



# MEDICAID PHARMACY BENEFITS

Vicki Cunningham, Director of Pharmacy Services  
November 2014



## **REIMBURSEMENT IS THE LOWER OF:**

- Average Wholesale Price (AWP) -15% + \$2.50 for brands
- Average Wholesale Price (AWP)-30% + \$5.30 for generics
- Submitted Usual and Customary charge
- State Maximum Allowable Cost
- Federal Upper Limit (FUL)
- Co-payments from \$0.00-\$3.00

**APPROVED BY CMS AS PART OF THE STATE PLAN**

## **OMNIBUS BUDGET RECONCILIATION ACT OF 1990**

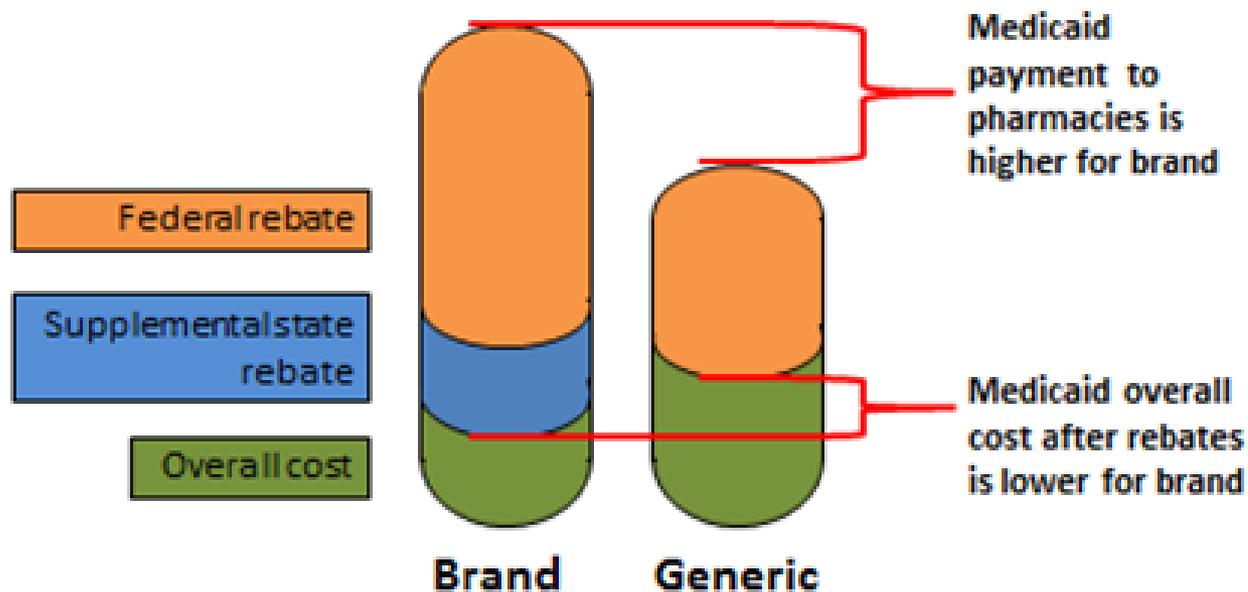
- Required coverage of all drugs produced by manufacturers that provide Federal rebates
- Prospective Drug Utilization Review
- Retrospective Drug Utilization Review
- Allowed prior authorization as a management tool

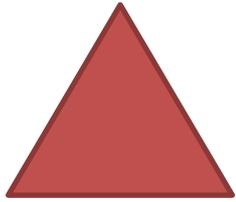
# Savings from OBRA '90

- Prospective DUR Savings-\$15,796,087
- Retrospective DUR Savings-\$6,364,864
- Federal Rebates-Based on CPI and setting of best price for Medicaid -Medicaid actually makes money on some drugs
- Rebates collected SFY 2014-\$184,703,201.51

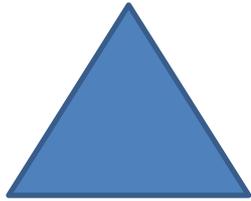
# The Complex World of Rebates

Occasionally the overall cost for a brand may be less than for the generic

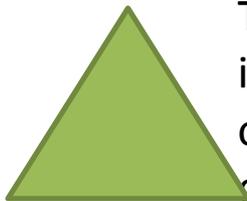




Innovator **Drugs** – the greater of 23.1 % of the Average Manufacturer Price (AMP) per unit or the difference between the AMP and the best price per unit and adjusted by the Consumer Price Index-Urban (CPI-U) based on launch date and current quarter AMP.



For "S" or "I" drugs, the URA is determined through four steps or calculations. The first calculation provides the basic URA, the second provides the additional URA, the third adds the basic URA and the additional URA together to determine the total URA, and the fourth compares the total URA and the quarterly AMP to determine whether the total URA exceeds the quarterly AMP.



This [consumer price index urban \(CPI-U\) value](#) is used as an integral part of the computation of the unit rebate amounts for innovator drugs. It is available from the [Bureau of Labor Statistics](#) and it shows every value from 1913 to the present.

# Preferred Drug List

- State Legislation required and passed in 2002
- 84 Therapeutic Categories-encompass 95% of program utilization
- Additional rebates from manufacturers for preferred positioning on Preferred Drug List
- Contracts are for Guaranteed Net Unit Pricing (GNUP) or % discount of Wholesale Acquisition Cost (WAC)

# PDL and Supplemental Rebates

- PDL legislation allows for negotiation of supplemental rebates, often with PA criteria for preferred drugs
- Allows flexibility for preferring certain dosage forms and brands, when cost-effective
  - Example: Saved \$640,000 in Q2 2014 preferring gabapentin capsules instead of tablets
  - 2015 switch to Crestor in response to rising cost of simvastatin

WV Medicaid is a member of the Sovereign States Drug Consortium (SSDC), a purchasing pool owned by the member states, and negotiation for combined lives coverage increases supplemental rebates

# Preferred Diabetes Supplies List

- Implemented in January 2014
- West Virginia Medicaid, with the help of the SSDC, negotiated for rebates on diabetes testing strips
- Two preferred products
- Rebates invoiced=\$1.2 million

# State Maximum Allowable Cost Program (SMAC)

- Algorithm for calculation defined in the State Plan
- Drugs included must have three manufacturers
- Encourages pharmacies to purchase wisely
- Cost avoidance for FFY 2014-\$81,741,016

## **OBRA '90 REQUIRES DRUG UTILIZATION REVIEW BOARDS TO MANAGE DRUGS THAT HAVE THE POTENTIAL FOR MISUSE, HAVE THE POTENTIAL TO BE DANGEROUS OR ARE EXPENSIVE**

- Prior authorization criteria for
  - Oncology Agents
  - Hepatitis C Drugs
  - Biologics
  - HIV Combination Drugs

- April 2014-97.4% of claims had Federal rebates
- Federal rebates averaged 43.7% of the cost of the claim
- Supplemental rebates were 4.4% of the cost of the claim
- Total rebate=48.1% of the cost of the claim

- Increase in spending is roughly 20% per year-four times the percentage rise in health care costs in the United States
- Trending-Specialty drugs will account for half the U.S. healthcare drug spend in a few years
- HCV treatments could add \$200-\$300 per year to each insured patient's drug costs in the US

- Pharmacy expenditures have remained flat over the past few years, even though both the costs of brand name and generic drugs have risen
- But, with the advent of very expensive specialty drugs, new ideas will be necessary for pharmacy programs to remain viable

- Increase in spending is roughly 20% per year-four times the percentage rise in health care costs in the United States
- Trending-Specialty drugs will account for half the U.S. healthcare drug spend in a few years
- HCV treatments could add \$200-\$300 per year to each insured patient's drug costs in the US
- What will it take to change the trend?

- TODAY'S TOP NEWS
- [U.K. UNVEILS TOP CANCER BRANDS FACING YEA-OR-NAY FOR CDF FUNDING](#)
- More than two dozen top-selling cancer drugs are on a hit list in the U.K. The country's Cancer Drugs Fund, designed to cover oncology meds not approved by cost-effectiveness watchdogs, plans to take a sharp look at these drugs at a meeting next month. And some of them may find themselves shut out for funding--unless new discount plans are in the offing.

# Open Box Solution (Transparency)

- A decision-making framework that accounts for the key criteria on which plans construct their formularies.
- Gather the data and source materials required for a decision.
- Systematically assess the drugs themselves, relative to their competitors, according to the evidence on clinical efficacy and economic impact.
- Do all of these things transparently, so that any interested party could check the logic and the details of each assessment.

# Drug Effectiveness Review Project (DERP)

Nationally recognized for its clinical objectivity and high-quality research, DERP focuses on specialty and other high-impact drugs— particularly those that have potential to change clinical practice. DERP reports evaluate efficacy, effectiveness, and safety of drugs to ultimately help improve patient safety and quality of care while helping government programs contain exploding costs for new therapies.

## **BREAKTHROUGH NATIONAL MEDICAID LETTER TO CONGRESS**

- **FEDERAL PURCHASING OF THE AVAILABLE SUPPLY AND/OR THE SUPPLY CHAIN, WITH SUBSEQUENT DISCOUNTED DISTRIBUTION OF PRODUCT TO THE STATES OR A REQUIREMENT THAT STATES PAY ONLY THE ADMINISTRATIVE FEE (MODELED ON FEDERAL PURCHASING OF VACCINES FOR CHILDREN AND OTHER PUBLIC HEALTH EMERGENCY SITUATIONS);**
- **ENHANCED FEDERAL MATCH RATES FOR THIS, OR OTHER SUCH “CURATIVE” SPECIALTY DRUGS;**
- **MANDATE ADDITIONAL REBATES FROM A MANUFACTURER, FOR EXAMPLE ONE THAT IS TRIGGERED IF A DISEASE STATE OR CONDITION AFFECTS A CERTAIN PERCENTAGE OF THE MEDICAID POPULATION;**
- **MODIFY THE “BEST PRICE” POLICIES FOR BREAKTHROUGH DRUGS TO INCLUDE THE SELLING PRICE IN OTHER COUNTRIES;**
- **RISK CORRIDORS OR OTHER REINSURANCE APPROACHES, BASED ON SUBSIDIZING ANY STATE SPENDING IN EXCESS OF CLEARLY ARTICULATED FEDERAL PROJECTIONS OF COVERAGE AND COSTS;**
- **A SEPARATE FEDERAL PROGRAM CREATED FOR THE SOLE PURPOSE OF FINANCING THE PROVISION OF THIS DRUG TO THE AFFECTED POPULATION, SIMILAR TO THE RYAN WHITE AND STATE ADAP PROGRAMS FOR HIV/AIDS DRUGS, WITH MEDICAID SERVING AS A PAYER OF LAST RESORT; AND**
- **ALLOW MEDICAID PROGRAMS TO UTILIZE COST-EFFECTIVENESS RESEARCH TO IDENTIFY WHETHER OR NOT A PARTICULAR DRUG WILL BE INCLUDED IN THE PROGRAM’S FORMULARY BY GRANTING MEDICAID THE FLEXIBILITY TO EXCLUDE PRODUCTS THAT ARE FOUND TO NOT BE COST-EFFECTIVE; AND**
- **CREATE WAIVER FLEXIBILITY ALLOWING STATES TO CONTRACT WITH DRUG MANUFACTURERS OUTSIDE OF THE MEDICAID REBATE PROGRAM STRUCTURE TO ALLOW INNOVATIVE PAYMENT ARRANGEMENTS. FOR EXAMPLE, ALLOW STATES TO ENTER INTO OUTCOMES-BASED CONTRACTS WITH MANUFACTURERS, WHERE PAYMENT IS MADE PER SUCCESSFUL COURSE OF TREATMENT RATHER THAN PER PILL.**

- A National Formulary with an “above and below” payment line for each therapeutic category. Every company will have to ‘play nicely” or have no sales
- Support for leaders in the movement (DERP) to based decisions on evidence obtained objectively and independently
- Education of consumers and healthcare providers
- Engagement with legislators and expectations that healthcare providers have more influence than PhRMA
- Transparency in contributions from PhRMA to legislators and healthcare providers