Prescription Drug Cost Control

Options and Limitations

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Current Pressures

- Cost of prescription drugs as percentage of health care have remained relatively stable over time.
- Many brand name drugs have gone generic
- State rebate percentages have leveled off as new drug prices increase
  - State does not currently share rebates with CCOs
- New and very expensive drugs are coming to a pharmacy near you

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Pharmacy 101
Commonly Used Terms

- Pharmacy Benefit Manager (PBM)—private company that adjudicates all prescription claims, enforces preferred drug list, and, in many cases negotiates rebates on behalf of the payer.
- Payer—The entity that is paying the bill and setting the policies around prescription drugs. This might include OHA, CCOs, PEBB, OEBB, private insurance company.
- Prescriber—the person, usually a physician, who writes the prescription for a drug
- Pharmacy—store where a patient has a prescription filled
- Pharmaceutical Company or Manufacturer—company that makes the drugs and pays rebates.
- Rebates—amount paid by a manufacturer to a payer to bring the cost of the drug down to the amount agreed to between the two.

Pharmacy 101
Commonly Used Terms

- Federally Mandated Rebates—amount set in federal law that a manufacturer must pay for the manufacturer's drugs to be paid for by Medicaid. Minimum amount is 23.1%
- State Supplemental Rebates—rebates (above and beyond the federal rebate) between the manufacturer and the state
- Pharmacy and Therapeutics (P&T) Committee—a committee of experts that reviews the evidence about prescription drugs and recommends their placement on a PDL
- Preferred Drug List (PDL)—a list of preferred drugs that is established by the P&T Committee.
- Health Evidence Review Committee (HERC)—establishes the "line" for coverage within the OHP program

Pharmacy 101

- Patient is handed prescription by a doctor
- Patient takes prescription to pharmacy or e-prescription is sent to pharmacy
- Pharmacy checks with Pharmacy Benefit Manager to assure:
  - Patient is covered by insurance company
  - The prescription is on the payer's Preferred Drug List
  - If there are Prior Authorization requirements (established by the payer) that must be met
  - The amount of co-payment or co-insurance to collect from patient
  - Gives patient drug, collects co-payment and send patient home
- PBM sends check to Pharmacy for agreed up on reimbursement of cost of drug and a dispensing fee.

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Pharmacy 101

- PBM notifies payer of amount sent to pharmacy
- Payer sends check to PBM
- Payer notifies drug manufacturer that their drug has been paid for.
- Drug manufacturer sends payment to payer equal to negotiated rebate to payer.
- Example:
  - $100 cost of drug
  - 10% co-payment paid by patient
  - $90 sent to pharmacy
  - Payer sends $90 to PBM---PBM is now whole
  - $50 rebate from Drug manufacturer sent to payer
  - $40 net cost to payer

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Options for better management of prescription drugs--Medicaid

- Set up formal process to review drugs prior to approval
  - Can be done administratively
  - Discuss with provider groups on appropriate use
  - Develop Prior Authorization criteria using input from provider groups
- Require diagnosis code on prescriptions as means to assure appropriate use.
  - Can be done administratively
  - Assures drugs used on label only
  - Many doctors don't know codes
  - Getting easier with e-prescribing

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Options for better management of prescription drugs--Medicaid

- Limit coverage of new drugs for six months while staff develops policy around appropriate use
  - Requires legislative approval
  - Provides breathing room to accomplish above after drug on market
  - Common among private payers
  - Some other states follow this option

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Increase Purchasing Power of State

- Consolidate all drug purchases under one operation
  - Medicaid FFS
  - Medicaid CCO
  - State Hospital
  - Public Employees Benefit Board
  - Oregon Education Benefit Board
  - Department of Corrections
  - Youth Authority
  - Local governments health clinics and jails
  - Offer to other private entities
- Around 1.3 million state paid for lives, more with local governments
- Larger pool better purchasing power

(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

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Increase Purchasing Power of State

- Align formularies on certain high cost drugs.
  - Can be done administratively
  - Dramatically changes negotiating strategy
  - Requires CCOs, PEBB and OEBB to agree to statewide standards. Others may follow
  - Process to share rebates may need to be developed
  - Makes doctor's life easier

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Increase Purchasing Power of State

- Utilize 340B pharmacy network for certain high cost drugs
  - Can be done administratively
  - All payers could take advantage
  - Lowest prices in market
  - Doctor and pharmacy must be connected
  - Expensive specialty drugs most logical
  - Getting drug to patient may be problematic
  - Replenishment model to address location

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Increase Purchasing Power of State

- Establish state run specialty pharmacy for high cost drugs
  - Can be done administratively
  - All payers can be included
  - May require a RFP
  - Issue around mandating use for FFS
  - Removes pharmacy mark-up
  - Some purchasing power advantage
  - Better utilization controls

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Increase Purchasing Power of State

- Build a state run PBM
  - May require legislative change
  - All payers may be included
  - State builds contract, entities would contract using state terms.
  - Some increase in purchasing power (won't solve Solvaldi problem)
  - Pharmacies will be nervous
  - Would lead to single statewide formulary
  - Rebates may continue to be issue

Discussion

- Are there other options?
- Which direction should we head?
- Who should be invited to play?
- Will any of these protect against the coming tidal wave?
- What will these save?
- How quickly can they be implemented?