Sunshine in the Black Box of Pharmacy Benefits Management

Florida Medicaid Pharmacy Claims Analysis

January 27, 2020

Prepared for the Florida Pharmacy Association (FPA) and American Pharmacy Cooperative Inc. (APCI)

1 About this Report

The Florida Pharmacy Association (FPA) and American Pharmacy Cooperative, Inc. (APCI) commissioned 3 Axis Advisors LLC to study the Florida Medicaid program with the initial intention of understanding the impact of **spread pricing** on Florida's small community pharmacy providers. Our prior work has found strong evidence of spread pricing in Medicaid programs in New York, Illinois, and Michigan, while state government work in Ohio, Kentucky, Georgia, Virginia, and Maryland has definitively quantified spread in their state's Medicaid programs as well.[1,2,3,4,5,6,7,8] While we did not have all of the data required to perform an audit to completely pinpoint spread pricing in Florida Medicaid, it was the hope of FPA and APCI that we could perform a transparent assessment of spread in Florida, with the goal of providing any evidence to the state for it to research further.

As we started to gather data, we realized that Florida - owing to its laudable commitment to transparency - offered a unique opportunity to go well beyond spread pricing in our data analysis. The more than 350 million deidentified claims obtained through a Freedom of Information Act Request to the **Agency for Health Care Administration (AHCA)** gave us the most robust dataset to study how all funds related to outpatient prescription drugs flow through Medicaid. This dataset gave us the ability to definitively see what each **managed care organization (MCO)** reported paying for each drug - **National Drug Code (NDC)** - to each pharmacy - **National Provider Identifier (NPI)**. We could, for the first time, fully analyze and disclose to the public *the state's view* of who was collecting the funds that it was entrusting its MCOs to distribute to the pharmacy providers serving its Medicaid patients. Realizing this, we accepted this project with FPA and APCI with the agreement that the project would have a completely open-ended scope. Limiting the scope of our work to only an analysis of spread pricing would be a disservice to the learnings that could be gleaned from such a robust dataset and would be inconsistent with our mission of bringing better transparency to the very opaque manner in which the U.S. prescription drug supply chain operates.

One problem we immediately encountered was that due to spread pricing, we understood that the state's databases did not necessarily reflect the rates at which Florida's pharmacies were being reimbursed. As such, we invested a significant amount of time and effort to collect deidentified claims data from more than 100 small community pharmacies across Florida. The goal of this work was primarily to validate the state's claims data - to learn how biased it was due to spread pricing. We are grateful to the many pharmacy owners that worked with us to provide data to help validate the state's claims data. Without their help, we would have not been able to obtain as complete of a picture of how funds flow within Florida Medicaid managed care.

This report includes many terms uniquely used within the drug supply chain that may be foreign to the general public. We have done our best to highlight all such terms in **bold-orange** font and provide definitions in the Glossary. In addition, all green underlined text are hyperlinks, which the reader can click in an electronic version of this report for easier navigation from one section to another.

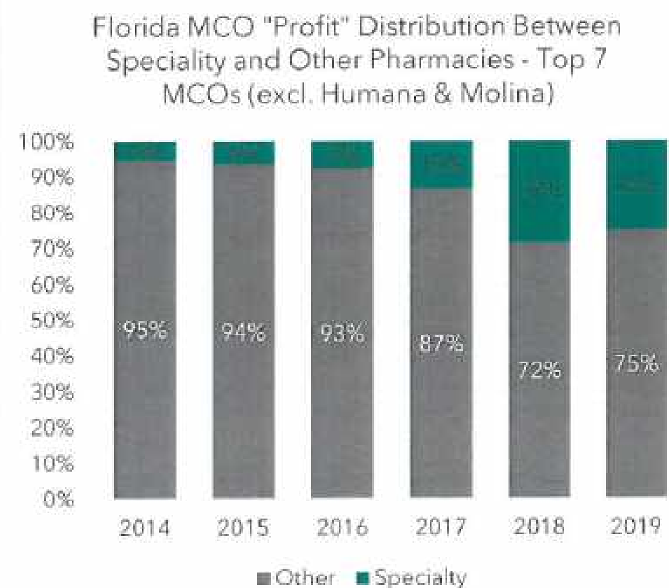
Lastly, this report includes the most robust Methodology section we have written to date. It attempts to present you with all the information you would need to replicate the analysis performed in this report, including all assumptions, transformations, and flows created to assemble our finished databases. It is our sincere hope that this level of transparency will help all parties interested in the inner workings of the U.S. drug supply chain find better fact-based answers to their questions.

2 EXECUTIVE SUMMARY

As is the case with any entity, a pharmacy incurs a cost to do business. In pharmacy, this is called the **cost of dispensing (COD)**. The Center for Medicare and Medicaid Services (CMS) requires all states to conduct a COD analysis for their pharmacy providers and reimburse them this amount for each Medicaid **fee-for-service (FFS)** claim on top of the cost to acquire the drug as measured by **National Average Drug Acquisition Cost (NADAC)** or a state's own **Actual Acquisition Cost (AAC)**. Florida has determined the COD incurred by pharmacies in the state to be $10.24 per claim.[9] Our analysis of Florida's claims data confirms that the state is reporting FFS costs on generic drug claims that includes this **professional dispensing fee**. As such, Florida's claims data suggests that Florida pharmacy providers are being reimbursed at a level that covers their COD in the state's FFS program.

However, CMS' required FFS pharmacy reimbursement methodology does not apply to Medicaid **managed care**. In managed care, the state makes **capitated payments** to MCOs, who then often hire **Pharmacy Benefit Managers (PBMs)** to administer the pharmacy benefit on their behalf. PBMs then set claim payments for pharmacies based on proprietary rate lists that are not subject to CMS' reimbursement requirements. The lack of any standards for provider payments within managed care has allowed Florida's MCOs and PBMs to place substantial pressure on pharmacy margins in Medicaid managed care - our analysis of Florida's top seven MCOs (excluding those that exhibited clear data errors or pricing spread) found that pharmacies were paid a weighted average of just $2.72 per claim in 2018 - enough to cover just 27 cents on the dollar spent to maintain pharmacy operations. This was down from $7.70 per claim in 2014.

Figure 2-1 Florida MCO Profit Distribution Between Specialty & Other Pharmacies - Top 7 MCO (excl. Humana & Molina)



But some pharmacies were spared from the substantial pressure on Medicaid managed care margins. As shown in **Figure 2-1**, the state's largest specialty pharmacies collected 28% of the available "profit" paid to all providers in Florida Medicaid managed care in 2018, up from just 5% in 2014. This was despite dispensing only 0.4% of all managed care claims.

It's critical to note that the Specialty group shown in **Figure 2-1** includes only five pharmacy groups: Acaria, Accredo, Briova, Exactus, and Perform Specialty. All five of these groups are either directly affiliated with one of Florida's MCOs or a PBM contracted to manage benefits for a Florida MCO. If we remove the margin paid out to these "affiliated" pharmacies, the rest of Florida pharmacies were left with a weighted average $1.97 per claim as payment for their services to Florida's Medicaid population.

Ultimately, our work in this report was to study the mechanism by which MCOs and PBMs are allocating the very limited amount of margin to providers across the state. The FFS mechanism is very simple - purely driven by the number of claims. But what about managed care? Throughout this

report, we highlight many examples of how MCOs and PBMs appear to be using their control in managed care to incrementally shift dollars to their affiliated companies. The examples include:

- The near-complete displacement of Walgreens pharmacies by CVS pharmacies in both Staywell/WellCare and Sunshine/Centene during the time when CVS Caremark was providing PBM services to both MCOs
- The extraction of an estimated $8.27 per claim in pricing spread by CVS Caremark off generic Molina claims dispensed at Small Pharmacies in 2018, resulting in Small Pharmacies receiving a net loss per Molina generic drug claim of $1.08
- Dramatic overpricing of selected high-utilization drugs by Sunshine/Centene (which receives PBM services in part from CVS Caremark) when dispensed at CVS pharmacies (**Figure 2-2**)
- Overpricing of specialty drugs when they are dispensed at "affiliated" pharmacies
- Mispricing by some PBMs (on behalf of their MCOs) of selected generic dermatological creams (most notably generic Dovonex - man-made Vitamin D cream), which resulted in abnormally high dispensing and expense on such drugs in Florida Medicaid managed care
    - The growth in byzantine **effective rate contracts** between PBMs and pharmacies, combined with the lack of standard industry brand/generic definitions, creates the possibility that a hidden form a spread can be collected from such pricing distortions

Figure 2-2: Sunshine/Centene Reported 2018 Aripiprazole Unit Cost by Pharmacy Group

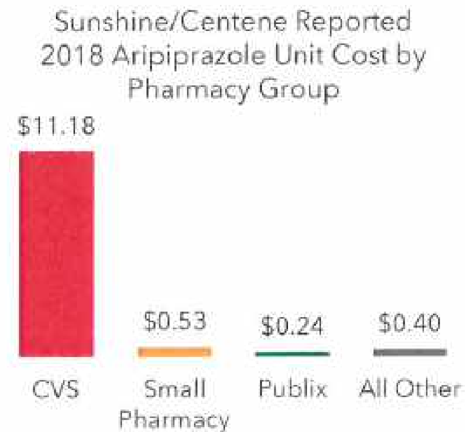


Figure 2-3: Brand Name Margin over Acquisition Cost, by Pharmacy Grouping in Top 6 MCOs, 2018-2019 (Excl. 340B)

While the benefits of such distortions are, in the aggregate, clear when it comes to affiliated specialty pharmacies (**Figure 2-3**), it is more challenging to see such benefits, in the aggregate, for the most dominant player in Florida managed care, CVS Health, who in 2018 filled 45% of all managed care prescriptions and also provided PBM services (in full or in part) for at least 46% of all managed care prescriptions. As this report will show, CVS appears to be overpaying itself on some plans (through mechanisms shown in **Figure 2-2**) but underpaying itself relative to competitors in other plans (e.g. Staywell/WellCare). There is no way with this dataset, in our view, to perfectly reverse engineer the company's complex pricing strategy across all of Florida managed care. However, we do believe that we have provided irrefutable evidence in this report that whatever strategy is in place is far from equitable for different drugs, MCOs, and

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pharmacies. **In our view, any pricing/payment strategy that is not equitable on all three dimensions risks having providers prioritize certain patients with certain disease states over others based on the arbitrary profitability an MCO (or its PBM) applies to the treatment.**

In addition to a granular analysis of relative claims pricing by MCO, pharmacy, and drug, this study also broadly raises questions on how well incentives are aligned between MCOs and the state. It shows how aggregate MCO administrative expenses have not declined as managed care has grown in Florida. This admittedly could be circumstantial evidence, or it could be the fallout of **Medical Loss Ratio (MLR)** requirements. These MLR requirements were intended to ensure that a minimum percentage of capitation revenue is spent on services but can be looked at from a different angle as granting MCOs a fixed percentage of revenue to allocate to overhead expenses. This could create the warped MCO incentive for higher capitation revenues to be able to generate and capture higher administrative fees.

We also provide data that calls into question a MCO's incentive to effectively manage drug utilization to the state's **Single Preferred Drug List (SPDL)**. MCOs are ultimately paid capitated rates based on pre-rebate dollars, while states ultimately are the beneficiaries from significant statutory and supplemental rebates. We illustrate that the lowest **net cost** drug for a given indication is not necessarily the lowest **gross cost** drug. Without being held accountable to dispensing the lowest net cost drug option for the state, MCOs may instead dispense the lowest gross cost drug, increasing net costs for Florida, and the federal government, which is paying for 61.96% of Florida's Medicaid program.[10]

Lastly, with regards to spread pricing (the initial impetus for this study), of the top six MCOs that we analyzed (between 2017 and 2019), we only found clear signs of pricing spread in Molina in 2017 and 2018, which abruptly disappeared at the start of 2019. The other large MCOs not only did not show signs of spread, but showed AHCA claims payments that were almost identical to claim-level pharmacy reimbursements collected from more than 100 small community pharmacies across the state. This is quite different from the experience of Ohio, Kentucky, Georgia, Virginia, and Maryland, which have found considerable pricing spread in their Medicaid managed care programs. We urge the state to audit the program to confirm or refute our findings.

Overall, our five-month exploration of Florida Medicaid claims data, which has produced this 200+ page document, leaves us with the following realization: The evolution of the drug supply chain, which has undergone substantial vertical integration in recent years, puts the vertically integrated companies that control Medicaid benefits in the best position to thrive. Meanwhile, players across the supply chain that are not vertically integrated are put at a disadvantage. As such, an increasingly consolidated supply chain may be able to, in the near-term, deliver a less expensive "product" due to numerous service-line cross-subsidies. Florida has displayed this with its razor thin MCO pharmacy margins. But what is the long-term cost of this to the state? Is it in the best interest of Medicaid to hand over prescription drug management to insurance companies that also own the PBM and pharmacy functions, without closely monitoring their interactions? Or should we return to the original benefit of the managed care model - where each function can, in an unconflicted manner, act as a check and balance on the other, forming a market-driven "invisible hand" that can competitively drive down costs without sacrificing service quality?

Our Florida claims analysis sheds light on some glaring structural concerns embedded at the core of all state managed care programs. We hope it is helpful in advancing the national dialogue towards creating the most pro-competitive Medicaid delivery system that creates the best value for our taxpayer dollars at the lowest long-term risk to our states and their beneficiaries.

3 KEY FINDINGS

This report is organized into seven sections, as follows:

- Analysis of Florida Medicaid Capitation Rate Payments
- Formulary Analysis
- Generic Drug Spending Analysis
- Brand Drug Spending Analysis
- Pharmacy Reimbursement Analysis
- Overall Drug Spending / Reimbursement Trends
- Methodology

The following sub-sections present the summary and key takeaways from each of the first six sections.

3.1 ANALYSIS OF FLORIDA MEDICAID CAPITATION RATE PAYMENTS

Managed care organizations (MCOs) - the companies hired by states to manage its Medicaid benefit - function like insurance companies. They receive premium payments from the state, called "**capitation payments**," that they use to pay for services for Medicaid beneficiaries and cover administrative expenses. The greater the gap between capitated payments and overall expenses, the more profit available for shareholders (for those MCOs that are for-profit entities).

While the direct aim of this study is to analyze Florida Medicaid pharmacy claims data, we added a high-level review of capitation rate payments to provide the reader with context on how managed care receives the funds that it then uses to pay for medical services and drug claims.

Our findings are:

- Total Florida Medicaid capitation payments are over $12 billion per year
  - Pharmacy Services account for 20-25% of MCO expenditures per year
- Audited Florida Medicaid Financial Statements demonstrate that Florida MCOs are working for minimal net operating margin
  - In aggregate, Florida's MCOs have produced negative operating margin in two of the last four years (2015-2018)
- Administrative expenses have grown in line with MCO capitation revenue
  - Administrative expenses have remained fixed at ~11% of revenue, showing no improvement in **operating leverage** over this period
- Data from other states demonstrate the potential profitability of pharmacy services to MCOs
  - Additional information is necessary to understand the extent to which such profitability exists within the Florida Medicaid program for MCOs
- The lack of identified managed care operating margin creates the risk, in our view, that vertically integrated MCOs may attempt to generate profit from their participation in Florida Medicaid through other less-monitored parts of the supply chain (i.e. PBM or Pharmacy)

3.2 Formulary Analysis

When it comes to prescription drug coverage, one of the most important decisions any payer must make is what drugs to cover and what drugs not to cover. Medicaid is unique in that it must cover ***all*** drugs produced by drug manufacturers that are willing to participate in the **Medicaid Drug Rebate Program (MDRP)**.

However, states have flexibility in determining which drugs to "prefer." A drug specified as non-preferred may have more barriers to being dispensed, such as requiring a **prior authorization (PA)** or step therapy before its usage, whereas a preferred drug does not typically have such barriers.

Florida Medicaid has set one **Single Preferred Drug List (SPDL)** for all pharmacy benefit managers (PBMs) and administrators to follow. Ostensibly, this SPDL has been set by the state to optimize the cost / benefit of providing drug benefits to its Medicaid members. By putting an SPDL in place, Florida has for all intents and purposes, taken formulary management away from its MCOs, instead asking simply for formulary execution.

The aim of this section was to determine how well managed care organizations and their PBMs were executing on the state's PDL.

Our key findings are:

- Medicaid is unique in that it receives minimum statutory rebates for most drug products available in the U.S., and it can negotiate additional rebates with manufacturers for preferential status.
  - Federal Medicaid rebate amounts increase automatically whenever a drug's price rises faster than the rate of inflation
  - In 2017, Medicaid rebates reduced prescription costs 55% in the aggregate nationwide; 58% in the aggregate in Florida
  - Use of non-rebateable products represented 8% of MCO utilization in 2018 potentially adding costs to the program
- Florida Medicaid has a single PDL across all MCOs, which can help reduce overall net costs while maximizing rebate collections for AHCA
  - Plans who deviate from AHCA-mandated formulary coverage risk adding costs to Medicaid operations at both the state and federal level
    - In H1 2019, MCOs' ability to conform to the state's *Brand Drug Preferred List* varied with plans utilizing between 4-17% of the non-preferred products
  - Further research is needed to fully quantify the impact of non-preferred product utilization in Florida Medicaid, both in terms of patient access and Florida Medicaid financials

3.3 Generic Drug Spending Analysis

To provide an incentive for drugmakers to invest in research and development of new medications, brand-name drugmakers are awarded patent protection and marketing exclusivity terms for a drug for a limited time. When such rights expire, inexpensive generic "copies" of brand drugs come to market. In 2018, Florida Medicaid reported a weighted average cost per claim for generic drugs of

just $16.41. This cost was just 3% of the $526.66 weighted average cost per claim of brand-name drugs, before rebates. Given the magnitude of cost savings available through generic drug utilization, it should come as no surprise that nearly 83% of all Florida Medicaid drug claims over the past five years were for generic drugs.

However, our research to date has uncovered significant pricing distortions on generic drugs. While the aggregate generic price is undoubtedly low relative to brands, mechanisms are in place within the supply chain to inflate the price a payer is charged for ***some*** generic drugs when compared to their actual acquisition cost. These hidden mechanisms can create incentives in the supply chain to dispense certain drugs over others, which is tantamount to serving some patients over others.

The focus of our analysis in this section was to determine if (and to what extent) generic drug pricing was being distorted by PBMs, on behalf of their MCO clients. Furthermore, this section aims to explain and illustrate how such practices can lead to unintended consequences and costs.

Our key findings are:

- Managed care has collectively cut its reported generic drug **Margin over NADAC**[a] to $3 per claim in 2018, and $2.78 per claim in 2019
    - This is more than $7 below the $10.24 per claim professional dispensing fee set by Florida in its Medicaid fee-for-service (FFS) program - a fee that, per CMS, should capture all "reasonable expenses" incurred by a pharmacy to dispense a claim[11]
- The available Margin over NADAC to compensate pharmacies for services was heavily skewed based on the type of drug the pharmacy dispensed
    - 48% of all generic drug Margin over NADAC was paid out on generic drugs comprising only 1.5% of overall claims
- We found three drivers behind which pharmacies gained access to the most profitable generic drugs. The section provides several examples of each driver directly from Florida's claims data:
    - **Differential drug pricing**: PBMs set prices differently for different pharmacies, in some cases, creating an advantage for **affiliated pharmacies**
    - **Following pricing signals**: PBMs priced some drugs very high relative to acquisition cost, creating an incentive for unaffiliated pharmacies to over-dispense such drugs
    - **Specialty pharmacy steering**: MCOs and PBMs often require that generic specialty drugs be dispensed at their affiliated pharmacies, and report payments to these pharmacies far exceeding their cost to dispense
- We created a "payer/pharmacy matrix" to show how payments for generic drugs vary across MCOs and between pharmacies within the same MCO:
    - As an example, in 2018, Sunshine/Centene (managed in part by CVS Caremark) reported the cost of generic Abilify (on a per unit basis) to be $11.18, $0.53, and $0.24 at CVS, Small Pharmacies, and Publix, respectively
    - Similarly, it reported generic Nexium to cost (on a per unit basis) $3.72, $0.38, and $0.24 at CVS, Small Pharmacies, and Publix, respectively
    - Conversely, it reported levothyroxine sodium tablet to cost $0.05, $0.42, and $0.43 at CVS, Small Pharmacies, and Publix, respectively

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[a] Margin over NADAC is our proxy for claim "profit." It is the total reported MCO claim payment less the claim's National Average Drug Acquisition Cost. See "Margin over NADAC," and other key terms and definitions for a detailed discussion on this metric.

- As PBMs look to transition away from **spread pricing** without sacrificing profitability, payers will have to more closely monitor post-transaction claw backs related to **effective rate** contracts between PBMs and pharmacies. Without accounting for these claw backs, Florida Medicaid will not have a complete picture of how Medicaid dollars are being managed and distributed across the drug supply chain, which risks adding costs to the program.

3.4 Brand Drug Spending Analysis

While only comprising 17% of Florida Medicaid's claims, brand-name (i.e. trademarked) drugs are responsible for the overwhelming majority of gross Medicaid pharmacy spending. As an example, in 2018, Florida Medicaid spent over $2.5 billion on brand-name drugs, out of a total drug spend of just over $2.9 billion. In 2018, the weighted average brand-drug gross cost per claim in Florida Medicaid was $526.66, up 20% from 2015.

With such high gross ingredient costs on brand-name drugs, pharmacies are required to make an increasing investment to keep such drugs on their shelves. This is because retail pharmacies purchase brand drugs from their wholesalers at slight discounts to their growing list prices. In other words, retail pharmacies are completely blind to the substantial rebates collected by the state on brand drugs driven by the MDRP.

It follows that to continue to have any economic incentive to dispense brand drugs, Florida pharmacies must make a reasonable rate of return on brand drug claims. The focus on our analysis in this section was to analyze the magnitude and direction of the pharmacy **Margin over Acquisition Cost** reported by Florida's MCOs on brand-drug claims. To the extent that Florida sees value in dispensing brand drugs (which it should, given that some have lower net costs than equivalent generics, owing to sizable brand rebates[b]), we conducted an analysis to identify the key drivers of Florida's brand prescription spending.

Our key findings are:

- Based on a direct analysis of Medicaid's MCO claims data, Margin over Acquisition Cost reported on brand drugs was ($1.12) per prescription in 2019 down from $18.00 in 2014
    - This suggests that, on average in 2019, pharmacies were incurring losses to dispense brand name drugs in Florida Medicaid managed care
- However, on further inspection, we noticed that roughly 10% of brand drug claims were priced at substantial (30%+) discounts to the drug's **Average Wholesale Price (AWP)**
    - These are more than likely **340B** claims - highly discounted drugs that manufacturers are required to provide to eligible health care organizations
    - Reported 340B costs likely do not reflect the price paid to the pharmacy and, as a result, must be removed from analysis geared towards a better understanding of pharmacy profitability
- After removing estimated 340B claims, we calculate Margin over Acquisition Cost reported on brand drugs was $7.07 per claim in 2019, down from $20.94 in 2014

[b] Florida demonstrates importance of some of these products by maintaining a *Brand Preferred Over Generic* list, see Brand vs. Generic Compliance for more a more detailed discussion.

- This translates to a 1.2% gross profit margin for the pharmacy in 2019, assuming full pass through of reported costs
- All top six Florida MCOs have materially cut Margin over Acquisition Cost over the past four years

- However, this overstates payments to retail pharmacies that do not have the ability to dispense the most lucrative specialty drugs
  - Claims dispensed at retail pharmacy groups (e.g. CVS, Publix, Walmart) are being reported at a weighted average Margin over Acquisition Cost between $2 and 4 per claim within Florida's MCOs
- Meanwhile, claims dispensed at affiliated or specialty pharmacies (e.g. Acaria, Exactus, Briova, Accredo) are being reported with a weighted average Margin over Acquisition Cost of up to $200 per claim within Florida's MCOs
  - Some MCOs (Sunshine/Centene, Staywell/WellCare, United) directly own these pharmacies (Acaria, Exactus, and Briova, respectively) while others direct claims to a specialty pharmacy owned by Express Scripts (Accredo).
- We surprisingly found a disparity between per claim costs reported at these "affiliated" specialty pharmacies versus those reported outside these pharmacies
  - Expensive brand-drug claims (those that cost $2,000 or more per claim) were, in aggregate, slightly ***more*** expensive when dispensed at an affiliated specialty pharmacy
  - This relative mispricing holds when looking at individual drugs like Humira
  - Molina is the only top six Florida MCO that does not show this dynamic, but notably is using a specialty pharmacy (Accredo) that has no affiliation with itself or its PBM (CVS Caremark)

3.5 Pharmacy Reimbursement Analysis

Up to this point in this study, all analysis has been of pharmacy claims data from the **AHCA claims database**. This data reflects the reported claim payments from Florida's MCOs to their PBMs, not necessarily the reimbursements to Florida's pharmacy providers. The difference between the two is called spread pricing, and as found in Ohio, New York, Kentucky, Michigan, Illinois, Georgia, and Maryland, can be a considerable source of PBM profit within state Medicaid programs.

The goal of the analysis performed in this section was to ascertain to what extent spread pricing is occurring in Florida Medicaid managed care. To accomplish this, we collect deidentified claims data from more than 100 small community pharmacies in the state and compared this data to the claims data in AHCA's database.

Our key findings are:

- Of the claims we collected from pharmacies, we were able to match more than 350,000 within AHCA's database
  - We matched at least 22,000 claims for each of the top six MCOs, with the most being Staywell/WellCare, with 107,000 claims matched
- In 2017 and 2018, there was an **exact match** in the weighted average cost per unit reported by pharmacies and by AHCA for all matched claims reported by five of the top six MCOs

- Molina was the only MCO with a difference in unit cost between the two databases - AHCA's reported units were $0.18 per unit, or 50%, higher than pharmacy-reported reimbursements for matched generic claims. Applying this percentage to Molina's total 2018 oral solid drug spending gets us to an estimate of just over $10 million in 2018 PBM spread

- In 2019, Molina's pricing spread appears to have disappeared, suggesting that all six of Florida's top MCOs have shifted to a non-spread model
  - Our analysis strongly suggests that there was likely very little spread pricing (if any) in Florida Medicaid in 2019
- However, the analysis also lends credence to the notion that the warped payments reported in AHCA's claims data (detailed in the prior two sections on Generic and Brand drugs) largely reflects actual pharmacy experience within Florida Medicaid's program

3.6 OVERALL DRUG SPENDING/REIMBURSEMENT TRENDS

With the requisite knowledge regarding brand and generic pricing trends within Florida's MCOs, along with the knowledge that spread pricing does not appear to be impactful to five of the top six MCOs, we can construct an aggregate view of pharmacy profitability in Florida Medicaid.

Our key findings in this section are:

- Overall margins available for Florida's pharmacy providers offered by Florida's top six MCOs have materially declined from a high of $7.43 per claim in 2014 to a low of $3.45 per claim in 2019
- While the Florida's Medicaid profit "pie" is in the aggregate, undoubtedly shrinking, it is also getting redistributed to the pharmacies that handle of the bulk of Medicaid's vastly more expensive specialty drugs
  - Despite only accounting for 0.4% of the prescription claim volume, specialty pharmacies affiliated with MCOs and/or PBMs captured 28% of the available pharmacy dispensing margin in 2018
- There are inherent risks within such a concentrated system. Recent mergers amongst the largest MCOs within Florida Medicaid (Staywell/WellCare and Sunshine/Centene) could risk worsening the financial picture for Florida's Small Pharmacies going forward
  - In 2018, Staywell/WellCare was the best MCO payer for Florida pharmacies whereas Sunshine/Centene was the worst
  - If we apply 2019 Sunshine/Centene payment rates to Staywell/WellCare's pharmacy claims in the first half of 2019, it removes $11.4 million in margin from Small Pharmacies in less than six months.
  - This would bring WellCare's MCO-leading Small Pharmacy margin down from $9.69 per claim to a loss of $1.49 per claim
- In an environment characterized by razor thin (and declining) margins, the only legitimate controllable variable for pharmacies to improve their economics is to bring on incremental volume or cut cost by reducing staffing and abandoning under-profitable service offerings
  - This benefits growing population centers where volume can be more readily concentrated, whereas rural areas could risk losing access to pharmacy providers given their more limited ability to grow volume