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Medicaid Pharmacy Cost Savings:

Taking Policy Ideas to the Next Level

November 14, 2022

Sara Drake RPh, MPH, MBA, Principal, Minneapolis

Our discussion today on Medicaid Cost Savings

Sara Drake, RPh, MPH, MBA

A Principal and pharmacist in Mercer's Government Human Services Consulting practice, Sara assists state clients in evaluation, research, analysis and implementation of Medicaid pharmacy benefits in both the managed care and fee-for-service environments

1. **Pharmacy Program Redesign**
2. **Drug Product Selection and Manufacturer Contracting**
3. **Prescription Payment Rate**
4. **Utilization Improvement**

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Statement of Disclosure

Sara Drake has no relevant conflicts of interest to report

Learning Objectives

At the conclusion of this educational activity participants will be able to:

Describe the challenges that state Medicaid Pharmacy Directors face related to prescription drug cost and provider reimbursement

Identify at least three innovative cost containment policy options available to state Medicaid Programs

Recognize when incentives are or are not aligned with a cost containment objective

Learning Assessment Questions

True or False?

State Medicaid programs are unlikely to encounter stakeholder resistance to a change in policy such as 340B provider payment.

True or False?

If managed care capitation rates are increased due to brand over generic preference on a PDL, the MCO benefits if utilization of the generic is tightly managed.

Which of these does NOT represent a potential cost savings opportunity for state Medicaid Programs?

A. Expand MAC programs to encompass specialty drugs, biosimilars and/or DME
B. Establish 340B prices based on 340B provider survey
C. Use a AWP or WAC discount guarantee instead of a MAC program for generic drugs
D. Apply a subscription model contract for select drugs or drug classes

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Warm-up #1: What was the best concert you ever attended?

ⓘ Start presenting to display the poll results on this slide.

Who is this guy?

And what can we learn from him?

My best concert – Tom Petty – Berkeley, CA

During his great set, the power went out
Without hesitation, he says “That’s a bummer. I guess we’ll have to play acoustic now”

What can learn from Tom?

Sometimes the external environment creates obstacles that you don’t anticipate. But you can still be successful if you are able to adapt and also – the final product is often better if you are able to work with others in the field.

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Warm-up #2: What was the WORST concert you ever attended?

ⓘ Start presenting to display the poll results on this slide.

Who is this guy?

And what can we learn from him?

My worst concert – Timbaland

Entire set was to spin a record, get the crowd to cheer, ask if they like the song, “do you want to take it to the next level” – rinse and repeat

What can learn from Timbaland?

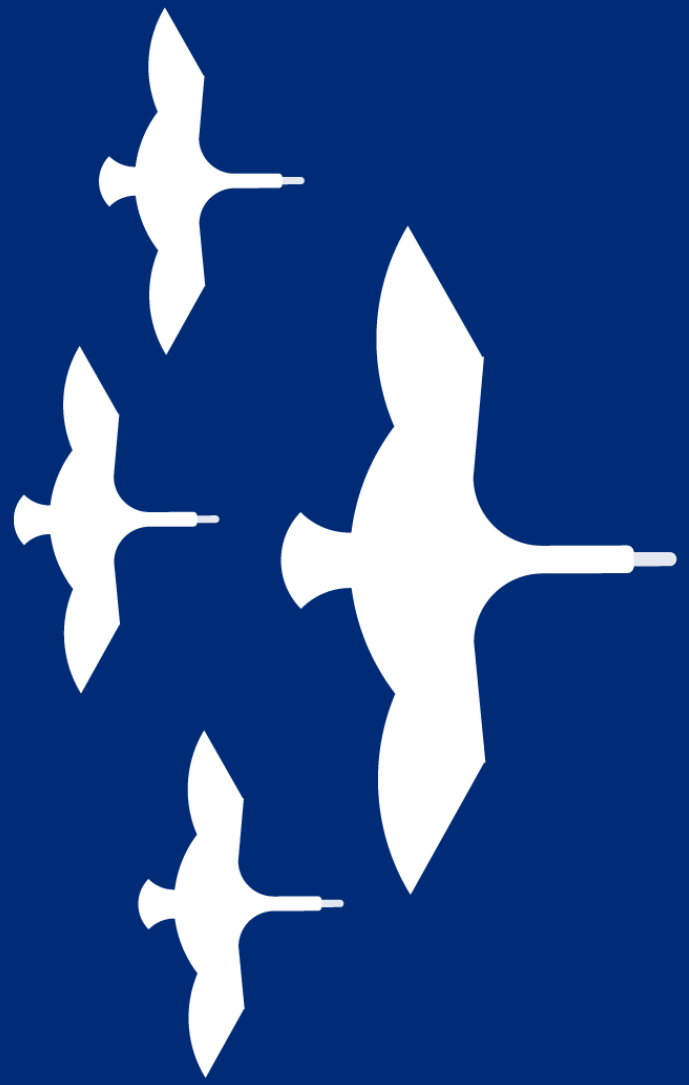
Even if things seem to be going well, even if stakeholders seem to generally like how things are going…there’s always an opportunity for continuous improvement – always an opportunity to take it to the next level.

Pharmacy Program Redesign Options

- Pharmacy Service Delivery Design
- PBM Contracting and Transparency
- High Cost Drug Risk Mitigation

1

Pharmacy Service Delivery Design



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How many states have fully carved pharmacy out of managed care to either FFS or a Single PBM?

a) 4
b) 50
c) 8
d) 20

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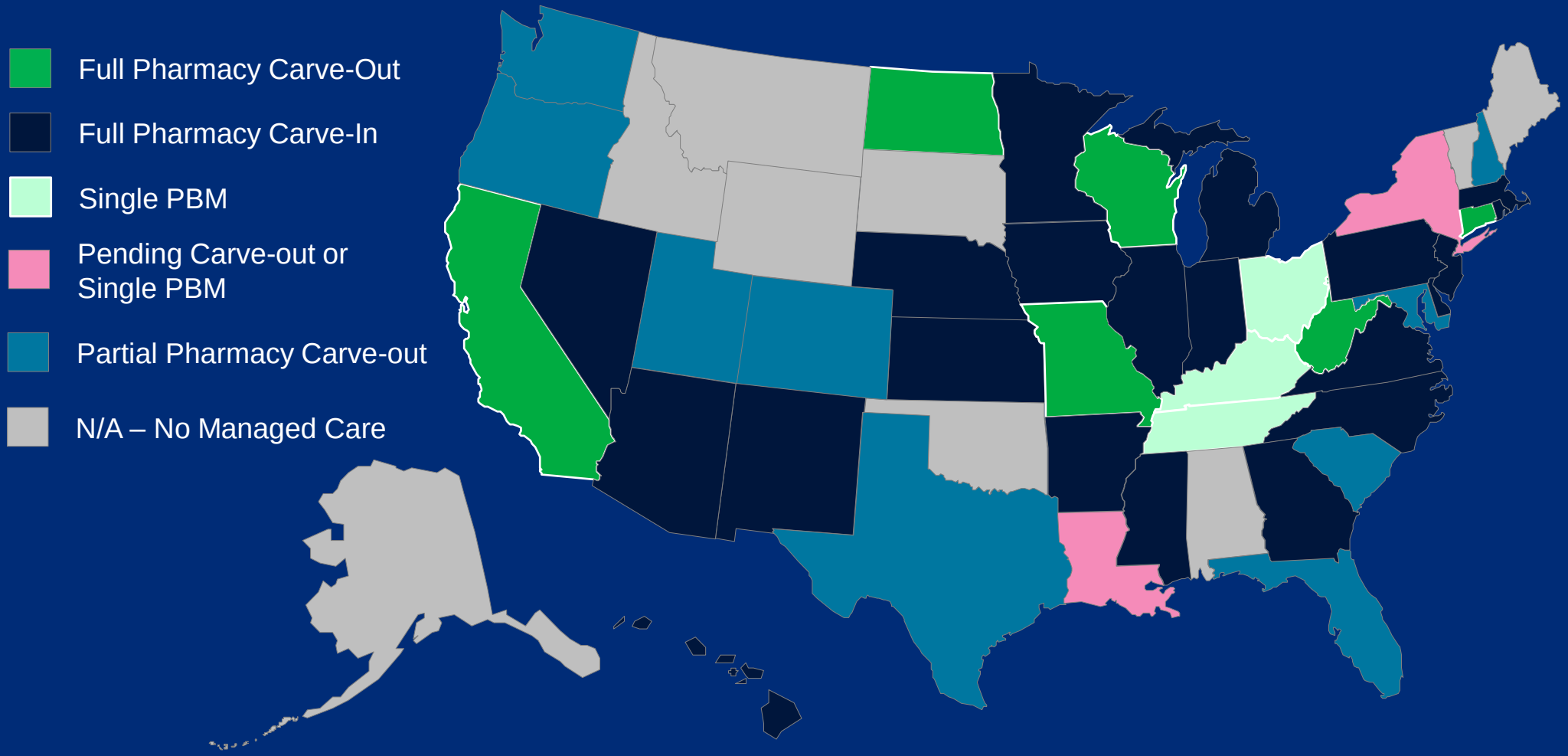
Pharmacy Program Design Trends



Beyond Carve-In or Carve-Out

Next Level Pharmacy Program Designs

State Mandated Pharmacy Reimbursement	• MCOs **required** to pay pharmacy providers using the FFS methodology
Mandated Single PBM	• State selects a **single** PBM and requires all MCOs to contract with that PBM • The MCOs remain at **risk** for the cost of drugs
Non-Risk Managed Care	• MCOs **administer** the drug benefit but are not at risk for the cost of outpatient drugs • States can **include** or **exclude** physician-administered drugs from the non-risk arrangement
Single PBM as a Prepaid Ambulatory Health Plan	• State hires a **single** PBM to manage the pharmacy benefit for all enrollees • Single PBM structured as a PAHP provides **flexibility** in network contracting and reimbursement

PBM Contracting and Transparency

PBM Revenue Sources

How PBMs Make Money

Retail Spread

AWP discounts and dispensing fees; PBM pays one rate and bills the payer a different rate

Mail/Specialty Margin

PBM pre-tax operating margins for mail and specialty channels

Rebates

Rebates received from drug manufacturers; some percentage may be retained by PBM

Rebate Admin Fees

2%–4% admin fee charged to drug manufacturer

Data/Other

Claims and other utilization data is for sale–PBM requests unrestricted grants from pharma

Misc. Fees

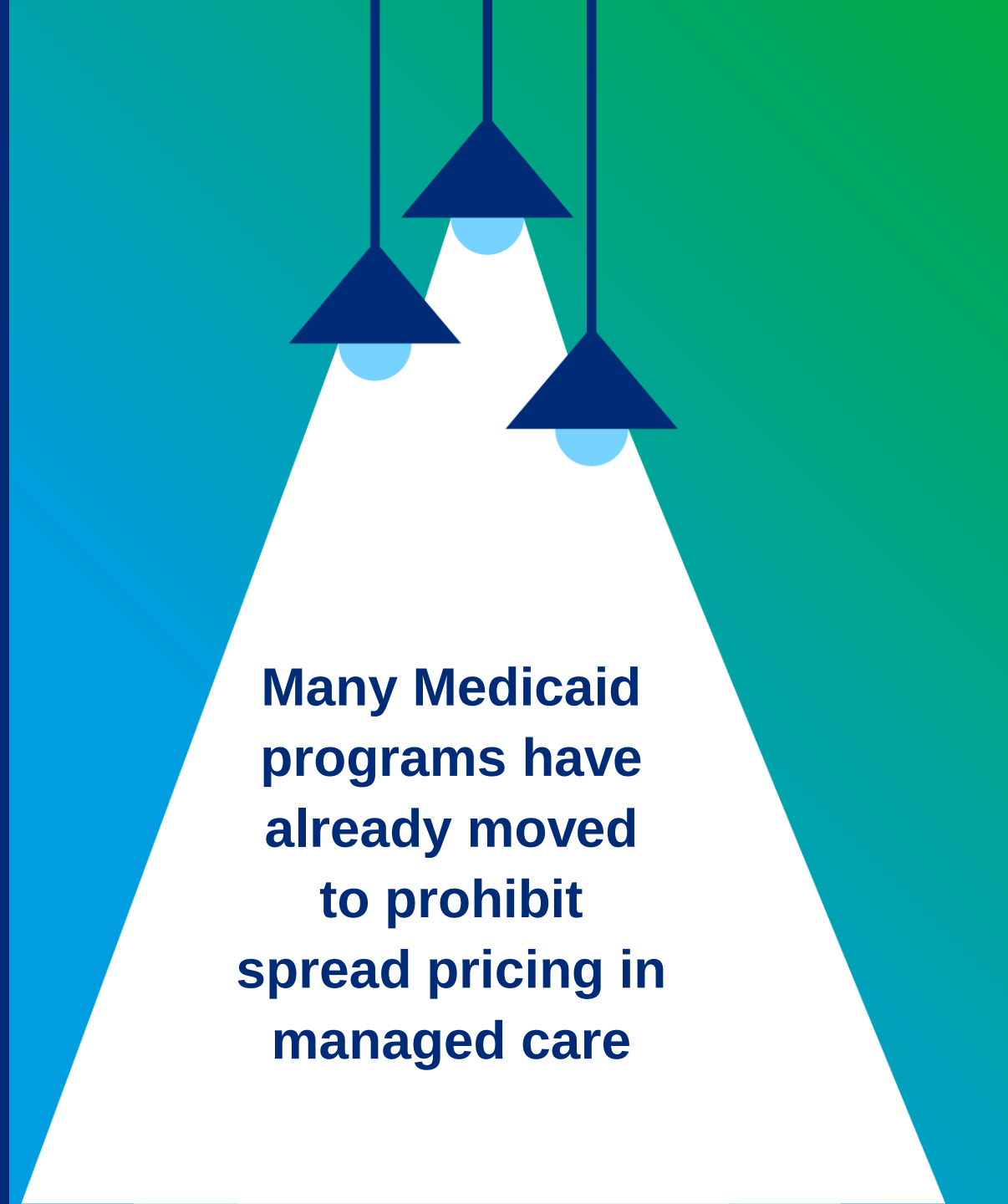
Postage, admin fees, clinical programs, mailings, etc.

Spread pricing is just the beginning

Next Level PBM Transparency

Moving Beyond Spread Pricing

Rebates	Address rebate retention in MCO and PBM contracts Are PBMs allowed to retain a portion of manufacturer rebates? Manufacturer admin fees?
GER/BER	Address pharmacy provider Generic Effective Rate (GER) or Brand Effective Rate (BER) reconciliations Are provider reconciliations allowed? If so, how much is passed back to the MCO?
Discount Guarantees	Encourage movement away from discount guarantees and toward a fixed benchmark
Contract Access	Ensure Medicaid program has access to unredacted PBM contracts



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High Cost Drug Risk Mitigation

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How do high cost gene therapies challenge Medicaid managed care programs?

a) Difficult to predict utilization or uptake rate
b) Possible to overpay MCOs for utilization that doesn't materialize
c) Likely uneven distribution across MCOs
d) Uncertainty of market availability timing
e) All of the above

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Next Level Managed Care Risk Mitigation

Non-Risk Arrangement

- MCO processes claims
- Select drugs excluded from capitation
- State reimburses MCO no more than FFS rate

Partial Carve-Out

- Select drugs carved out of managed care
- FFS program processes claims and performs utilization review

Risk Corridor

- Target expense ratio for select drugs
- Risk is shared if expenses fall above or below corridor

Risk Pool

- Capitation is reduced by a mandatory “premium” that funds the pool
- Pool funds distributed to plans based on utilization

Kick Payment

- Cost of select treatments excluded from capitation
- MCO receives set payment each time a trigger event occurs

Reinsurance

- Can be private or state administered
- MCOs pay a premium in return for coverage of services

CMS requires any risk mitigation be defined in advance of contract period

High Level Overview of Risk Mitigation Considerations

General Managed Care Philosophy

- Is there a risk of uneven distribution across MCOs?
- How predictable is the utilization of the drug?
- What is the prevalence of the condition being treated?
- Is there a concern about overutilization?
- How important is care management to this drug or condition?
- Will the state pay a premium for the plan to manage the risk?
- How administratively complex is the risk mitigation?

Questions and considerations driving the selection of a risk mitigation tool

Drug Product Selection and Manufacturer Contracting

- Preferred Drug Lists
- Subscription Payment Models
- Value Based Purchasing (VBP)

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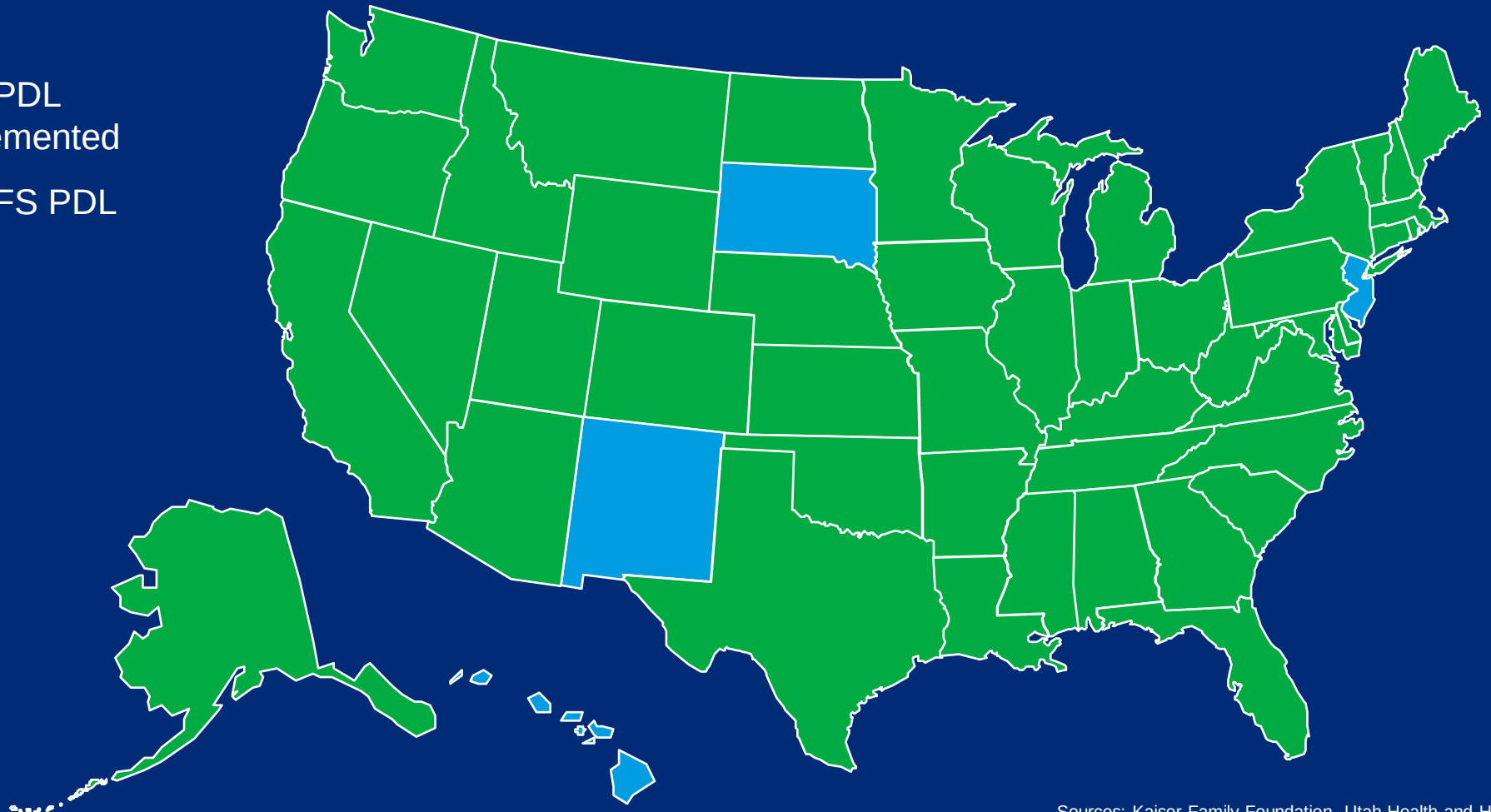
Preferred Drug Lists

FFS Preferred Drug List (PDL)

Majority of States Have Implemented PDLs

FFS PDL Implemented

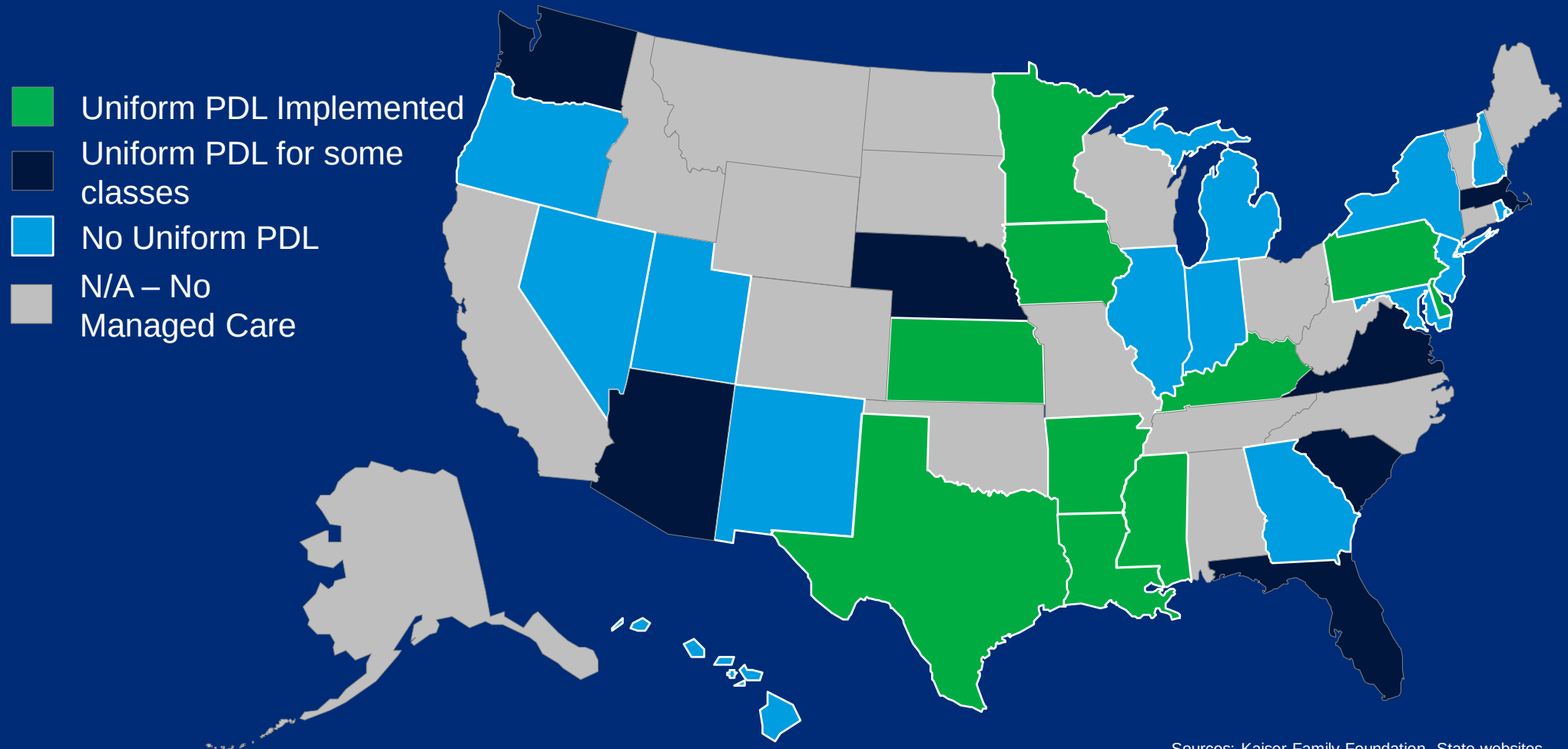
No FFS PDL



Sources: Kaiser Family Foundation, Utah Health and Human Services website

Uniform PDL Applied to Managed Care

Majority of States Have Implemented PDLs



Sources: Kaiser Family Foundation, State websites

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Identify a challenge of implementing a PDL in managed care:

a) 340B
b) Pharmacy Provider Concerns
c) Managed Care Adherence to PDL
d) All of the above

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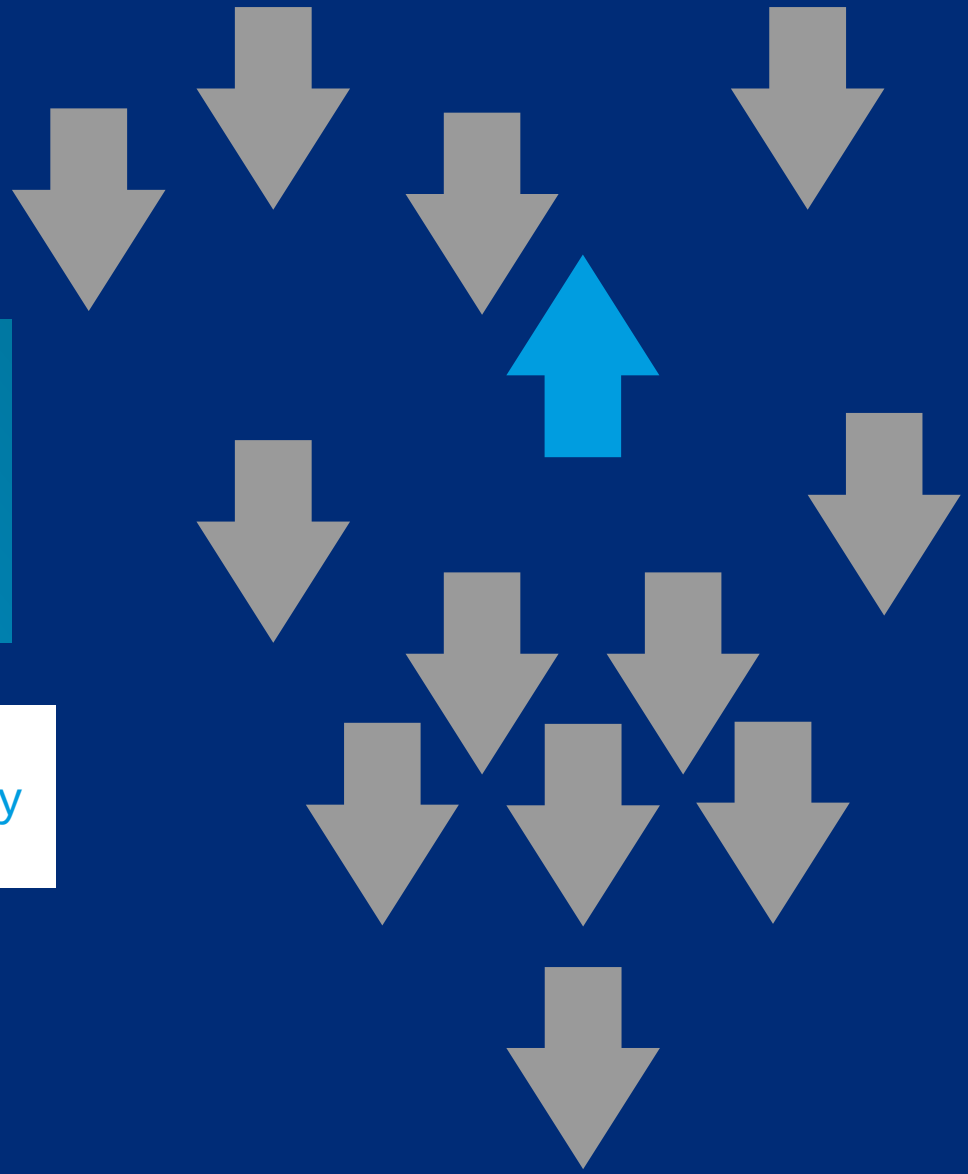
Uniform PDL Adherence Challenges

Misaligned Incentives

Uniform PDLs often prefer brands over generics

- MCO rates are set higher to accommodate higher gross cost
- If MCO allows generic rather than brand, MCO costs are lower

The MCO benefits financially by not complying with PDL policy



Next Level PDL Savings Opportunities

Mechanisms to Maximize Uniform PDL Savings

Establish PDL adherence expectations in MCO contracts

- Consider establishing targets at therapeutic class level rather than globally
- Normalize all prescriptions to a standard days supply for accurate comparison

Monitor PDL adherence on a monthly or quarterly basis

- Identify non-compliance early in the contract period and course correct
- Compare and benchmark similar populations

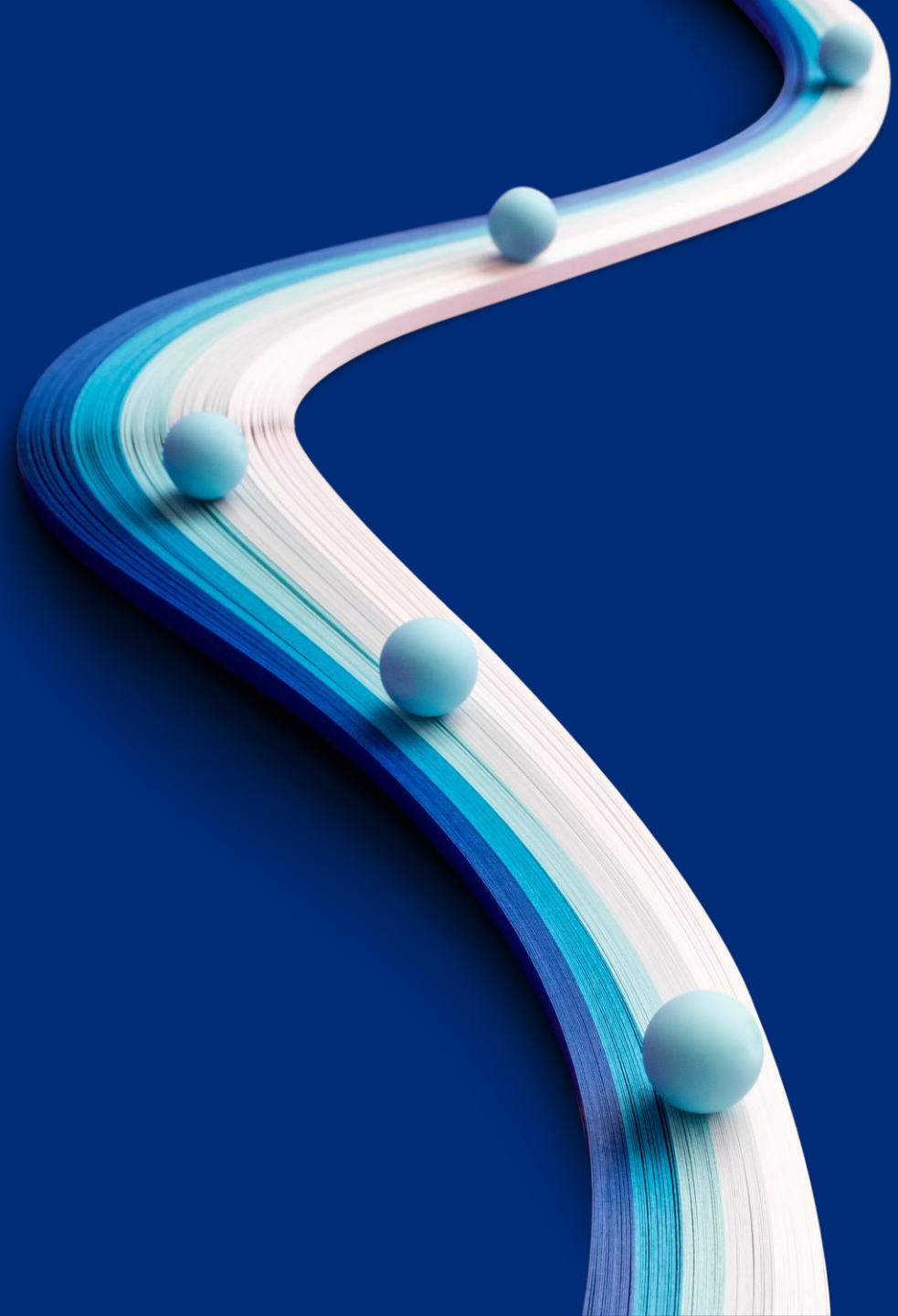
Apply a penalty if MCOs do not adhere to PDL

- Consider tying penalty amount to lost rebate opportunity for state

Share PDL savings and decision making with MCOs

- Offer a performance reward to MCOs that exceed PDL adherence expectations
- Include MCOs in clinical review of PDL categories

Subscription Payment Models



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States have successfully negotiated subscription model payments for drugs treating which disease state?

a) Spinal Muscular Atrophy
b) Cystic Fibrosis
c) Hepatitis C
d) Hypertension

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c) **Hepatitis C**
d) Hypertension

Next Level Subscription Payment Models

Where could subscription models go next?

Additional disease states:

HIV/PrEP
Diabetes
Rare diseases (SMA, Hemophilia)

Combine drugs and contract with pharmacy providers rather than manufacturers

Use outcome-based metrics to drive subscription price

Value-Based Purchasing

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What recent regulatory change has the potential to increase VBP opportunities?

a) Inflation Reduction Act
b) CMS Multiple Best Prices Rule
c) CMS Medicaid Quality Reporting Rule
d) CMS Interoperability and Patient Access Final Rule

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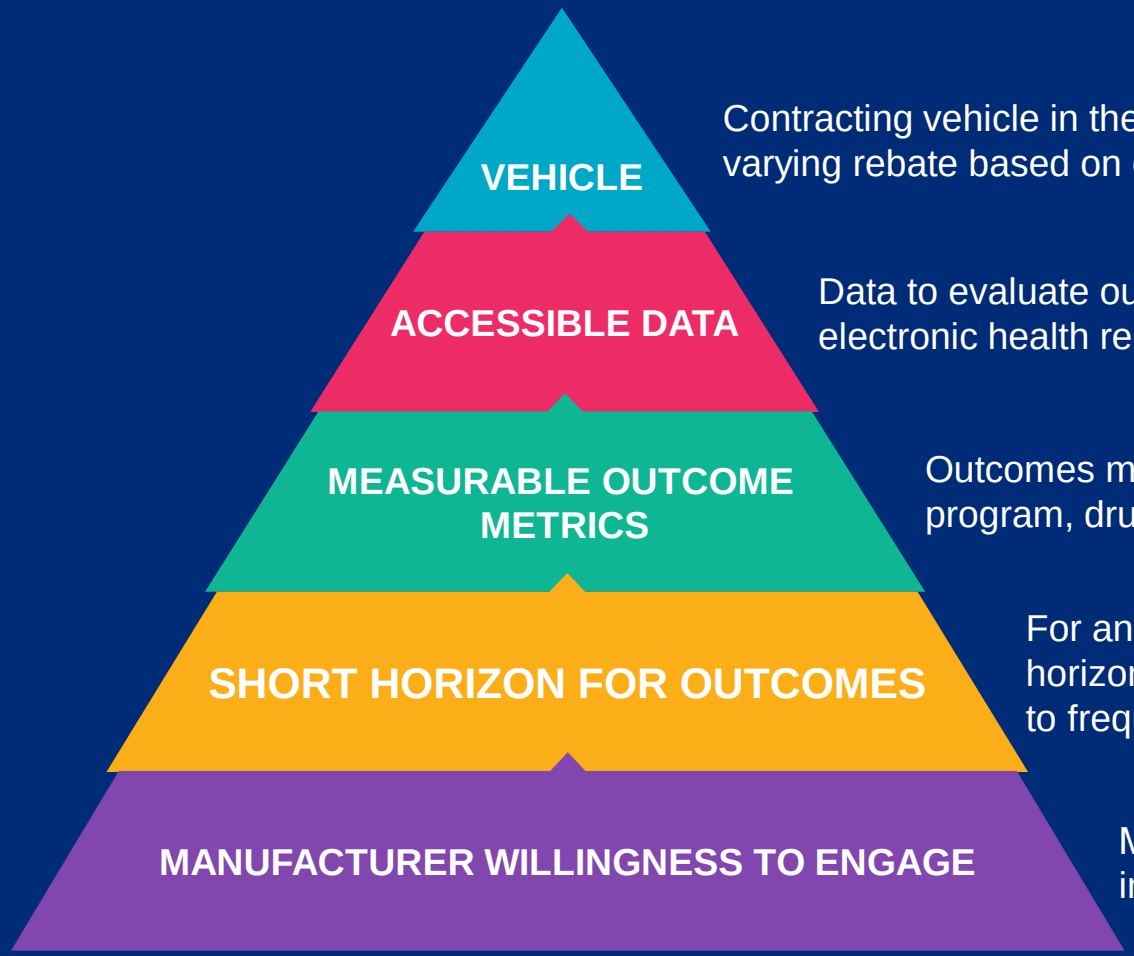
Building Blocks for Next Level VBP



Contracting vehicle in the form of a supplemental rebate contract which allows for varying rebate based on outcomes data and monitoring

Data to evaluate outcomes must be available either via claims data or electronic health records

Outcomes measures must be well defined and agreeable to the Medicaid program, drug manufacturers and stakeholders

For an outcomes-based contract to work in a Medicaid environment, the time horizon for outcome measurement and evaluation must be relatively short due to frequent eligibility churn

Manufacturer must be willing to negotiate with the State or State's vendor in good faith – OR offer is available through CMS Best Price

Prescription Payment Rate

- Pharmacy Reimbursement
- Medical Provider Reimbursement
- 340B Policy Options

Pharmacy Reimbursement

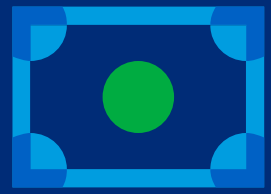
Pharmacy Reimbursement Savings Opportunities

Ingredient Cost Savings Programs

Maximum Allowable Cost (MAC) Programs

- Drugs available as generic

State-specific AAC programs



Dispensing Fee

Updated Cost of Dispensing Study

- Differentiate dispensing fees based on:
  - Prescription volume
  - Location
  - Provider characteristics

Establish Dispensing Fee Limits

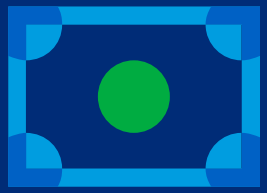
- One fee per month per drug, with exceptions
- Minimum day supply per dispensing fee

Next Level Pharmacy Reimbursement Opportunities

Ingredient Cost

Innovative Cost Management

- Maximum Allowable Cost (MAC) programs
  - Specialty MAC
  - Biosimilar MAC
  - Non-drug DME items
- State-specific AAC programs
  - AAC by provider characteristics
    - Chain vs Independent
    - Open vs Closed Door Pharmacy



Dispensing Fee

Tie dispensing fee to quality

- Define process or outcome quality metrics
- Offer higher dispensing fees to higher quality providers

90-day supply requirements for maintenance drugs

Pay pharmacies a monthly “subscription” dispensing fee

Medical Provider Reimbursement

Medical Provider Reimbursement

Physician Administered Drugs: Common Policy Decision and Challenges

Challenge: ASP + 6% rewards providers for using higher cost products

Challenge: New IRA provisions increase margin for biosimilars

Challenge: Administration fees can vary by provider type—outpatient hospital typically the most costly

Most Medicaid programs use Medicare ASP based methodology

Next Level Medical Provider Reimbursement Options

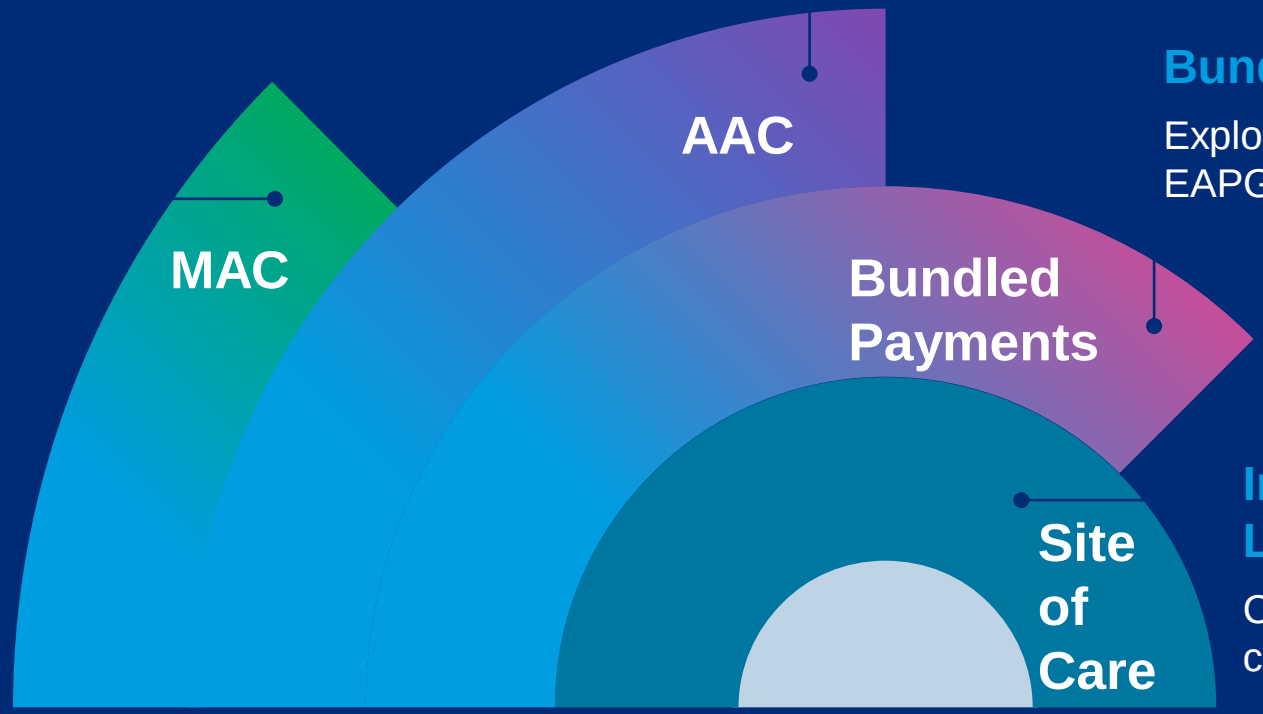
Acquisition Cost Survey

Set AAC rates for HCPCS codes

Establish MAC Rates

Align reimbursement with pharmacy channel

Establish MAC rates on drug groups including biosimilars



Bundle Drugs with Services

Explore bundled payments such as EAPG

Improve Reimbursement at Lower Cost Sites of Care

Consider home infusion or clinic vs outpatient hospital

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What other provider reimbursement changes have been successful in your state?

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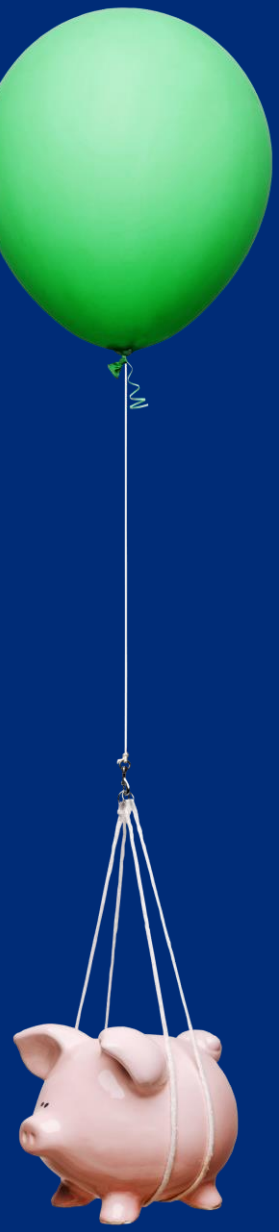
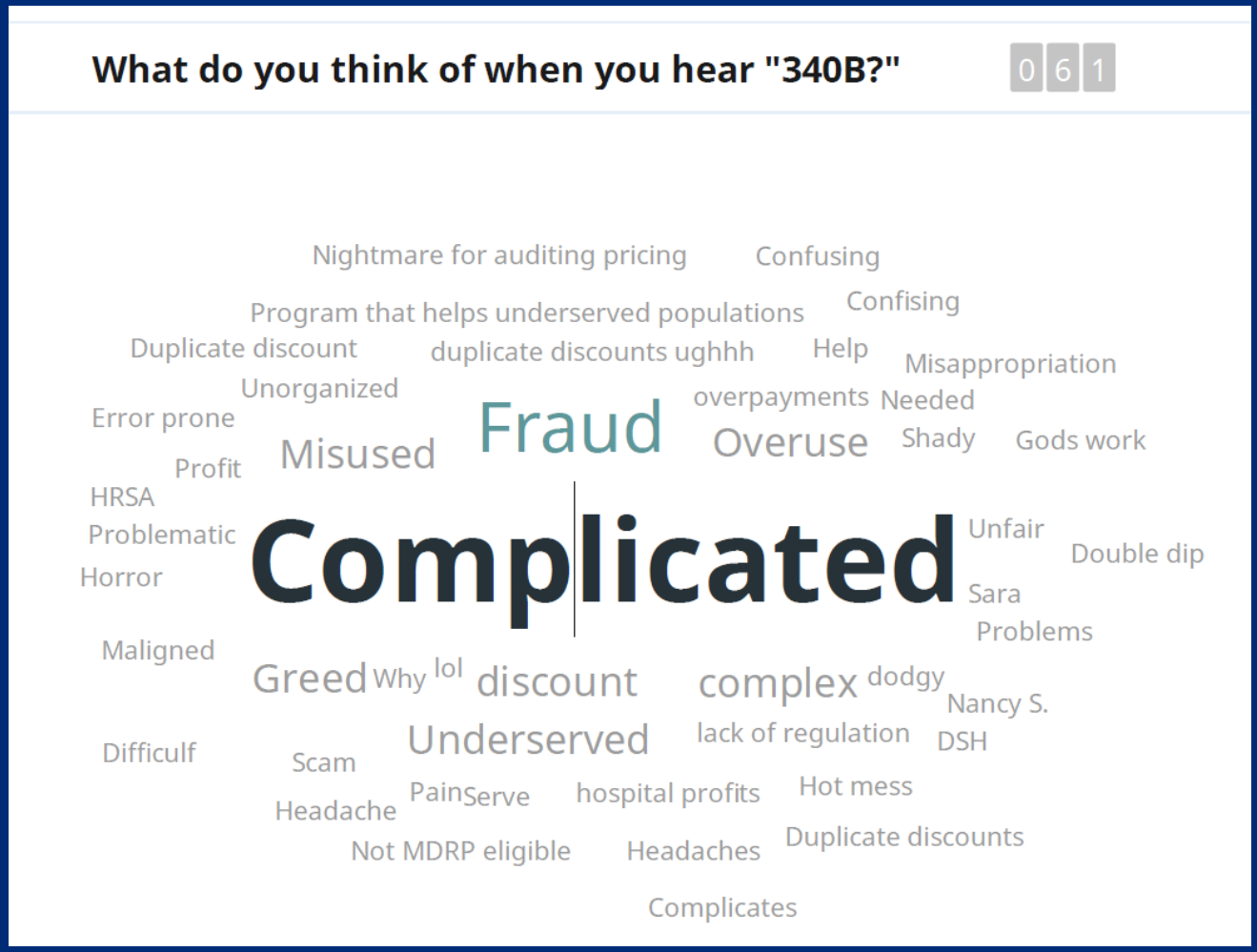
340B Policy Options



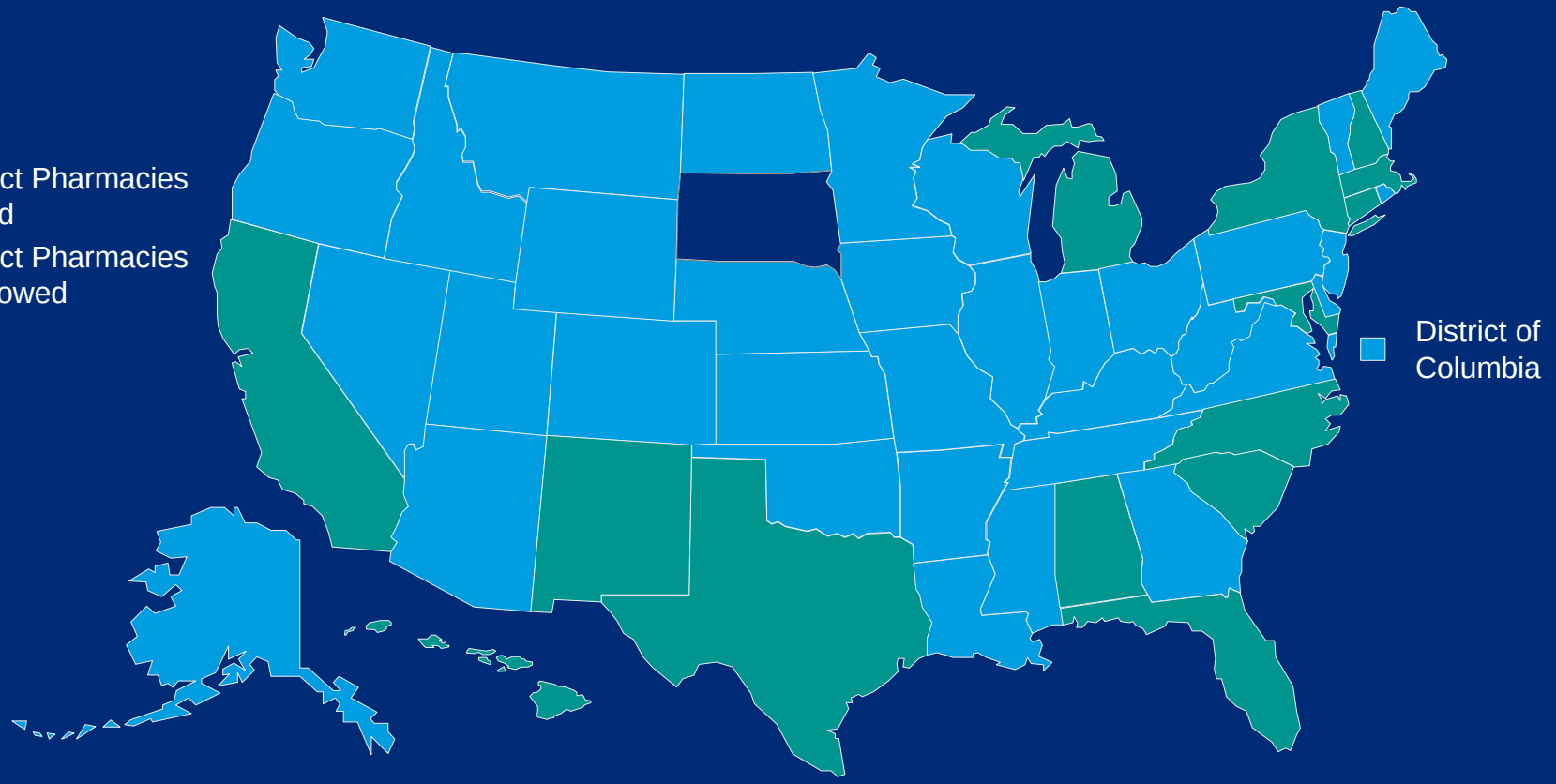
EMPAA Attendees are Passionate about 340B

Responses to a Question Asked at the 2021 EMPAA Conference



Frequently Implemented 340B Policies

FFS Contract Pharmacies Policy



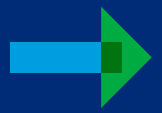
Source: US Government Accountability Office. 340B Drug Discount Program: Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement. January 2020.

- **California** — only hemophilia treatment centers have state-approved contract pharmacy arrangements
- **New Hampshire** — only allowed for family planning medications prescribed at family planning clinics
- **Utah** — would allow contract pharmacies, but currently does not have any state-approved contract pharmacy arrangements

Next Level 340B Savings Opportunities

340B AAC Survey

- Survey 340B providers to identify actual costs
- Audit price submitted on 340B claims



Apply 340B AAC requirement to managed care

- Adjust capitation rates

Identify 340B opportunities in other state programs

- Basic Health Plan
- CHIP Programs
- Corrections

Encourage 340B for some drugs or categories

- Maximize savings on UROA

Any 340B policy change will elicit strong stakeholder response

Utilization Improvement

- Utilization Management
- Pharmacy Clinical Programs

4

Utilization Management

Utilization Management Best Practices

Integrate medical data with prior authorization process

- Use medical data to validate diagnoses of members requesting prescriptions
- Identify missed opportunities for care or case management

Prior authorization at market entry

- Apply prior authorization edit to new drugs as they enter claim system
- Prior authorization edit removed only after clinical review by state staff and/or advisory committee

Partial first fill programs

- Identify drug classes with potential for side effects and early discontinuation
- Limit first fill to 14 days to ensure tolerance and reduce waste

Next Level Utilization Management

Trust but verify

Align prior authorization criteria across medical and pharmacy benefits

- Align prior authorization criteria for physician administered drugs across medical and pharmacy benefits

Review managed care prior authorization criteria

- Require approval of prior authorization criteria by state staff
- Alternatively, require MCOs to follow FFS prior authorization criteria for select categories

Prior authorization vendor audit

- Review data to identify claims for members who do not have evidence of appropriate diagnosis
- Request prior authorization documentation from authorization vendor or from MCOs
- Identify opportunities for process improvement or provider education

Pharmacy Clinical Programs

Next Level Pharmacist Clinical Services

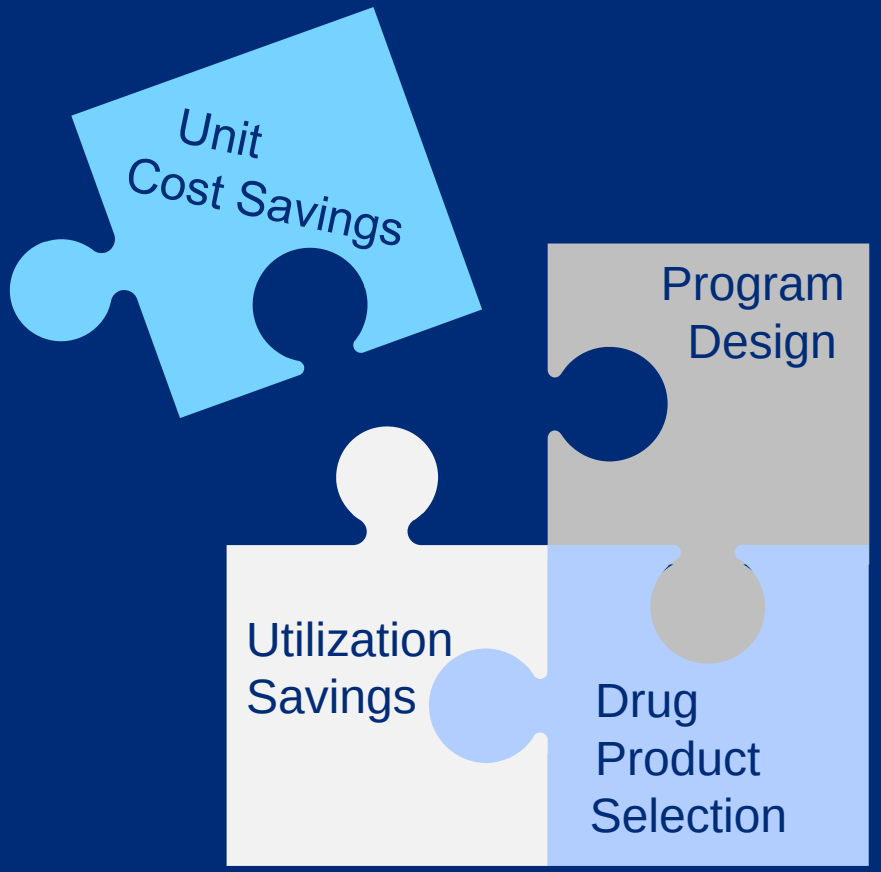
Is it possible to pay pharmacies or pharmacists a monthly subscription fee for medication or disease management?

Tie quality measures to provider eligibility and payment rate

Are You Ready to Take It to the Next Level?

Who is this guy and what can we learn from him?

Pitbull – known for “turning a negative into a positive” and always perservering



Patience, passion and perseverance equals success

– Pitbull

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True or False?

State Medicaid programs are unlikely to encounter stakeholder resistance to a change in policy such as 340B provider payment.

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True or False?

State Medicaid programs are unlikely to encounter stakeholder resistance to a change in policy such as 340B provider payment.

A: False

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A: False

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Questions

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