Payments to pharmacies, claims processing fees, special program fees, administrative fees, and other.
- Pharmacy revenue, including claw-backs from pharmacies, transaction fees, other and the total. This will provide information to determine whether there are preferential payments to vertically integrated pharmacies.

Data Element #3 – "PBM revenue from the manufacturer at the drug level and what was passed on to the Plan." This should include the total amount the PBM received from a manufacturer by drug and the total amount passed on to the Plan by drug. This would allow the DMHC to calculate the amount retained by the PBM. This data element should include the top 25 drugs by the revenue of the PBM. The data should reveal whether the top 25 drugs that the PBM is making money on are the same as the top 25 drugs dispensed. This would shed some light into "spread" pricing.

Data Element #4 – "Impact of PBM fees on total payments to pharmacies." This should include total payments to pharmacies minus fees, audits, and other charges broken out by the following categories: all retail pharmacies aggregated, mail order pharmacies, independent pharmacies, specialty pharmacies, retail pharmacies owned by the PBM (if applicable), retail pharmacies not owned by the PBM, and other.

Data Element #8 – "Cost variation by integrated pharmacy (PBM owns the pharmacy) versus non-integrated pharmacy." Collect cost and volume for the top 100 drugs by pharmacy type (e.g., retail, mail order, and specialty) to determine whether a PBM is driving consumers to specific pharmacies.

Data Element #9 – “Detailed information on what the Plan pays the PBM (dispensing fee, Maximum Allowable Cost (MAC), etc.).” This should include the reference WAC price and the Plan’s allowed amount which will help to determine how aggressive the difference is. This will provide information on what the PBM pays the pharmacy versus what the PBM charged the Plan for the drug.

Data Element #14 – “PBM should report the number of Plan members the PBM contracted to support for the past five years.”

Public Comments

Cher Gonzalez, representing Advocating for Access Specialty Pharmacy Coalition, remarked that the impact of claw-backs on pharmacy revenues is very important to independent specialty pharmacies. PBMs will claw-back money from pharmacies for things as minor as a typographical error. PBM audits lead to thousands of dollars in claw-backs from pharmacies. Independent specialty pharmacies are struggling and concerned with their lack of bargaining power. In addition, there is no dispute resolution process in place.

Nicole Thibeau commented that PBMs often choose very expensive drugs to audit, but they’re not looking at all the claims. The pharmacy has already filled the prescription and the patient has already taken the drug so there is no recourse. This is not a random sample and is targeted by drug. She asked the Task Force to recommend including specific language around audits.

Dr. Ghotbi commented that independent and specialty pharmacies are in competition with the PBM-owned pharmacies.

Ms. Gonzalez said the PBMs get the pharmacy claims data for a prescription then the pharmacy that is owned by the PBM will send a letter to the patient and will waive the co-pay or refill the prescription without the patient’s consent or call the pharmacy to transfer the prescription without the patients’ knowledge.

Dr. Sood commented that the data element, “cost variation by integrated versus non-integrated pharmacy”, tries to get at this issue. The top 25 drugs sold by a PBM’s own pharmacy tell us the market share for their own pharmacy compared to other pharmacies.

Clint Hopkins stated his pharmacy calls the PBM to discuss terms of the contract but the PBM does not respond to the pharmacy. It’s a take it or leave it contract.

Sara Durston, DMHC, stated AB 315 included language to clarify that pharmacies are considered providers and can avail themselves of DMHC’s provider dispute resolution process.

Brett Johnson, California Life Sciences, mentioned AB 315's core intent is to understand how elements are offsetting or not offsetting patient premiums. He urged the Task Force not to underestimate the value of qualitative data points. For example, yes or no questions. Louisiana recently signed a law that gets at aggregate retained rebate information. The Task Force could also look to other states' Request for Proposals (RFPs). Connecticut's RFP issued in July this year shows the importance of definitions and details, such as formulary rebates or access rebates.

Shane Desselle asked whether the Task Force members are precluded from recommending asking a few simple qualitative questions about the value of PBMs. If PBMs are improving the medication use process that's fantastic, but if they are using profits to adjudicate claims that's not improving patient outcomes.

4. Stakeholder Panel Discussion Regarding Recommended Data Elements

Ms. Richardson asked the stakeholder panel members to introduce themselves and the organizations they represent. Each panel member provided feedback on the recommended data elements and answered questions from the Task Force. The panel members were:

- Danny Martinez, California Pharmacy Association (CPhA)
- Christina Wu, California Association of Health Plans (CAHP)
- Bill Head, Pharmacy Care Management Association (PCMA)
- Michael Valle and Chaz Chung, Office of Statewide Health Planning and Development (OSHPD)

Mr. Martinez recommended using the term "post-transaction fees" instead of "claw-backs" because it would encompass anything the PBM charges after the point of sale.

Patrick Robinson asked whether post-transaction fees include reversals, or a drug that was on the shelf that didn't go to the patient that was later re-stocked. Mr. Martinez answered that it should include any fee that affects what the pharmacy is paid. Mr. Martinez explained that his members have recently voiced concerns about a particular plan's formulary that only covers the brand name drug for Adderall XR and Advair. Any claim for the generic form will be denied even if the physician is recommending the generic version. A letter submitted from a different plan said the opposite, that they will only pay for the generic version, which highlights the importance of rebates.

Mr. Martinez discussed the challenges of the dispute resolution process. CPhA has created a booklet to help their members navigate the dispute resolution process, but pharmacists are not seen as providers by some PBMs. He recommended the Task Force consider the barriers of specific contractual clauses that prohibit the pharmacy from talking to the Plan on anything related to pricing.

Dr. Ghotbi asked whether CPhA has relationships with Plans and whether the experience is different if there's a relationship with a Plan rather than an intermediary. Mr. Martinez replied that they do and it depends on the Plan but many Plans pass on the issue to the PBM.

Bill Head said one of the things that was discussed early on is focusing on just one piece of the supply chain. There are other big pieces of the supply chain missing that would help to understand its totality and impacts from other players. For example, looking at the role of the pharmacy services administration organizations (PSAOs), and rebates between the manufacturer and the wholesaler. Some of PCMA's comments on the draft elements mention that some of these are captured under AB 315 and some are not. Also, the patient's needs must remain part of the focus. PCMA hopes that a lot of the proprietary and confidential information that has been considered for reporting be kept confidential. PCMA is not opposed to the collection of data but worries about making confidential data public.

Dr. Ghotbi asked whether any conversation today concerned PCMA regarding requiring PBMs to produce the data. Mr. Head answered that yes, in particular the conversation around claw-backs and rebates as revenue because they are not a source of revenue for PBMs. There's a great deal of lag time that should be considered if rebates and claw-backs will be required to be reported.

Dr. Thibeau stated that she appreciates Mr. Head's point that this is a complex arena but the focus is on PBMs because it seems like there are no rules or regulations on PBMs and no enforcement mechanisms in the same way that there are many rules and regulations on Plans and pharmacies. Dr. Ghotbi agreed on this point and also commented that there has not been scrutiny on wholesalers in this process.

Christina Wu stated the Plans want to ensure the recommendations provide meaningful information but also include the flexibility Plans need to be able to negotiate contracts with their delegated entities. Plans want to be sure that the additional reporting and metrics consider the confidential nature of contracts. With respect to Medi-Cal, AB 349 limits cost-sharing and has a lot of requirements related to the way in which a pharmacy and therapeutics committee will evaluate placements of drugs on a plan formulary.

Furthermore, Plans can collect information only on the membership of their Plan. It would be concerning if a Plan were required to collect information on another Plans' membership. Plans must submit their contracts to the DMHC for review, including PBM contracts. Plans need to do delegation oversight audits on their PBMs that include appropriateness and claims processing audits. If the PBM fails to do something it is the ultimate responsibility of the Plan to ensure that the member is made whole.

Dr. Sood asked whether Plans think the contracts with PBMs are transparent and easy to understand. Ms. Wu answered it's important for Plans to be able to negotiate contracts that are appropriate for their membership. One Plan might want a PBM specifically for claims processing but not formulary management, for example. In general, Plans must disclose what they're delegating and how much they're paying delegated entities, so from a contractual perspective, contract terms between Plans and their PBMs are based on their needs and what is appropriate for their members.

Michael Valle explained that OSHPD has held eight meetings of the Healthcare Payments Database (HPD) Committee and is reviewing the data specifications

recommended by the Committee. OSHPD will be recommending a Common Data Layout (CDL) version 2.0 that includes pharmacy claims and other forms of payment such as capitation. OSHPD will continue to receive the claims reports that have already been established and is working with the Committee to determine when to expand the data collection standards.

Mr. Robinson commented that the National Council for Prescription Drug Programs (NCPDP) sets parameters for rebates and post-adjudication standards. He asked how the post-adjudication standards reporting would fit in with the HPD. Ms. Wu stated that, with respect to the CDL, all data is claims data and pharmacy claims is an established dataset. Ultimately there is a desire to ensure that this data is meaningful and accurate, so before rebates (non-claims payment) can be considered, the HPD reporting must start with the lowest-hanging fruit and then expand the standards.

5. Closing Remarks

Ms. Rouillard closed the meeting by thanking the Task Force members for their participation. She said the DMHC will digest this information and prepare the report to the Legislature.