# 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%*

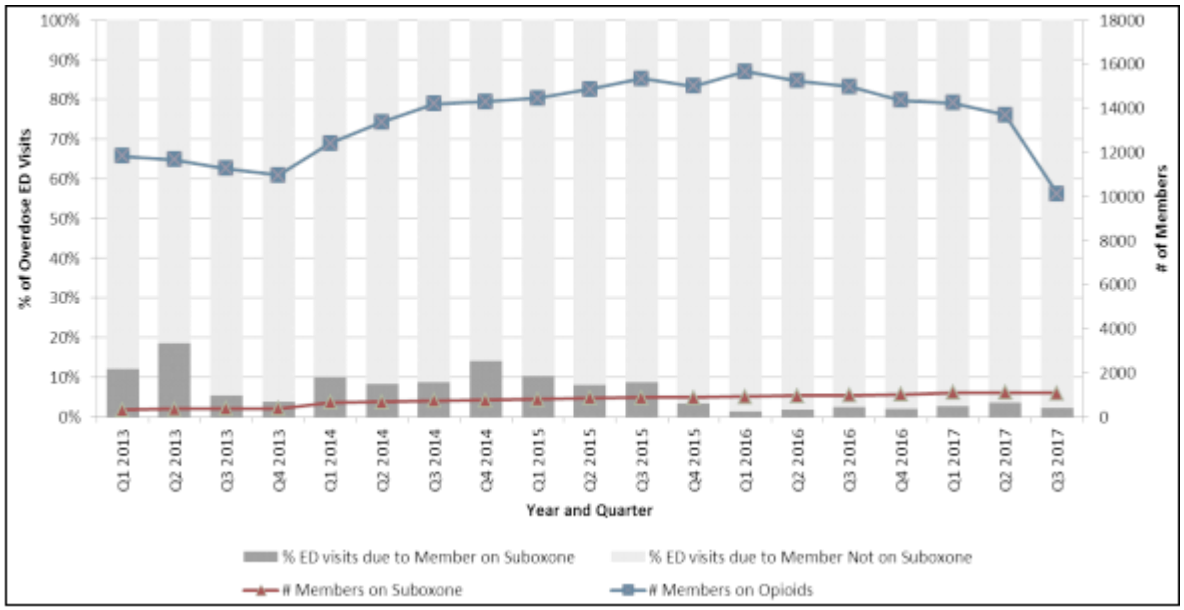
* Source: OptumRx White Paper: *Measuring the Financial Advantage*

# Integrated Care Model: Overview

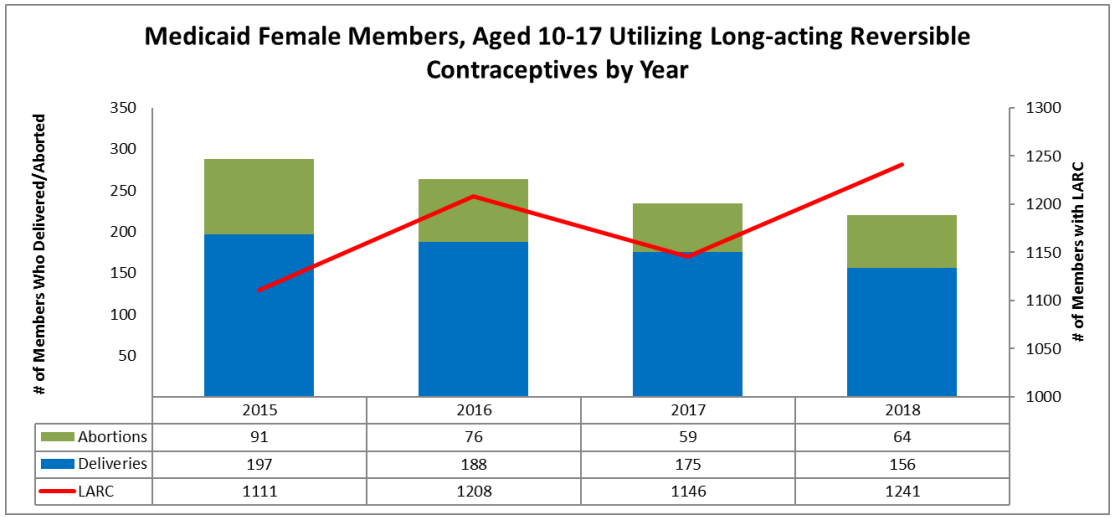
- Managed care organizations (MCOs) that effectively integrate their medical and pharmacy components are uniquely positioned to monitor and improve their memberships' health via:
  - Clinical programs such as medication therapy management (MTM) that identify opportunities for "deprescribing" unnecessary/duplicative 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)

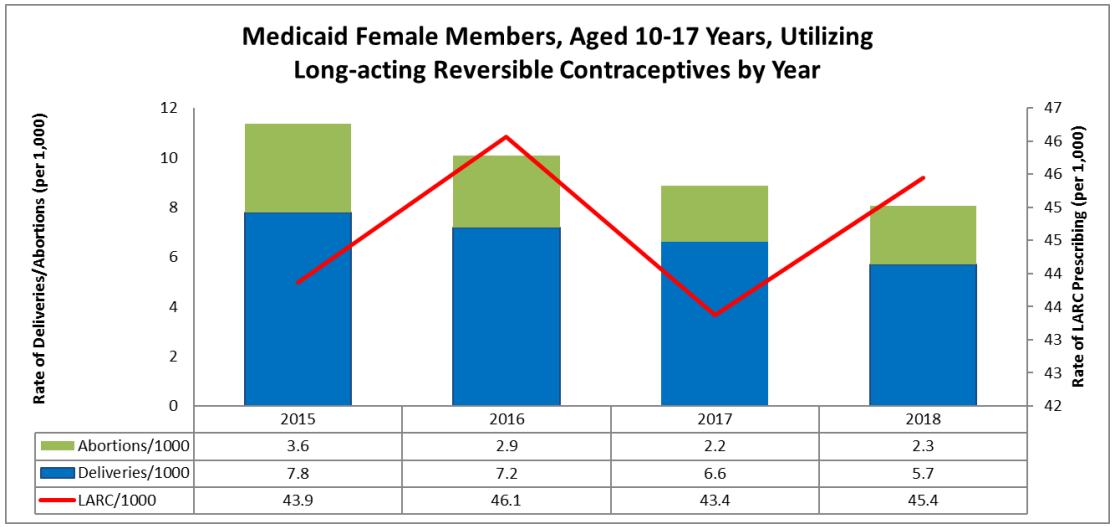
- On this slided and the next, combined pharmacy and medical claims data demonstrate optimal program outcomes.



# 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 |

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# Integrated Care Model Detail

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## 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

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## 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

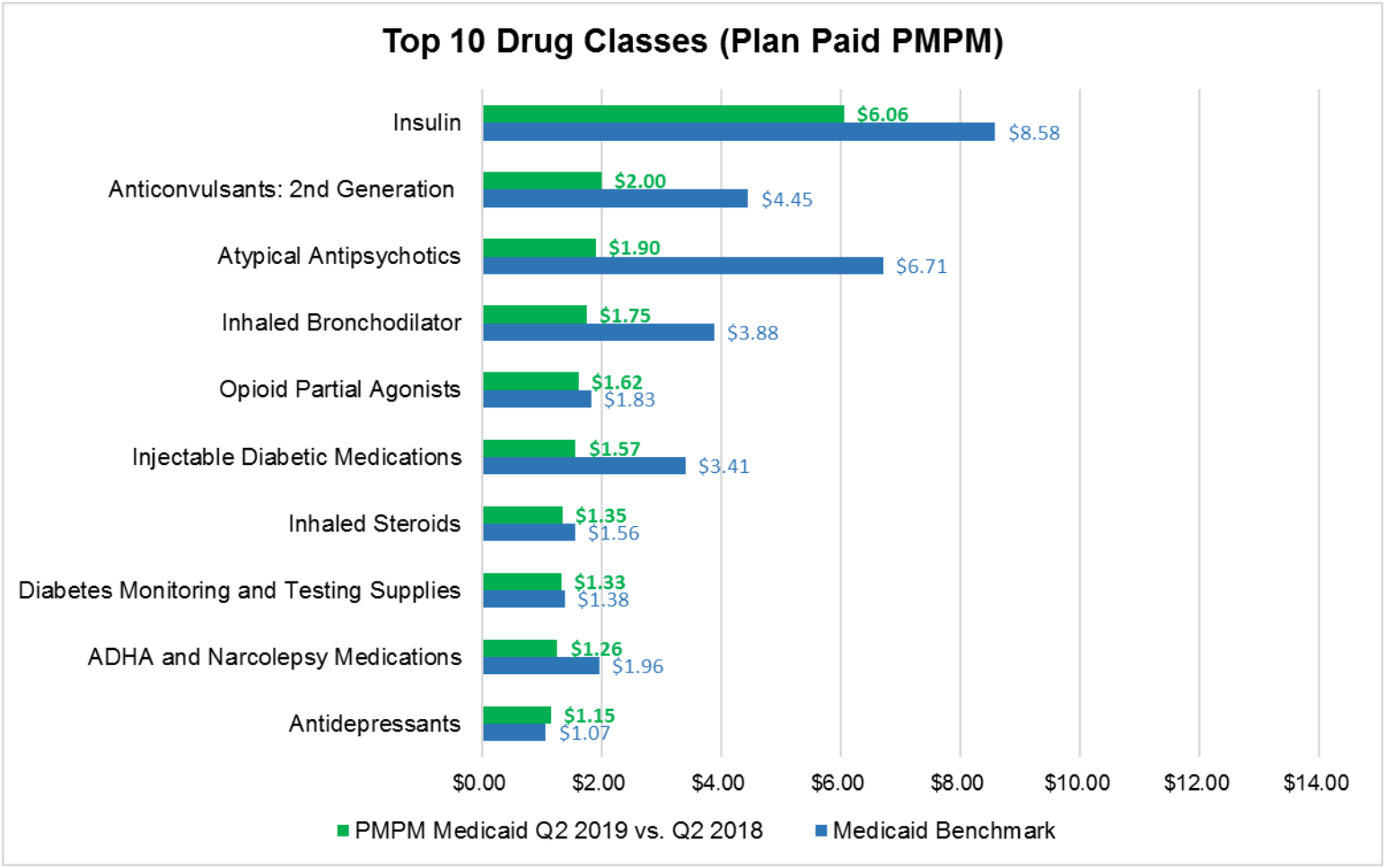
# Tools and Data

# 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)

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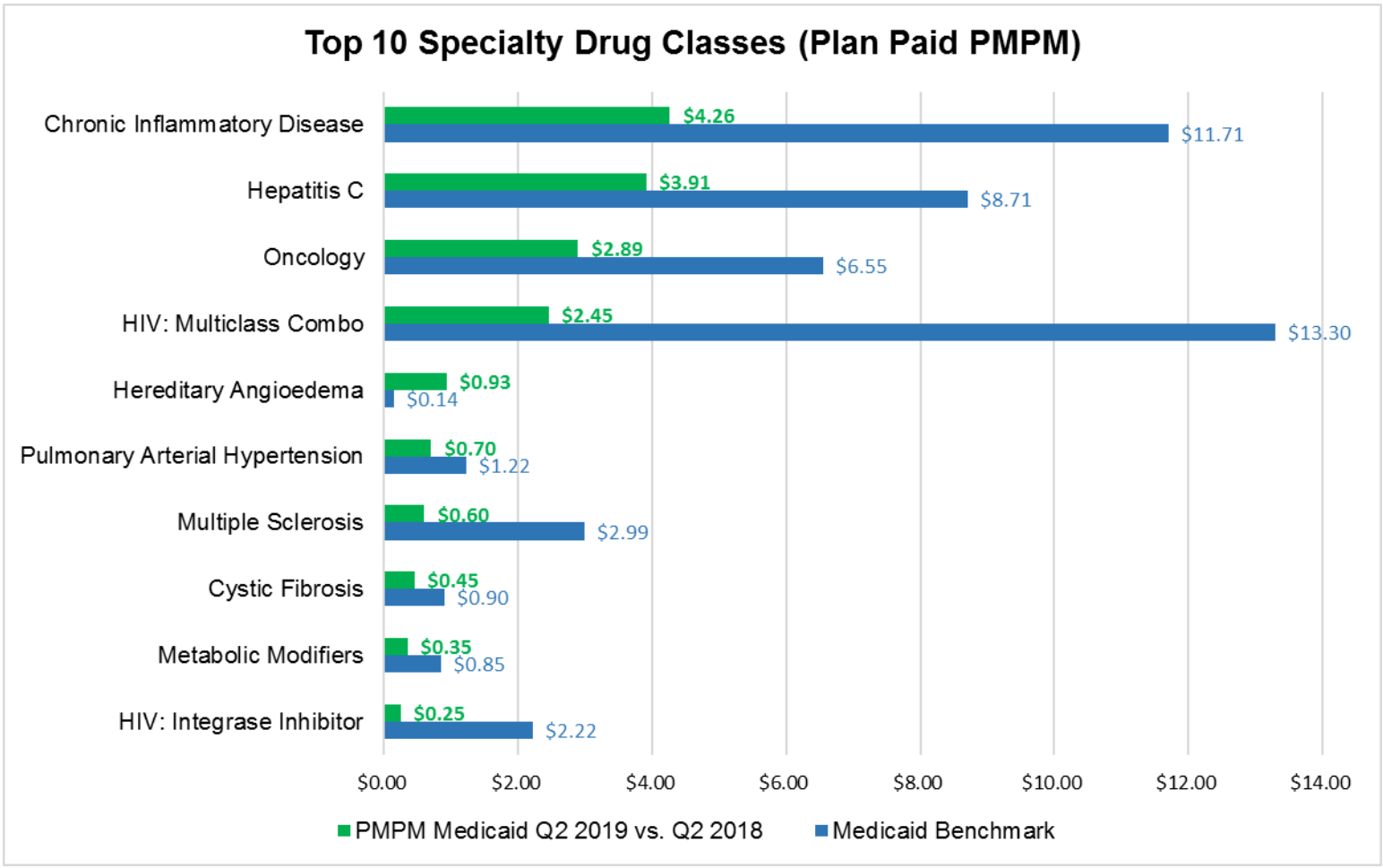
# Medicaid Specialty Drug Performance
(data provided by PHP)



# Current Rebate Arrangements

# Medicaid Drug Rebates

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- 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

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- **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

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- **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

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**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

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- 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

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- 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