Medicaid Costs and Options with High Cost Drugs

for the Utah State Legislature
Social Services Appropriations Subcommittee
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Presented by Richard Cauchi, Program Director
NCSL Health Program
National Conference of State Legislatures

NCSL takes no position on state health laws, legislation and programs.
Getting beyond the
Headlines....
State Legislative roles
1. High Cost Drugs: an Overview

• Lower-cost generics = 90% of the prescriptions filled in U.S.

• Nationally 15% of Medicaid spending goes to prescription drugs
  • 2/3 for brand-name; 1/3 for generics

• “Specialty drugs” (Brands; often $600+/month; injected, biologics, infused)
  New focal point of concern. 15.4% average increase for 2018

• Rapid growth of new “innovator” products. Hepatitis C drugs as “miracle cure;” cost $84k, eventually lowered to $26,400 for a course of treatment

• Medicaid programs get “best price” through a fairly complex set of formulas no less than a statutory minimum percentage

• CMS also limits state Medicaid agencies to federal upper limits in their drug pricing methodologies.

(source: S. Fitton, MI Medicaid)
2- Medicaid Drug Structure (a 50-state perspective)

• **Federal Rebates laws** established a formal, industry-wide price rebate system, “OBRA 1990” modified by ACA 2010
  • **Brand** “Innovator” Rx receive 23.1% below **Average Manufacturer Price (AMP)**
  • **Generic** or “Non-innovator” **Drugs** – 13 % below the AMP per unit
  • All “medically necessary” drugs must be available (exceptions, exclusions)

• **Preferred Drug Lists** – designed by states (using 2-columns)

<table>
<thead>
<tr>
<th>Preferred Drug</th>
<th>Non-preferred Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>celecoxib</td>
</tr>
</tbody>
</table>

G=Generic; B= Brand  
Utah Medicaid PDL (08-01-18).pdf 36 pages

• **Prior Authorization** – physician/prescriber request to use a more costly drug. Approval granted in 90% +/- of cases

• **Individual Patient Appeals**
• **Utilization Review Board**
• **“P & T” Committees** (Pharmaceutical & Therapeutics)
3- State-Initiated Supplemental Rebates + Negotiations
Multistate Rx Purchasing – 4 groups

**Sovereign States Drug Consortium (SSDC)**
non-profit structure, started 2005 for Medicaid purchases.
12 states: Utah, Delaware, Iowa, Maine, Mississippi, North Dakota, Ohio (joined 2017), Oklahoma, Oregon, Vermont, West Virginia and Wyoming are operational members as of 2018.

Advantages:
- Achieve larger discounts on specific large-volume or newly-marketed drugs
- Negotiation “strength in numbers”
- Compare state agency results

Drawbacks/Limits:
- Most prices are confidential
- Legislatures often express concern at what role they can play
- Managed care (1/3 of states)
4- **State Use of Drug Price & Cost Transparency**

• New/expanded HHS/CMS “Medicaid Dashboard”
  • Provides Rx by brand name: annual increase rate by percent & dollars
    (Example: Lantus 18.7% annual; $13 to $25 in 4 years) – *Details in NCSL Memo*

• State law initiatives 2016 -2018
  • 6 states: laws to require price transparency and disclosure, including research, manufacturing and marketing costs. CT, LA, ME, NV, OR, VT.
  • NY: Establishes a Medicaid drug spend cap, “a limit on annual growth.”
  • AR: Prior Authorization Transparency Act, “do not hinder patient care” ([S 318](#))
  • “Step Therapy” and consumer rights (cost vs. consumer access)
  • Drug importation- extensive state history; state-based wholesale (VT)
5 – Rx Effectiveness or Value-Based Purchasing

A) Drug Effectiveness Review Project (DERP)
DERP initiated in 2003 in response to dramatic increases in the cost of pharmaceuticals to state Medicaid budgets. A collaborative state Medicaid agencies and other organizations. Comparative effectiveness reviews to inform evidence-based decisions for Medicaid recipients. Coordinated by the Center for Evidence-based Policy (CEbP) at Oregon Health & Science University (OHSU). 12 states pool funds for research.

B) State Medicaid Alternative Reimbursement and Purchasing Test For High-cost Drugs (SMART-D)
• Oregon-based project: Value-based industry collaboration plan
• “… help bring clarity to the complicated landscape of drug purchasing for state Medicaid programs and provide alternative payment models (APMs) to help improve patient access to evidence-based therapies while allowing states to predict and manage prescription drug costs. SMART-D project includes:
  • Mapping the landscape of Medicaid drug purchasing; Identifying alternative payment options for states
  • Working to increase patient access and improve outcomes; Identifying specific opportunities to collaborate with drug manufacturers; Providing implementation, technical assistance and support to states

C) CMS Approves 1st value –based Medicaid rebate plan for Oklahoma
New State Plan amendment allows new supplemental rebates for state “if clinical outcomes are not achieved.” Uses benchmarks based on health outcomes. (June 27, 2018) States are watching...
What’s Next for States?

• Trump Administration announced “Blueprint to Lower Prices and Reduce Out-of-Pocket Costs.”
  More than 25 strategies in 4 categories: improved competition, better negotiation, incentives to lower list prices and lower out-of-pocket costs
• Federal action will affect multiple Medicare transactions;
• So far, Medicaid is mostly not directly affected. (see KFF memo)
• Medicaid Demonstration Waivers –voluntary for up to 5 states- could create an in-state formulary
• Accelerated FDA approval of interchangeable biosimilars? None yet.

2019 State Legislation or Budget Changes? ? ?

Update 8/8/2018