Minutes of the
INTERAGENCY PHARMACEUTICALS PURCHASING COUNCIL
Meeting November 14, 2019
State Capitol, Room 321 Santa Fe, NM 87507
1:00 pm to 4:00 pm

1. CALL TO ORDER

Ken Ortiz, Director of the Interagency Pharmaceuticals Purchasing Council (IPPC) called the meeting to order at 1:06 p.m. in Room 321, of the New Mexico State Capitol. A quorum was established with roll call.

ROLL CALL
Ken Ortiz, Director IPPC
Secretary, Human Services Department, Dr. David Scrase
Designee, Department of Health, Dr. Abinash Achrekar
Designee, Children Youth and Families Department, Terry Locke
Secretary, Corrections Department, Alisha Tafoya Lucero
Director, Risk Management Division, General Services Department, Clinton Nicley
Executive Director, Retiree Health Care Authority, David Archuleta
Designee, Albuquerque Public Schools, Mark Tyndall
Designee, University of New Mexico, Joey Evans
Executive Director, New Mexico Counties, Steve Kopelman
Executive Director, New Mexico Municipal League, William Fulginiti

ABSENT/EXCUSED

Executive Director, Public School Insurance Authority, Ernestine Chavez

2. APPROVAL OF THE AGENDA

MOTION: Mr. Archuleta moved to approve the agenda with a second from Mr. Nicley which passed by voice vote.

3. APPROVAL OF MINUTES FROM OCTOBER 3, 2019

MOTION: Mr. Tyndall moved to approve the minutes with a second from Ms. Tafoya Lucero. The motion passed unanimously.

4. IPPC CONSULTANT PROCUREMENT REPORT by IPPC SUBCOMMITTEE

Mr. Nicely reported on the work the subcommittee performed to choose the IPPC consultant who will perform the agreed upon scope of work. All IPPC members were provided a copy of the DRAFT Professional Services Agreement on Friday, November 8, 2019.

Director Ortiz explained the IPPC will hold a Special Meeting next week to take a formal vote on the professional services agreement to allow new IPPC members, as well as all council members, ample time to review the DRAFT Professional Services Agreement, ask questions of the subcommittee, and provide feedback on the agreement after the report by the subcommittee.

The subcommittee reviewed the small purchase rules, took the IPPC Consultant Scope of Work that was approved by the council, and solicited several vendors the subcommittee thought had the potential to perform the Scope of Work. The vendors were given 10 business days in which to

respond. Responses were received by all vendors. The consultant chosen for the IPPC Consultant is Horvath Health Policy.

This is a contract for professional services and in the compensation portion there is not just the quoted price, there are tax implementations that were included. Mr. Nicely encouraged the members take the draft with them to review.

Director Ortiz received consensus from all IPPC members that one week is enough time for them to review the agreement in order to have a formal vote next Thursday (11/21/19). He also stated the special meeting next week will be held in the State Capitol; however, if any members need to attend via telephone they can do so.

5. UPDATE OF PHARMACEUTICAL PURCHASING PROGRAM

1) NEW MEXICO MUNICIPAL LEAGUE

Mr. Fulgeniti provided notice that his representative was unavailable to present at this council's meeting; New Mexico Municipal League will make its presentation at the upcoming Special meeting.

2) NEW MEXICO COUNTIES

Mr. Kopelman introduced Ms. Kamie Denton who is the Workers' Compensation Manager and Pharmacy Benefits Manager.

Ms. Denton presented the NM Counties Workers' Compensation Pharmaceutical Purchasing Program slide deck. (S*ee attached*). Twenty-nine of 33 counties participates in the Workers' Compensation fund, which covers over 7,800 employees; there are roughly 800 claims per year.

The plan issues an RFP to select a Pharmacy Benefit Manager (PBM). Ms. Denton also reviewed the top drugs by volume and by cost.

NM Counties is obligated to deny the brand drugs and give the generic version; however, if a doctor prescribes a brand drug, NM Counties must allow it.

6. PHARMACEUTICAL PURCHASING OVERVIEW

MANAGED CARE ORGANIZATIONS

Director Ortiz invited the MCOs (Managed Care Organizations) to make their joint presentation. Frank Allen, BlueCross BlueShield, Nathan Varley with Western Sky Community Care, and Louanne Cunico with Presbyterian Health Plan were on hand to make the presentation (*see attached*).

Ms. Cunico explained there were concerns with the struggles with specialty drugs at the last IPPC meeting so they wanted to address those issues.

Mr. Allen provided sample data of specialty drug costs and Mr. Varley introduced new precision high cost drugs. There are drugs that will cover up to three conditions in a single dose, but comes with a cost. Dr. Archrekar stated many of these are single cures, but they come at a cost.

A discussion was held about the advertisements for drugs and the federal legislation that has been proposed around drug advertising. Dr. Scrase stated that there are efforts to combat advertising. Some businesses do not allow the drug representatives in their offices.

Dr. Archrekar explained, as a specialist, the research of specialty drugs takes a while. As specialists, they need to interact with the representatives on durable medical devices.

A brief discussion was held on the waste of drugs. Mr. Varley discussed the new regulations to prevent waste.

Mr. Tyndall asked about the $51 million dollars in savings associated with the carve out model that the LFC came up with. Ms. Cunico explained that the majority of the savings was in dispensing fees.

Dr. Scrase discussed projected savings and carve outs.

Dr. Archrekar asked about the ceiling prices and overcharging for drugs; Ms. Cunico explained this process. She also stated that MCOs have so many contracts that monitoring the pricing and charges of drugs can be tricky because these contracts can fluctuate so frequently.

7. FORMATION OF IPPC SPECIALTY DRUG SUBCOMMITTEE

Dr. Scrase stated that the presenters highlighted an increase on specialty drugs cost.

Dr. Archrekar thinks it will be important, however they need to define what a specialty drug is and what the goal of the committee will be.

Director Ortiz would accept volunteers that would focus on the mission and definition and report in the interim.

Dr. Scrase speaking for himself does not feel he would bring any expertise to this committee. He said maybe someone from his agency has the requisite expertise.

Mr. Tyndall explained part of the conversation could be the cost and how to finance it and if we cannot find ways to finance these costly drugs, discuss ways to make sure we can pay for it.

Dr. Scrase stated the group can identify experts within the community to participate in the subcommittee.

Mr. Archuleta suggested the specialty drug issues could be part of the scope of work for the consultant; perhaps it should be specified as a deliverable.

MOTION: Mr. Tyndall moved to form the subcommittee to work on the specialty drug issue, with a second from Mr. Kopelman. A vote was not taken as there was more discussion.

Dr. Scrase would ask the subcommittee to come back with an interagency solution.

Dr. Archrekar stated if they add specialty drugs to the scope of work, the IPPC should wait to form the subcommittee until after the council receives reports from the IPPC consultant.

Mr. Tyndall withdrew his motion.

Director Ortiz stated the IPPC will wait for the consultant. However, the next regular scheduled meeting is in February.

Mr. Evans understands that there are differences in employer plans and governmental plans so he is concerned that forming a subcommittee now would not move the council any further to its mission without guidance from a consultant that can help with strategy. He stated that it may be more beneficial to form a subcommittee after council members have guidance from a consultant.

Mr. Tyndall thinks the council members take a week to think about establishing a specialty drug subcommittee and the issue be tabled until next week.

Mr. Archuleta mentioned that the contract states a whitepaper is due from the Consultant on January 11, 2020 and council members will not have time to review it.

Mr. Nicely stated his understanding is the consultant can report on findings at the first IPPC meeting following the issuance of the whitepaper.

Ms. Trujillo stated the Consultant Procurement subcommittee wanted to have something to report for the 2020 legislative session, which is why the January 11th date for the whitepaper was set.

Director Ortiz stated that providing council members a week to review the DRAFT agreement will give all IPPC members a chance to add their recommendations to the agreement, taking all issues into account.

MOTION: Mr. Tyndall moved to table this item until next week, with a second from Mr. Kopleman. The motion passed by unanimously.

8. PUBLIC COMMENT

- Dale Tinker NM Pharmacists Association thanked the MCOs for their presentation; they did a great job. He stated the $51 million savings would help with the dispensing fees. He wants to encourage the formation of the specialty drug subcommittee because it is the specialty drugs that are the cost driver. The subcommittee can be tasked with helping contain costs. He offered his association to help with the specialty drug committee.

  Dr. Achrekar discussed prevention and the ways to treat disease before it starts.

- Collin Baillio Health Action NM, thanked the MCOs for their presentation noting there was some good information given. Health Action NM helped with the formation of the council and are looking at budgets and pharmaceutical out of pocket costs. He was able to find an AARP survey that showed that 25% of New Mexicans from the ages of 19-64 stopped taking medications because of the cost in 2017. Mr. Baillio said his group had met with some Maryland advocates and that Maryland has passed legislation to form a Drug Affordability Board; Mr. Baillio offered to supply Maryland's Act.

  The Board would have the authority to identify medications and brands that meet certain cost criteria, evaluate whether the costs are creating an affordability challenge for consumers, then the Board would go through a process to establish an upper payment limit. It helps consumers even if they are on a private insurance. He asked that IPPC members take Maryland's approach into consideration.

  Director Ortiz asked Mr. Baillio to email Ms. Trujillo some information on the Maryland model as he continued to review its progress.

- Senator Steinborn thanked the Council and is glad to see the public as well. He explained that Senate Bill 131 requires the IPPC to conduct an analysis of 13 different cost containment strategies. Also, it does not require that one strategy be chosen over another; the IPPC can open it to some other possibilities and suggestions for pharmaceutical cost containment. Other suggestions can also mean joining other states and bringing in other groups to speak about other proposals that have an effect on the costs. The idea to have the Consultant report before the session starts has good merit. Many legislators will be around before the session starts.

  Director Ortiz explained the different phases of the IPPC Consultant Contract.

- Mary Feldblum, Health Security for New Mexicans Campaign, suggested the IPPC compare US specialty drug prices to international specialty prices. She knows Jane Wishner reported two

Utah State Senators introduced a bill to enable Utah to purchase drugs from other countries. She hopes the IPPC looks at purchasing specialty drugs from other countries as an option.

Director Ortiz explained that looking at purchasing pharmaceuticals from other states is part of the Consultant's scope of work.

- Ms. Jane Wishner, Governor's Health Policy Advisor, did not recall Utah but recalls Nevada and its focus on drug transparency laws. She has been working hard with this administration on pharmaceutical initiatives along with other national groups. She provided some of the work going on with drug importation.

  The National Governor's Association (NGA) has a pharmaceuticals working group and some New Mexico people will be attending an NGA summit in Washington D.C. in December in which Ms. Wishner asked that drug importation be added to that agenda. There is a law under the FDA Act that allows states to apply for approval to do wholesale drug importation; approval will come from US Health and Human Services. In July there was talk in the Trump administration to propose rulemaking to open up importation with Canada. She also participated in a call about bulk purchasing and interstate purchasing; she also asked about the consideration for bulk purchasing for Corrections. There are a lot of ideas but many states are limited.

  Dr. Achrekar asked about the safety with importation. A lot of manufacturing is being done abroad. Ms. Wishner stated this issue has been discussed and that wholesale pharmaceuticals have safety regulations in place.

- A brief discussion was held on 340B.

  Mr. Tyndall understands it was to allow hospitals to serve indigent populations and for this service, received breaks from drug manufacturers. He also understands that other entities have been trying to expand 340B and get it to do what it was never intended to do. He hopes these entities' actions would not jeopardize the program.

  Mr. Evans stated UNM, from an employee health plan standpoint, has done a study. UNM has a hospital eligible for 340B pricing and the study looked into whether employees would benefit from 340B pricing if they were using UNM's provider network and the hospital for services. They ran into challenges that were contrary to the intent of the 340B program. The study was non-conclusive on whether it was beneficial for employees to utilize 340B pricing because drug manufacturers may not have offered rebates at premium rates.

  Dr. Scrase explained health care costs. We could squeeze down out of pocket expenses, but other costs have to be recouped in other ways. The IPPC needs to figure out a way to add resources or find creative ways to save cost. They need the appropriations if there are savings down the line.

9. NEXT STEPS FOR IPPC

Director Ortiz explained the special meeting will be in a room at the State Capitol next Thursday November 21, 2019 at 3:00 pm. Proposed topics will be approval of the meeting agenda and minutes from 11/14/19, the NM Municipal League's presentation, and the approval and vote of the IPPC Consultant Contract and formulation of the Specialty Drug Subcommittee.

10. ADJOURN

MOTION: With all business conducted, Dr. Scrase moved to adjourn at 3:37 p.m. with a second from Mr. Archuleta.

Ken Ortiz, Director

11/21/19
Date

Interagency Pharmaceutical Purchasing Council

November 14, 2019

Steve Kopelman, Executive Director

Kamie Denton, Workers' Compensation Manager

NEW MEXICO COUNTIES

33 STRONG

New Mexico Counties' Workers' Compensation Fund

- The New Mexico Workers' Compensation Act allows for pooling of public entities for their workers' compensation coverage.
- 29 of the 33 New Mexico counties participate in our Workers' Compensation Fund, which covers 7,874 county employees.
- Coverage includes indemnity, medical and pharmaceutical benefits for a compensable work related injury.

NEW MEXICO COUNTIES
33 STRONG

Prescriptions and NM Workers' Compensation

New Mexico Workers' Compensation

- Created through a legislative act in 1991; a no-fault system of rules and regulations to protect workers injured in the course and scope of employment and their employers.
- Medical care, including prescription medications, are covered so long as it is prescribed by the authorized health care provider and is considered reasonable and medically necessary.
- The New Mexico Workers' Compensation Administration sets the fee schedule, also known as the Maximum Allowable Price (MAP), by which medical bills are paid.
- Prescriptions are paid based on the MAP using the Average Wholesale Price (AWP) and a formula set forth by the Workers' Compensation Administration.
- There are no out-of-pocket expenses (co-pays) for medical care or prescription medications.

Current Plan Design

New Mexico Counties issues a Request for Proposal and selects the Pharmacy Benefit Manager. Once the selection process begins, we are able to negotiate our rates for both brand and generic prescriptions.

Retail and Mail Order Prescriptions

- Brand: 13.23% below Maximum Allowable Price
- Generic: 42% below Maximum Allowable Price

NEW MEXICO COUNTIES
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Top 5 Drugs by Volume

December 2018-November 2019

Number of Fills	Total Units	Description	Total Cost
84	6320	IBUPROFEN TAB 800MG	$2,176.75
77	8435	TRAMADOL HCL TAB 50MG	$4,084.43
66	3303	HYDROCO/APAP TAB 5-325MG	$1,322.65
65	5318	HYDROCO/APAP TAB 10-325MG	$2,780.95
63	5250	GABAPENTIN CAP 300MG	$1,674.25

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Top 5 Drugs by Cost

December 2018-November 2019

Drug Name	Number of Fills	Total Cost	AVG Cost per Fill	AVG Quantity per Fill
GRALISE TAB 600MG	31	$19,919.15	$642.55	70
LYRICA CAP 75MG	22	$10,431.48	$474.16	59
LYRICA CAP 50MG	16	$9,508.09	$594.26	73
CELECOXIB CAP 200MG	58	$9,223.90	$159.03	37
METAXALONE TAB 800MG	28	$8,749.85	$312.49	100

NEW MEXICO COUNTIES
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Cost Data

December 2018-November 2019

	Fee Schedule Price	PBM Price	Savings Over Fee Schedule	% of Savings	Average Cost per Prescrition
Brand	$97,509.21	$92,885.64	$4,623.57	4.74%	$398.65
Generic	$174,285.38	$107,101.36	$67,184.02	38.55%	$75.90
Total	**$271,794.59**	**$199,987.00**	**$71,807.59**	**26.42%**	

Number of Claimants	198	
Number of Prescriptions	1644	
Number of Generic Prescriptions	1411	85.8% Generic Penetration

NEW MEXICO COUNTIES
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New Mexico Interagency Pharmaceutical Purchasing Council (IPPC)

Joint MCO Presentation

November 11, 2019

BlueCross BlueShield of New Mexico

PRESBYTERIAN Health Plan, Inc.

western sky community care

Concerns Raised at Prior IPPC Meetings

- Approaching end of ability to control total pharmaceutical costs through rebate programs
- Lack of transparency in some rebate programs
- Pharmaceutical expenses rising faster than other medical expenses
- Primary cost driver is specialty medication, including but not limited to novel orphan drugs, precision medicine, and gene therapies
- Fragmented care and less-than-optimal member engagement limit the potential to optimize management of pharmacy expense, total cost of care, and quality outcomes

Topics

- Challenges
- Benefits of Pharmacy Administration under an Integrated Care Management Model
- Tools and Data
- Current Rebate Arrangements
- Recommendations for Consideration

Challenges

Specialty Drug Costs

- Specialty drugs are high cost medication used to treat complex chronic conditions (e.g., cancer) multiple sclerosis, and rheumatoid arthritis.
- Sample data from legacy MCOs: Q3 2019 vs Q3 2018 specialty drug trend is up 2.4%, 38% of total drugs costs.
  - Autoimmune: 33.2% increase based on PMPM
  - Cancer oral: 14.2% increase based on PMPM
  - Cystic fibrosis: 62.5% increase
    - 33% increase in utilization
    - Trikafta (new drug): $311,000 per member per year (over 10% more than previous treatments)
  - Hemophilia – 55.5% increase based on PMPM

New Gene and Cellular Based Therapies

Precision Drug	Category	Disease State	Drug Cost
Kymriah	Cellular therapy (CAR-T)	Lymphoma, all	$373K x 1 dose, $475K x 1 dose (“indication-based”)
Yescarta	Cellular therapy (CAR-T)	Lymphoma	$368K x 1 dose
Luxturna	Gene therapy	Hereditary blindness	$850K ($425K x 1 dose ea. eye)
Spinraza	Gene modifying	Spinal muscular atrophy	$750K year 1, $375K per year
Exondys-51	Gene modifying	Duchenne’s muscular dystrophy	$300K-$450K per year
Zolgensma	Gene therapy	Spinal muscular dystrophy	$2.125M x 1 dose

- Many of these could be considered a cure, i.e., the cost is one-time.
- Current utilization and trend not established.
- How we provide appropriate and timely access is critical.

Benefits of Pharmacy Administration under an Integrated Care Model

Fee-for-Service vs. Integrated Care

Given:

- Fiscal impact report from NM Legislative Finance Committee (LFC) estimated $51M increase in Medicaid spend if NM moved pharmacy to fee-for-service (FFS) model (SB 184)

Greater Benefit:

- Compared to the FFS model, integrated care models:
  - Save between $11-$16 per member per month in medical expenses*
  - Reduce inpatient admissions by 6.4%*
  - Reduce emergency department visits by 5.3%*

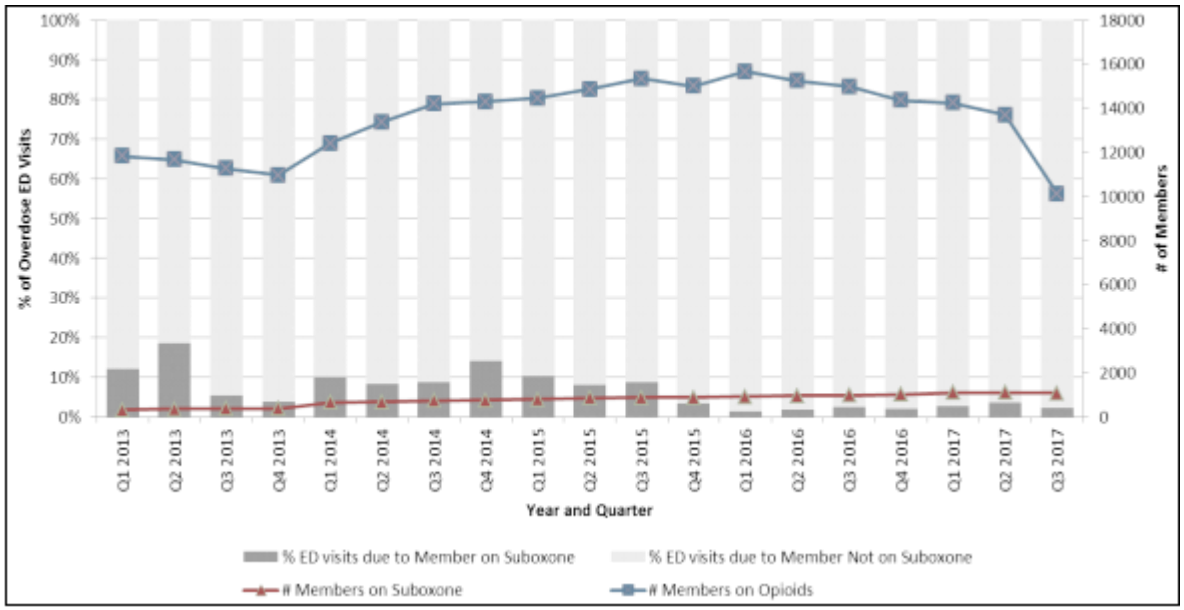
* Source: OptumRx White Paper: *Measuring the Financial Advantage*

Integrated Care Model: Overview

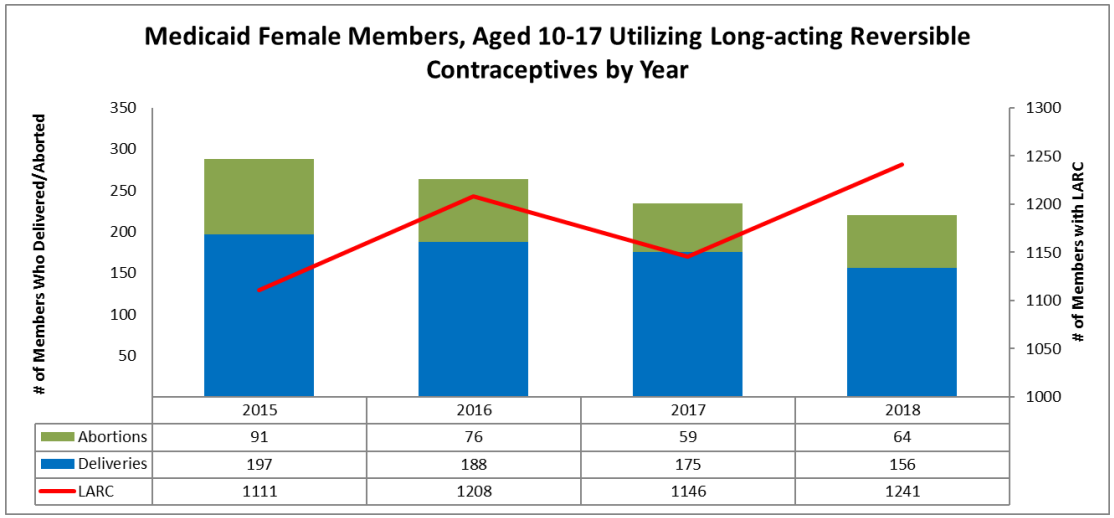
- Managed care organizations (MCOs) that effectively integrate their medical and pharmacy components are uniquely positioned to monitor and improve their memberships' health via:
  - Clinical programs such as medication therapy management (MTM) that identify opportunities for "deprescribing" unnecessary/duplicative therapies and for management of high-risk medications
  - Gaps in care programs that identify needed therapies and/or dose optimization
  - Real-time coordination between disease management, care coordination, utilization management, and MTM
  - Concurrent drug utilization review that ensures safe and effective medication therapy
- See the following two slides for an example of success that is best achieved by an integrated managed care model.

Integrated Care Model Example (1)

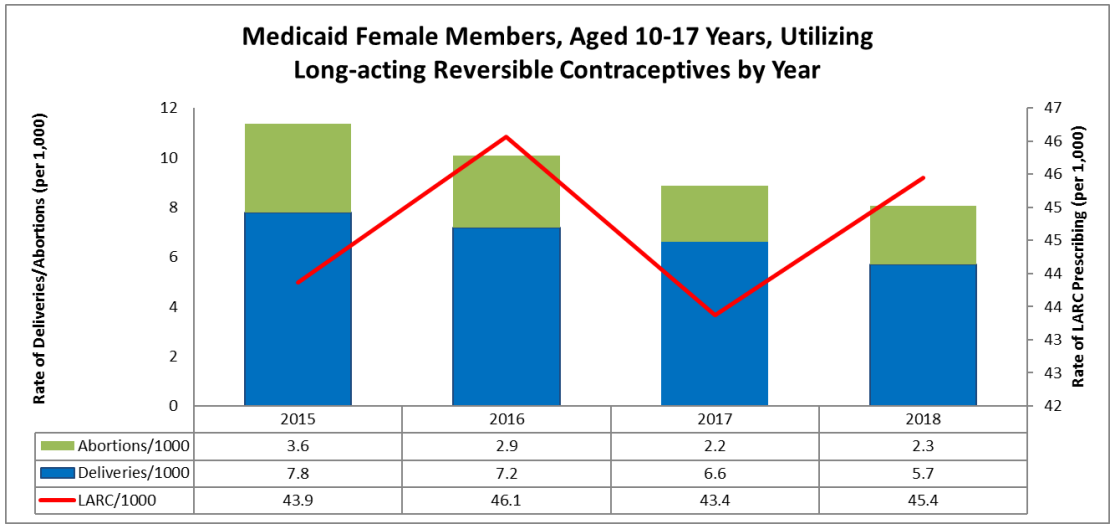
- On this slided and the next, combined pharmacy and medical claims data demonstrate optimal program outcomes.



Integrated Care Model Example (2)



	2015	2016	2017	2018
Abortions	91	76	59	64
Deliveries	197	188	175	156
LARC	1111	1208	1146	1241



	2015	2016	2017	2018
Abortions/1000	3.6	2.9	2.2	2.3
Deliveries/1000	7.8	7.2	6.6	5.7
LARC/1000	43.9	46.1	43.4	45.4

BlueCross BlueShield of New Mexico

PRESBYTERIAN Health Plan, Inc.

western sky community care

Integrated Care Model Detail

slide 1 of 2

Specialty Drug Management

- Specialty drugs require close clinical management
- Allows for patient monitoring and utilization review (adherence gaps, appropriateness of use)
- Right drug, right dose, right cost, right site of service
- Formulary management through local Pharmacy and Therapeutic (P&T) Committees that include local community providers
- Specialty pharmacy coordination (ownership of specialty pharmacies)

Integrated Care for Improved Member Engagment

- Local staff/leadership with extensive experience serving NM members
- Local provider relationships to ensure appropriate medication use
- Effective coordination among health plan services, e.g., care coordinators, community health workers, customer care, provider services
- Integration of medical and pharmacy data and analytics
- Management of drugs across benefits

Integrated Care Model Detail

slide 2 of 2

Cost Management and Transparency

- Lowest net cost model
- Generic dispensing rates higher than national benchmarks
- MCOs not incentivized by volume of prescriptions (basis of rebate programs)
- Utilization management for specialty drugs
- Focus on quality and health outcomes
- Minimize polypharmacy – ensure safety and eliminate waste
- Financial alignment with providers through value based purchasing
- Decision support tools that increase cost transparency for providers and members

Integrated Medical / Pharmacy Care

- Members are proactively engaged in their care via the interdisciplinary care planning team (ICPT)
- Clinical pharmacists are key participants in ICPT
- Population health management focuses on medical and pharmacy benefit integration to achieve superior cost and quality outcomes
- Less duplication and complexity of services contributes to holistic member experience

MCO Enhancements

- Clinical pharmacists integrated with clinical care team
- Claims edits designed by local clinical pharmacists and medical staff, utilizing best practices
- Quality, safety, appropriate care, and effective cost management achieved by team collaboration within and across MCOs
- Medication therapy management (MTM) conducted by clinical pharmacists in collaboration with medical partners, all of whom are aware of challenges specific to their membership
- Over- and under-utilization managed by local clinical staff
- DUR process managed by clinical pharmacists
- NM provider input incorporated into formulary design
- Ongoing optimization of relationships with local providers

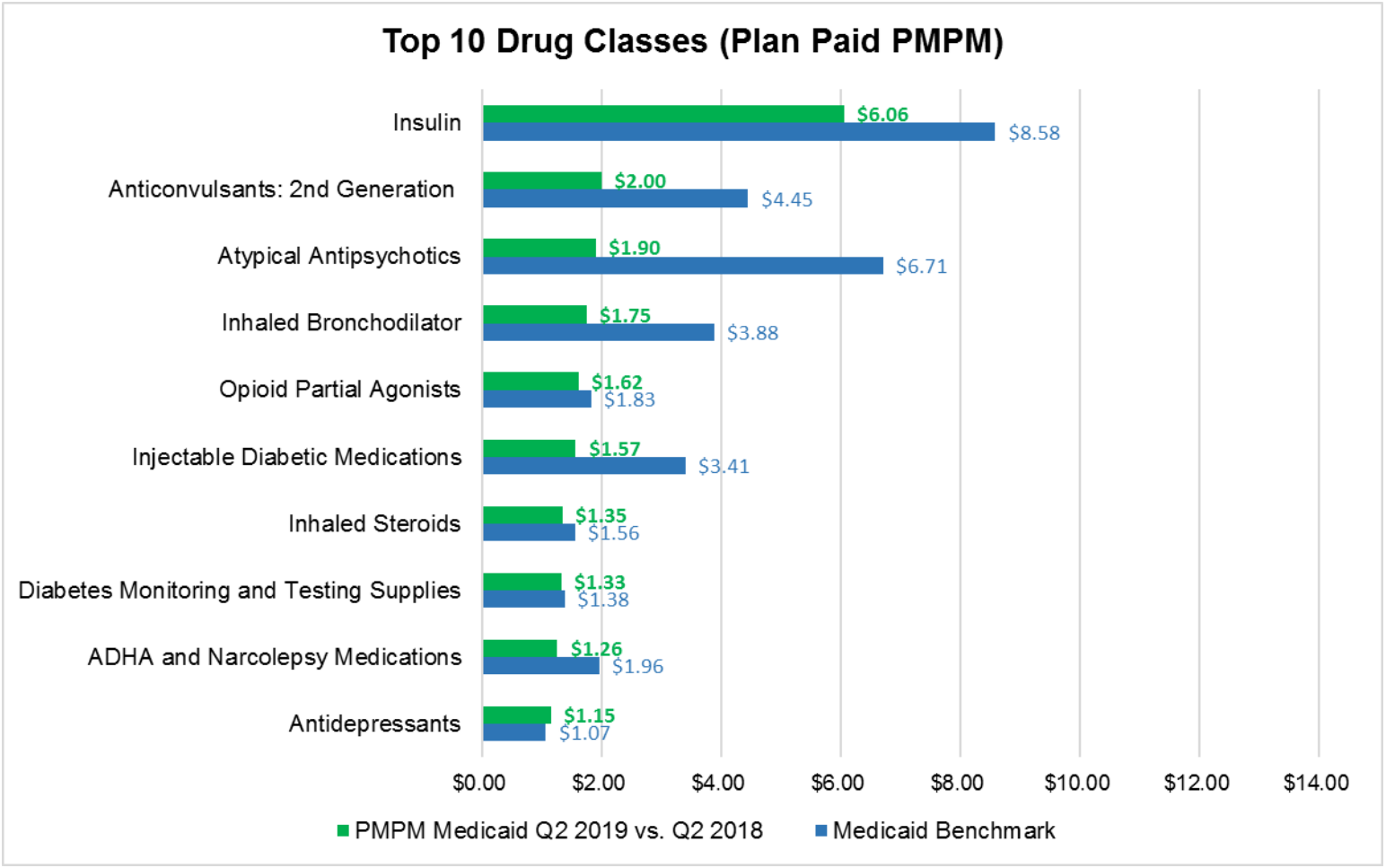
Tools and Data

Over and Under-Utilization Mgmt. Tools

Method/Tool	Description
Retrospective Drug Utilization Review	Identifies gaps in care for Members with conditions such as asthma, diabetes, HIV, cardiovascular, migraine, and long-term use of steroids in osteoporosis. We support the provider's practice by supplying specific reports listing Members.
Controlled Substance Monitoring	Monitoring of prescribers and Patient use patterns using the RxTrack® tool. We use controls such as step therapy and quantity limits to assist prescribers and monitor utilization of control substances.
Complex Member Multi-Disciplinary Rounds	Multi-disciplinary team meets weekly for complex Member rounds where care plans are reviewed by medical directors, care coordination, peer support, community health workers, and pharmacists. Recommendations for improving Patient outcomes are communicated to the Member's care team. Follows the Member to ascertain whether outcomes have improved and/or whether additional intervention is needed.
Quarterly Reports and Analysis	RxTrack® reports identify Members who did not pick up prescriptions three or more times in a quarter and who filled three or more prescriptions in a therapeutic class within a 30 day period.
Medication Adherence Program and Care Coordination	Members with under-utilization referred to Medication Adherence Program which includes automated refill reminder calls, medication counseling, and education to promote adherence and improve clinical outcomes. Members with over-utilization of controlled substances referred to care coordination for potential prescriber or pharmacy lock-in.

Medicaid Traditional Drug Performance

(data provided by PHP)



BlueCross BlueShield of New Mexico

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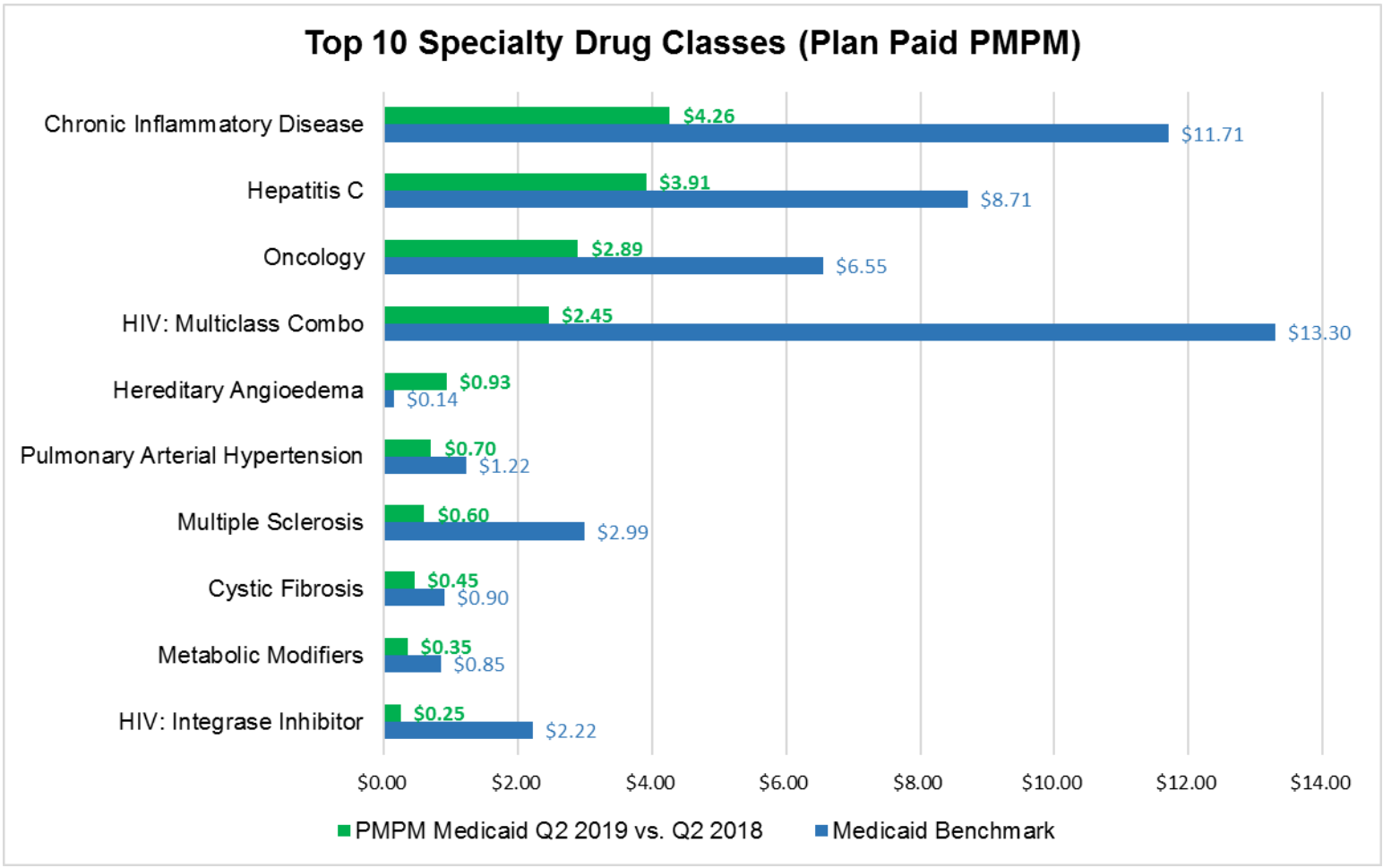
western sky community care

Medicaid Specialty Drug Performance
(data provided by PHP)



Current Rebate Arrangements

Medicaid Drug Rebates

slide 1 of 4

- Medicaid drug rebate program is administered by CMS
- Approximately 600 drug manufacturers currently participate in this program
- The program requires a drug manufacturer to enter into, and have in effect, a national rebate agreement with the Secretary of the Department of Health and Human Services in exchange for state Medicaid coverage of the manufacturer's drugs
- ALL drugs covered by New Mexico Centennial Care 2.0 managed care organizations (MCOs) have a rebate agreement in place

Medicaid Drug Rebates

slide 2 of 4

- **Base manufacturer rebate:** This is paid to the state plan, not to MCOs.
- In most cases, drug manufacturers must pay the state Medicaid plan 23.1% of average manufacturer price (AMP) for brand name drugs and 13% for generic drugs
- **Inflationary rebate penalty**: This penalty increases the base rebate if the manufacturer increases the price of the drug at a rate greater than inflation.
- **Maximum Rebate Amount:** This is 100% of the AMP, applies to the sum of the basic rebate and the inflationary rebate amounts.
- In 2016, Medicaid drug rebates totaled $31.2 billion.

Medicaid Drug Rebates

slide 3 of 4

- **Supplemental Rebates**: Rebates paid in excess of the mandated base rebate
  - In New Mexico, supplemental rebates are paid to MCOs
  - Base rebate + supplemental rebate must not exceed “best price”
    - Best price: The **lowest price** available to any entity
    - Ensures Medicaid plans have access to the lowest price available
  - Due to best-price limitations on rebates, supplemental rebates paid to MCOs are much lower than what would be paid to a commercial plan or even to the state Medicaid plan (23.1%)
    - Supplemental rebates are usually less than 10%
    - By comparison commercial plans often have rebates near or above 40% - 50%
  - Many drugs do not offer a supplemental rebate for Medicaid

Medicaid Drug Rebates

slide 4 of 4

Summary

Rebates drive very few MCO decisions about Medicaid formularies.

If drugs are considered equally safe and effective, MCOs will choose the most cost-effective agent. This results in high generic drug utilization, which is key to controlling drug costs.

Recommendations for Consideration

Recommendations for Consideration

slide 1 of 2

- Explore payment solutions for specific gene and cellular based therapies (slide 6)
- Explore value/outcomes based payment models for appropriate drug classes and very high cost therapies
- Explore collaborative legislative opportunities to increase transparency and improve drugs costs

Recommendations for Consideration

slide 2 of 2

- Aggressive generics/biosimilar requirements
  - Examples: Basaglar, Admelog, Inflectra, Renflexis, Retacrit
  - Generic-first policy
- Encourage pass-through pharmacy benefit manager (PBM) arrangements, expand beyond Centennial Care
  - Improves transparency of drug pricing in NM
  - Will increase administrative cost effecting medical loss ratio
- Medical drugs: Solution for abandoned units (wastage)
  - Create option to return abandoned units to the pharmacy for credit
  - Develop process for drug to be redirected to another member
  - Expand buy and bill


Thank You