



STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: February 24, 2020

To: Wisconsin Pharmacy Cost Study Committee

From: Renee Walk, Strategic Advisor
Office of Strategic Health Policy

Subject: Summary of Pooled Purchasing Approaches & Update on Analytics
Proposal

Background

The Wisconsin Pharmacy Cost Study Committee (WPCSC) has to date investigated two avenues for cost savings for prescriptions drugs that are purchased by State of Wisconsin agencies. At their December 2019 meeting WPCSC recommended that the Department of Corrections (DOC) pursue a 340B subgrantee relationship with the Department of Health Services (DHS) under Section 318 of the Public Health Service Act. DOC is in the process of implementing this arrangement, with a goal to being receiving drugs at 340B prices by July 1, 2020.

WPCSC also considered options for value-based purchasing arrangements but determined that evidence of the benefits of these arrangements was minimal at this point in time. Also, the staff time to create and maintain these contracts is substantial, and without clear evidence of their effectiveness in maintaining costs, WPCSC opted to table them for the time being.

The memo provides and initial discussion of the final option for drug cost savings to be investigated by the committee: pooled purchasing. It presents a brief overview of the purchasing approaches that the Department of Employee Trust Funds (ETF), DOC, and Medicaid currently use, pooled purchasing approach concepts, and considerations for each of the concepts. Finally, this memo provides an update on the pharmacy cost analysis proposal provided by PillarRx and next steps.

Current Agency Purchasing

As discussed in prior meetings, each of the agencies in the WPCSC purchases drugs in a slightly different way. DHS's Medicaid program pays for drugs directly to pharmacies for its covered membership. To be allowed inclusion in coverage, manufacturers must participate in the Medicaid Drug Rebate Program (MDRP). Medicaid programs must, in turn, cover all drugs from manufacturers who participate in the MDRP. Wisconsin's Medicaid program also works with a vendor (The Optimal PDL \$olution or TOP\$) to

receive supplemental rebates. Medicaid receives money in the form of rebates from manufacturers, as well as the Centers for Medicare and Medicaid Services (CMS) in the form of their federal matching funds percentage, net of a portion of the MDRP rebates. The only money that Medicaid pays out is to pharmacies, in the form of reimbursement for the drug being taken by the member at the time the drug is dispensed. A visualization of the purchasing flow for a Medicaid program is included in [Attachment A](#) of this document. It should be noted, however, that Wisconsin Medicaid does not use a Pharmacy Benefit Manager, as the diagram shows.

DOC currently purchases drugs for its inmate population through a group purchasing contract with MMCAP Infuse. Wisconsin's contract with MMCAP is authorized under Wis. Stats. §16.73(4) and held by the Department of Administration (DOA). MMCAP Infuse is a multi-state purchasing alliance that negotiates prices on behalf of government entities. Through their relationship with MMCAP, DOC receives actual drug products through Cardinal Health, their selected wholesale distributor. According to MMCAP's contract, DOC may be eligible to receive a portion of unused administrative fees received from suppliers. Once DOC is allowed as a 340B subgrantee, they will be able to submit replenishment orders for their 340B drugs through the same contracting arrangement.

The Division of Care and Treatment Services (DCTS), a division of DHS, purchases drugs for its patients who reside at its secure facilities. The majority of the secure facilities also take advantage of the MMCAP contract administered by DOA. Non-secure facilities bill other insurance or Medicaid as available.

ETF purchases drugs through a pharmacy benefit manager (PBM). ETF pays the PBM a per-member rate, and the PBM in turn negotiates manufacturer discounts and rebates, as well as at-pharmacy costs and dispensing fees. Attachment B gives an example of a typical pathway for the flow of product, money, and contractual relationships in the US system. In ETF's case, the pharmacy program is carved out from the health plans, and so there is no health plan or other third-party payer to whom ETF sends premiums on behalf of members. The PBM also receives all rebates on behalf of ETF; unlike the pathway described in [Attachment B](#), the PBM passes all revenues from rebates and other manufacturer agreements to ETF, which ETF then uses to reduce annual member premium costs.

Pooled Purchasing Concepts

Pooled purchasing in this paper refers to arrangements amongst entities who are responsible for purchasing drugs that leverage the volume of drugs purchased in order to get better pricing. These arrangements can and have taken a variety of forms.

Intra-State Arrangements: Some states like Washington have attempted to combine state purchasing amongst the agencies in the state that are purchasers. The Washington State Healthcare Authority was created by the Washington legislature in 2005 and purchases drugs for its Medicaid members, state

employees, and school employees, among other public entities in the state. The state of Oregon's legislature created a similar arrangement in 2003.

Benefits to this arrangement include internal transparency on pricing between the various contracts, which provides a more holistic picture when negotiating contracts. These arrangements also may yield lower administrative costs and better ability to provide reporting. Challenges may include whether a state has the statutory authority to combine purchasing in such a way, as well as individual program requirements (particularly related to Medicaid) that can limit the ability of programs to negotiate prices.

Inter-State Arrangements: Some Wisconsin agencies already participate in inter-state purchasing arrangements. MMCAP Infuse is one example; this group is managed by the State of Minnesota, and specifically serves government purchasers. MMCAP cites membership in all 50 states. MMCAP currently includes over 13,000 member groups. Another inter-state arrangement currently in place is the Northwest Prescription Drug Consortium (NPDC), which Oregon and Washington both participate in. Similar to MMCAP, NPDC offers group purchasing arrangements for both of these entities. They currently manage more than 1.1 million members.

Benefits to these arrangements include expanding the number of potential lives covered under the group purchasing arrangement. For patients who might cross state lines at some point and change coverage, this would also create continuity since groups generally agree to a single preferred drug list as a part of participating in a group purchasing arrangement. These single preferred drug lists can become a challenge as well, however, and changing to a new purchasing arrangement may cause substantial member disruption if preferred drugs are different.

In addition to how purchasers themselves are aggregated, there are also options in terms of how many or which types of drugs are aggregated for purchase. For example, ETF provides coverage for all drugs through its single PBM contract. DOC purchases all non-specialty medications through MMCAP, but purchases specialty drugs outside of that arrangement. While not a group purchasing agreement, Louisiana has undertaken a contract arrangement for unlimited subscription access to a single Hepatitis C drug.

Benefits of negotiating all or the majority of drugs through a pooled purchasing arrangement again include greater volume of products, as well as the ability to leverage better discounts at the manufacturer level; some manufacturers will provide rebates across several products which makes purchasing all such drugs from a manufacturer more beneficial. It is also administratively simpler to maintain a sole group purchasing contract instead of several. There may be challenges in terms of verifying cost savings, however. In initial analysis of utilization, there is only limited overlap in the types of drugs that DOC, ETF, and DHS provide access to. It is possible that utilization

differences, combined with preferred drugs and discounts, could lead to higher costs for some agencies even if there are lower costs for others. Also, transitioning completely to a new purchasing arrangement would be a substantial administrative shift for any agency, and could cause member disruption.

There may be benefits of only adding some drugs to a pooled purchasing arrangement. WPCSC could focus on the drugs where there is known overlap amongst agencies and then focus a pooled procurement activity around those drugs. This would help ensure that there was enough volume to obtain best price, while limiting disruption. This may also be a means to test the ability of Wisconsin to move towards more comprehensive pooled purchasing efforts. The challenges, though, include the aforementioned manufacturer-level discounts, staff time to implement and agency authority to procure and manage such contracts, and how such arrangements would integrate into existing contractual arrangements.

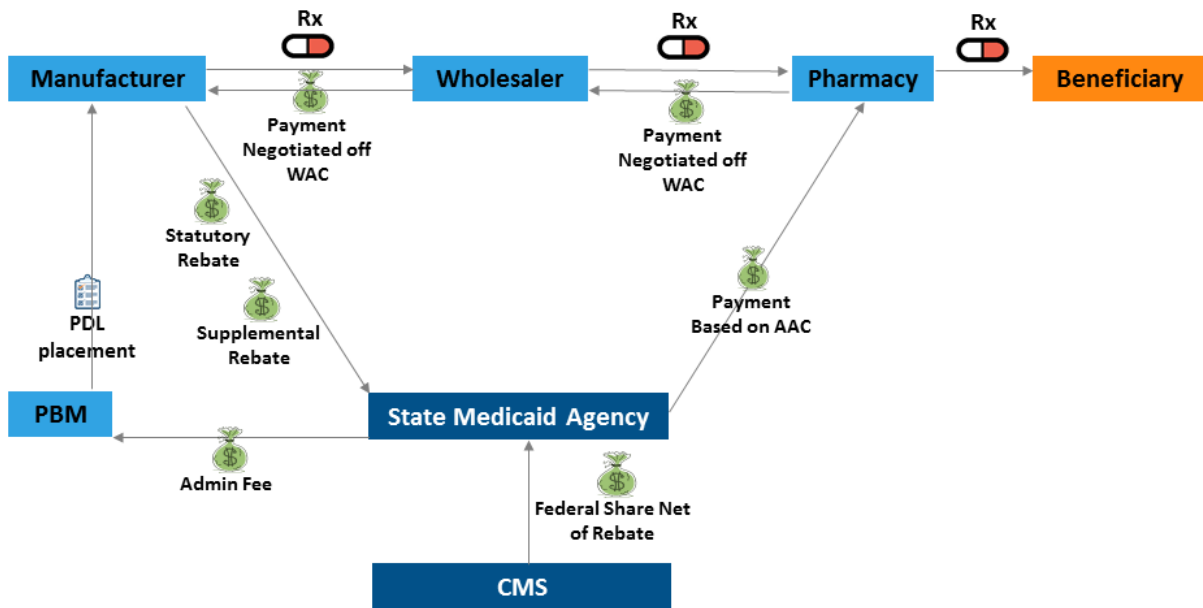
Update on Analytics Proposal

A key missing piece of the discussion above is a true comparison of costs amongst agencies. At the December 2019 WPCSC meeting, WPCSC discussed the option of having a third party, PillarRx, provide an analysis of claims data to determine opportunities to pool purchasing.

ETF received a proposal from PillarRx on February 20 and is reviewing that proposal with the National Governor's Association (NGA). There are still a few outstanding questions on the proposal, and ETF will be convening a call to clarify details on Friday, February 28. Once the proposal is finalized, ETF will share with the Committee for consideration.

Attachment A: Medicaid Pharmacy Purchasing Flow

Complexity and Lack of Transparency in Payment and Drug Supply Chain in Medicaid Pharmacy Benefits



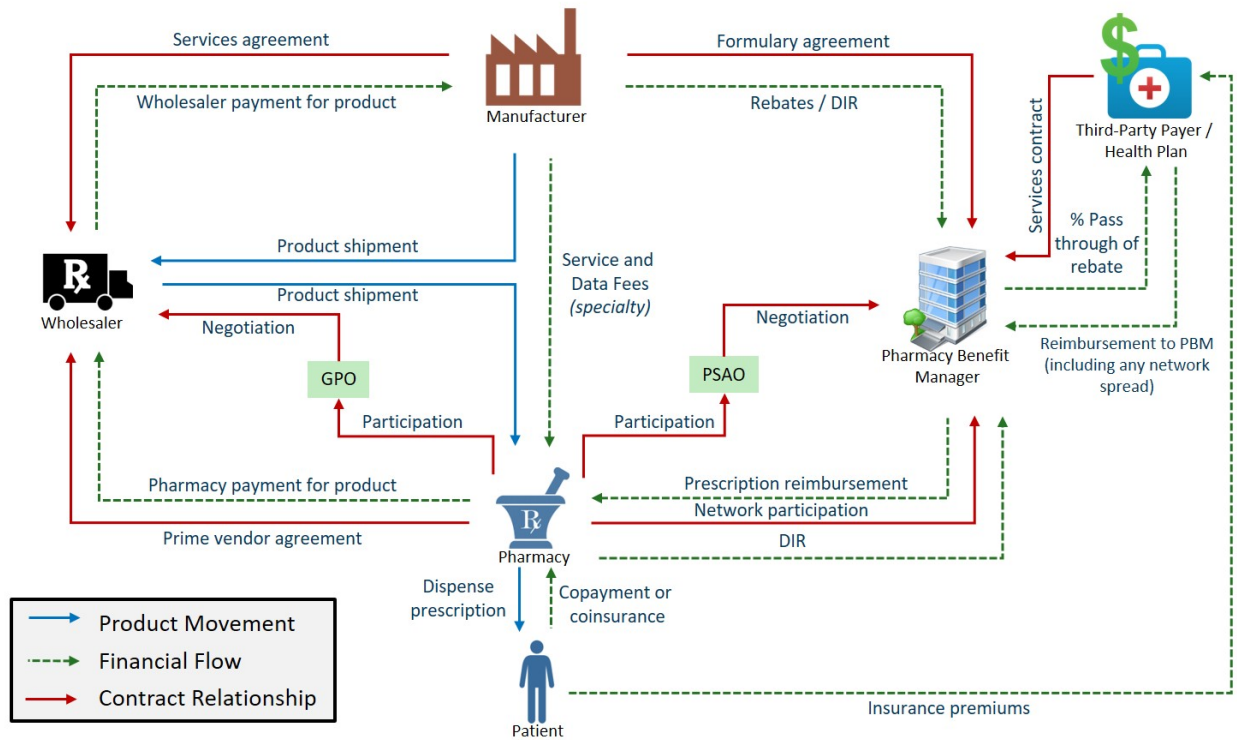
Notes: This figure is a simplified depiction of the payment and drug supply chain in the Medicaid prescription drug benefit provided through a fee-for-service setting. WAC is Wholesale Acquisition Cost. While WAC is known, the negotiated amount is not. AAC is Actual Acquisition Cost and is based on a published schedule such as NADAC or WAC.



Source: Kaiser Family Foundation, "Pricing and Payment for Medicaid Prescription Drugs." Published January 23, 2020. <https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicoid-prescription-drugs/>

Attachment B: Commercial PBM Purchasing Flow Example

U.S. Distribution and Reimbursement System: Patient-Administered, Outpatient Drugs



GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization; DIR = Direct and Indirect Remuneration
 Source: Drug Channels Institute. Chart illustrates flows for Patient-Administered, Outpatient Drugs. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of product movement, financial flow, or contractual relationship in the marketplace.



Source: Drug Channels Institute, <https://drugchannelsinstitute.com/files/Drug-Channels-2019.pdf>