Medicaid Alternative Payment Models for Prescription Drugs: Do They Add Value for States?

Wednesday, December 12, 2018
2:00pm-3:00pm Eastern

For Audio, please listen through your computer speakers or call:
(800) 289-0459, conference ID#: **209696**

Webinar Agenda

2:00 pm	**Welcome and Introductions** **Jennifer Reck**, MA, Project Director, NASHP	
	Burl Beasley, MPH, MS Pharm Director, Pharmacy Services, Oklahoma Health Care Authority	
	Terry Cothran, D.Ph Director, Pharmacy Management Consultants, University of Oklahoma College of Pharmacy	
	Russell Knoth, MA, Ph.D Director, Health Economics and Outcomes, Eisai	
	Questions and Discussion	

Alternative Payment Model Oklahoma Medicaid

Burl Beasley, BS Pharm, MPH, MS Pharm
Director, Pharmacy Services

SOONERCARE (OKLAHOMA MEDICAID)

Oklahoma Health Care Authority
SFY 2017

FAST FACTS

MEMBERS

62% CHILDREN, AGES 0-20

38% ADULTS

1,014,983
Unduplicated Members Enrolled in SoonerCare and Insure Oklahoma

or 26% of Oklahoma's Population

Urban 54%
Rural 46%

Children

578,667 children from the state of Oklahoma are enrolled in SoonerCare and Insure Oklahoma. This is 60.2 percent of all children aged 17 and younger.

578,667 CHILDREN

58.9 percent of children aged 0-17 enrolled in SoonerCare are under the poverty level.

Aged, Blind, and Disabled

ABD enrollees made up 16.8 percent of SoonerCare members and accounted for 46 percent of all expenditures.

All SoonerCare Members
ABD
16.8%

AGENCY

Administrative Costs

SoonerCare administrative costs comprised 4.05 percent of the total expenditures. The Oklahoma Health Care Authority (OHCA) operating costs represented 45.7 percent of OHCA administrative costs, and the other 54.3 percent were contract costs.

4.05%

OHCA: OPERATING COSTS, CONTRACT COSTS
SoonerCare: ADMIN BUDGET, ALL OTHER EXPENSES

Category

Most-used category

ADULTS: NURSING FACILITY
$550,753,495

CHILDREN: PHYSICIAN
$302,541,777

4.6 MILLION BED DAYS

SoonerCare funded 67.8 percent of the total long-term care-occupied bed days.

$305M
$111M

Drug Rebate Cost Savings

Federal and state prescription drug rebate collections led to a total of $305,676,273 in cost savings for OHCA in SFY 2017.

Generic Drugs

By limiting the amount paid for generic drugs, OHCA saved more than $111.6 million through the State Maximum Allowable Cost Program.

*State fiscal year (SFY)=July 1, 2016 - June 30, 2017

Pregnancy

SoonerCare covers approximately 58.0 percent of births in Oklahoma. In SFY 2017, SoonerCare deliveries accounted for 30,490 of the 52,607 births in Oklahoma.

58%

All Deliveries in Oklahoma
SoonerCare Deliveries

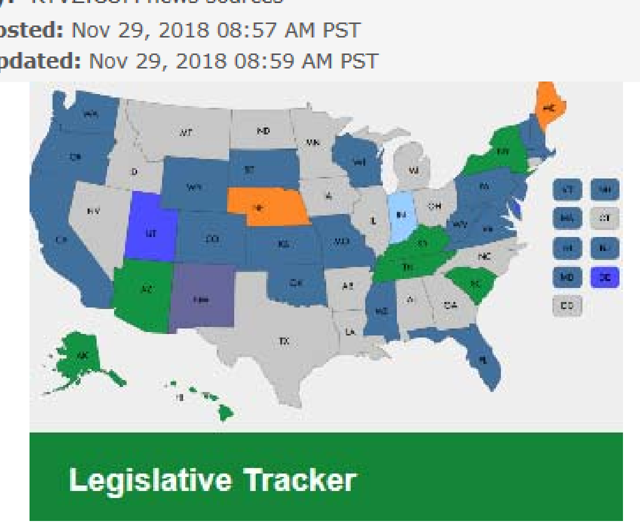
Drug Approval Trends

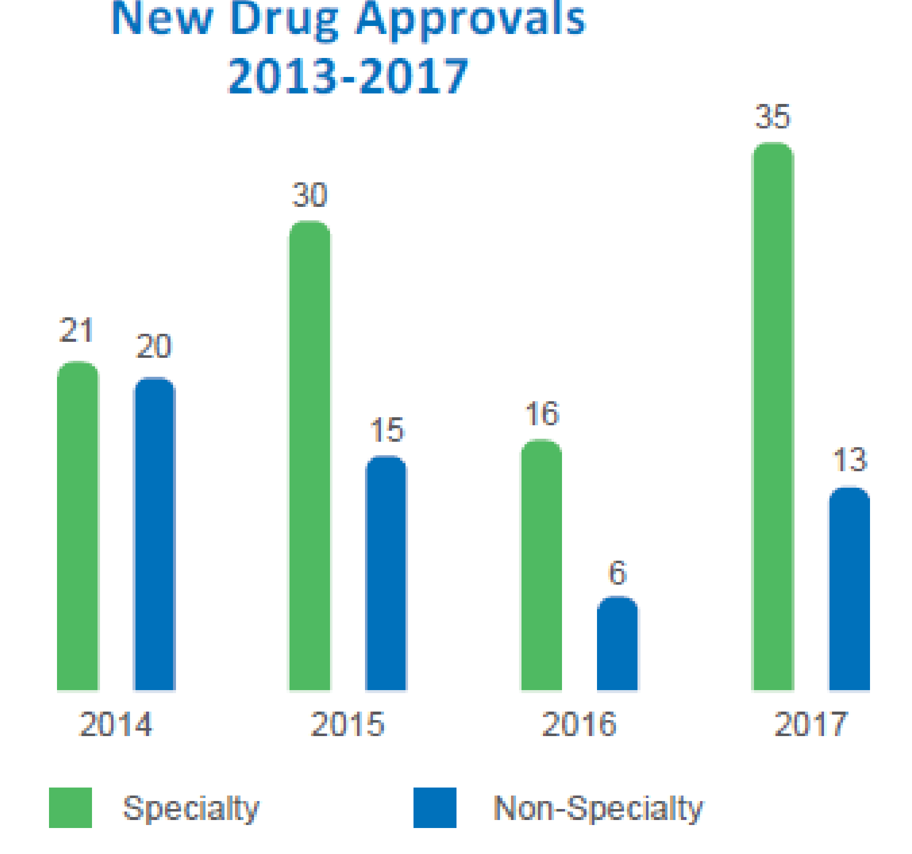
Loxo And Bayer's Amazing Drug Has An Expensive Price

Merkley intros bill to cut prescription drug prices

Would order HHS to keep prices below other nations

By: KTVZ.COM news sources
Posted: Nov 29, 2018 08:57 AM PST
Updated: Nov 29, 2018 08:59 AM PST





Background

- Rapid rise in prescription drug costs
- U.S. market prices set on what market can bear
- Specialty drugs are part of the spend
  - Special handling, monitoring, administration
  - Complex, chronic, costly, conditions

Payment Strategies

- Enhanced rebates & supplements
- Multi-state purchase agreements
- In-state purchasing pools
- Support from non-profit entities
  - SMART-D
  - NASHP

Alternate Payment Model

- Financial APM
  - Price volume agreements, market share, patient utilization
  - Easiest to administer
- Health Outcome Based APM
  - Guaranteed outcomes, PMPY guarantees, event based
  - More difficult to assess (none done…yet)

Partnerships

- The Oklahoma Health Care Authority (OHCA)
- Pharmacy Management Consultants (PMC)
- The National Academy for State Health Policy (NASHP)
- State Medicaid Alternative Reimbursement and Purchasing for High Cost Drugs (SMART-D)
- Drug Manufacturers
- Centers for Medicare & Medicaid Services (CMS)

Oklahoma Health Care Authority. Annual Review of the Pharmacy Benefit. April 2018.
National Academy for State Health Policy. NASHP Awards Grants to Colorado, Delaware, and Oklahoma to Tackle Rising Rx Drug Prices. 2017.
Stuard S, Beyer J, Bonetto M, et al. SMART-D Summary Report. Center for Evidence-Based Policy. September 2016.

The Approach

- Negotiate a mutually beneficial alternative payment model (APM) contract
- Open communication with drug manufacturers
- Worked with CMS to get approval of a state plan amendment (SPA)
  - Allowed Oklahoma Medicaid to treat value-based payment arrangements as supplemental rebate agreements
  - **Excluded from “best price” implications**

Stuard S, Beyer J, Bonetto M, et al. SMART-D Summary Report. Center for Evidence-Based Policy. September 2016.
Centers for Medicare and Medicaid Services. Press Release: CMS Approves State Proposal to Advance Specific Value-Based Arrangements with Drug Makers. June 2018.

Timeline

2016
- Began working with SMART-D
- Initiated discussions with several manufacturers

2017
- Initiated discussions with more than 20 manufacturers
- Established a collaboration agreement with 2 manufacturers
- Received support from NASHP

2018
- Received approval of our state plan amendment from CMS
- Established value-based agreements with 3 companies
- 2 more companies are in final contractual discussions

Considerations

- Fee for Service State vs Managed Care Organizations (FFS vs MCO)
- Timeline to accomplish APM/VBC goals
- Set specific goals/targets for VBC arrangements
- Political – cultural environment
- Administrative fees and functions
- Limitations in claims environment
- Staffing –Resources
- Legal

APM – next steps

- Negotiate contracts between payer and manufacturer
- Preliminary Results
  - Evaluation and results analysis
  - Considering short-term contract renewal
- Value Based Milestones discussions

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Terry Cothran, R.Ph.
Director

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants

Disclosures

- I have no potential conflict of interest to declare
- I am Employed by the University of Oklahoma College of Pharmacy

Background

- Prescription (RX) drug spending is a key driver in the increase in healthcare costs:
  - RX drug spending rose 12% for all payers in 2014 including a 24% increase for Medicaid
  - RX drug spending increased 9% to $324.6 billion in 2015; growth in 2015 was slower than the 12% growth in 2014, however spending on RX drugs outpaced all other services in 2015
  - Increase in high-cost specialty drugs: during SFY17 Oklahoma Medicaid spent 37.72% of total pharmacy expenditures on 0.84% of claims for medications costing >$1,000 per claim

MACPAC. Trends in Medicaid Spending. June 2016.
CMS. National Health Expenditures 2015 Highlights. 2017.

Oklahoma Details

- Annual Medicaid enrollment approximately 1 million members
- 100% fee-for-service
  - No managed care organizations
  - Allows for discussions and negotiations between one payer and one manufacturer for a more efficient process
- Pharmacy benefit managed by Pharmacy Management Consultants (a division of the OU College of Pharmacy)
  - Manage majority of pharmacy benefits (pharmacy claims, medical claims, hospital, etc) that allows for data aggregation and analysis
  - Capability to research other outcomes not necessarily stated in the agreement; unintended outcomes, additional benefits, and other health related outcomes

OHCA. Annual Report 2016.

Initial Contact with Manufacturer

- Have had conversations with 26 manufacturers
  - #3 prefer a data research agreement → APM
  - #2 could not reach an agreement
  - #13 opted out or not responded lately
  - #4 still in discussions
  - #4 executed agreements
- Manufacturer Interactions
  - Receptive
  - Open and non-confrontational
  - Understanding of the Medicaid environment
  - Required management of data requests

Goals and Approach

- To have different types of agreements
- Pave the way for other state Medicaid groups
- Utilize PMC research team for analysis of all findings
- Anything is on the table for discussion

Initial Lessons Learned

- A certain level of trust between the payer and the manufacturer is required
- More efficient process when getting key stakeholders at the table early (contracting, regulatory, legal, finance, etc.)
- Works best if manufacturers decide what they are comfortable with before negotiations begin
  - Oklahoma found that letting manufacturers bring what products they were interested in contracting in was most effective
- State Medicaid programs most likely need to pull utilization data initially
  - Will help determine if both parties are pursuing the right patient population, product, disease state, etc.
  - Determine the right benefit vs risk model
  - Both parties have understanding of how data is measured

Overview of Executed Contracts

- Alkermes – Long-acting injectable antipsychotic
  - Focuses on adherence down to the patient level
- Melinta – IV antibiotic
  - Focuses on overall costs and potential savings
- Eisai – Epilepsy
  - Focuses on reduction in hospitalizations
- Janssen/Johnson & Johnson – Long-acting injectable antipsychotic
  - Focuses on overall population adherence

It's All About Perspective

- Manufacturer Concerns:
  - Improving market access or market share
  - Avoiding restrictions
  - Avoiding "best price" implications
  - Gaining a competitive advantage
- Payer Concerns:
  - Reducing costs
  - Reducing waste
  - Improving health outcomes/quality of care
  - Reducing financial risks
  - Obtainable and accurate outcome measurement
  - Better value for money spent

Stuard S, Beyer J, Bonetto M, et al. SMART-D Summary Report. Center for Evidence-Based Policy. September 2016.
Goodman C. Value-Based Health Care: Identifying Benefits for Patients, Providers & Payers. November 2017.
Kenney JT. The Outcome of it All – The Impact and Value of Outcomes Based Contracts. October 2017.

Some Initial Findings

- Smaller companies seem to be able to move faster
- Not all agreements are focused solely on initial cost of product
- Return on Investment
- Fair agreement for both parties

Challenges

- Manufacturer Challenges:
  - "Beyond label" or "off label" concerns
  - "Best price" and possible purchasing pool implications
  - Anti-Kickback concerns
- Depending on the product there may not be enough patients to study or warrant an APM agreement
- Need to consider outcomes that show improvement in population health even if the financial outcomes are not produced
- Some outcomes may take longer to measure or be identified
- Concerns that manufacturers will have the MSRP approach and mark up the product initially with plans for an APM leading to no real savings

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Things to Consider

- Subjective measurements
- Consider current supplemental contracts
- Delayed claims
- State contract limitations
- Measuring discontinuation of therapy
- Measuring compliance (or lack of)

Things to Consider Cont'd

- Tracking members coverage
- Measurement could require pro-rated calculations
- Concerns of MSRP approach
- "Real World" project
- Could APMs have impact on future manufacturers clinical trials

Russell L. Knoth, Ph.D.
Director
Health Economics & Outcomes Research
Eisai, Inc.
Woodcliff Lake, NJ

Outcomes Based Contracting: Lessons Learned

- Driving the Process
- The Value of Real World Data
- Transitioning from Concept to Contract
- The Law of Small Numbers
- The Joy of the Good Outcome

Value to the Industry

- Examples of Outcomes-Based Contracts
- The Right Drug for the Right Patient
- Access to New Therapies
- Emphasis on Improvements in Health
- A Win-Win for Payers and Manufacturers

Questions & Discussion

Please type your questions into the chat box.

Thank you!

Your opinion is important to us. After the webinar ends, you will be redirected to a web page containing a **short survey**. Your answers to the survey will help us as we plan future NASHP webinars.