State Drug Pricing Policy

Colorado

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May-18

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Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

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Colorado Summary

Total Medicaid Lives:	Nearly 1.3 million Coloradans enrolled in Health First Colorado (Medicaid); almost 24% of the total state population 429,000 eligible through ACA expansion
Annual Pharmacy Spending:	Medicaid prescription drug spending was over $919 million in 2016 or 11.4% of total Medicaid expenditures
Fee For Service or Managed Care State:	Predominantly a Fee For Service state with only 10% in capitated managed care plan
Single Preferred Drug List (PDL) or Multiple PDL:	A single PDL applies to FFS expenditures; For the 10% enrolled in managed care, plans can deviate from PDL but cannot be more restrictive.
Multi-state Purchasing Pool:	Colorado is not a member of a purchasing pool
Value-Based Payment (VBP) Initiatives	Colorado is actively pursuing VBP initiatives focused on aligning incentives to improve health outcomes and cost efficiencies.

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Overview: Medicaid Drug Rebate Program

- Congress enacted MDRP in 1990
- MDRP created the construct of a voluntary rebate agreement between the drug manufacturer and HHS
  - If manufacturer enters into a rebate agreement, they are assured coverage of their drugs by Medicaid and Medicare
  - States are *required* to include drug on their formulary
- Rebate agreement ensures that CMS and the states:
  - Receive a rebate on a drug's price – set in statute
  - Do not pay more than a brand name drug's "Best Price" in the U.S. market
- Feds and states split rebates according to the state's federal medical assistance percentage (FMAP)

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Colorado Medicaid & Prescription Drugs

Current pharmacy management	• Cannot mandate use of generics for certain drug classes (state statute) • PDL • Reliance on prior authorization • Quantity limits, dosing limits
Pursuit of tools to manage cost and improve health outcomes	• SPA language to be well positioned for APM development • Section 1115 waiver to give state ability to better manage drug benefit

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Medicaid §1115 Waivers

§1115 of the Social Security Act gives HHS Secretary discretion to approve state requests for:	• Waivers of certain Medicaid requirements and/or • Use federal Medicaid funds for costs that are not otherwise allowable
§1115 demonstrations allow flexibility to "demonstrate and evaluate policy approaches" by:	• Expanding eligibility • Providing services not covered • Improving care, increasing efficiency, or reducing costs
Other §1115 demonstration elements:	• Budget neutral or generate savings • Time-limited, usually 5 years, and can be renewed • Public notice/input, reporting & evaluation requirements

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Current State of §1115 Waivers

- Historically very limited use to waive MDRP
- Administration has expressed interest in alternative payment models for high cost drugs
- FY 2019 President's Budget proposed new Medicaid demonstration
  - Authorize 5-year demo to test state-level formularies
  - Up to 5 states
- Massachusetts §1115 Waiver
- Arizona §1115 Waiver

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Colorado Waiver Request Concept

- Overarching Goal: Achieve the best health outcomes through the best use of public funds
- Pursue Section 1115 waiver authority to:
  - Focus the pharmacy benefit on the most efficacious and cost-effective treatment options, while continuing to cover full range of therapeutic classes

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Physician- Administered Drugs

- Trend toward bundled payment structures such as EAPG and DRG
- High cost drugs in EAPG and DRG methodologies
- Payment Options
  - Keep rates as is
  - Build drug cost into EAPG
  - Carve out drugs
  - Stop Loss

PAD Reimbursement

- National Academy for State Health Policy (NASHP) grant to fund an initiative involving PAD reimbursement
- Current rate methodology for PADs is based on Average Sales Price (ASP)
- By contrast, pharmacy reimbursement is Average Acquisition Cost (AAC)
- Can we use a cost-based methodology to reimburse PADs?
- Grant supports a survey and report

Questions or Concerns?

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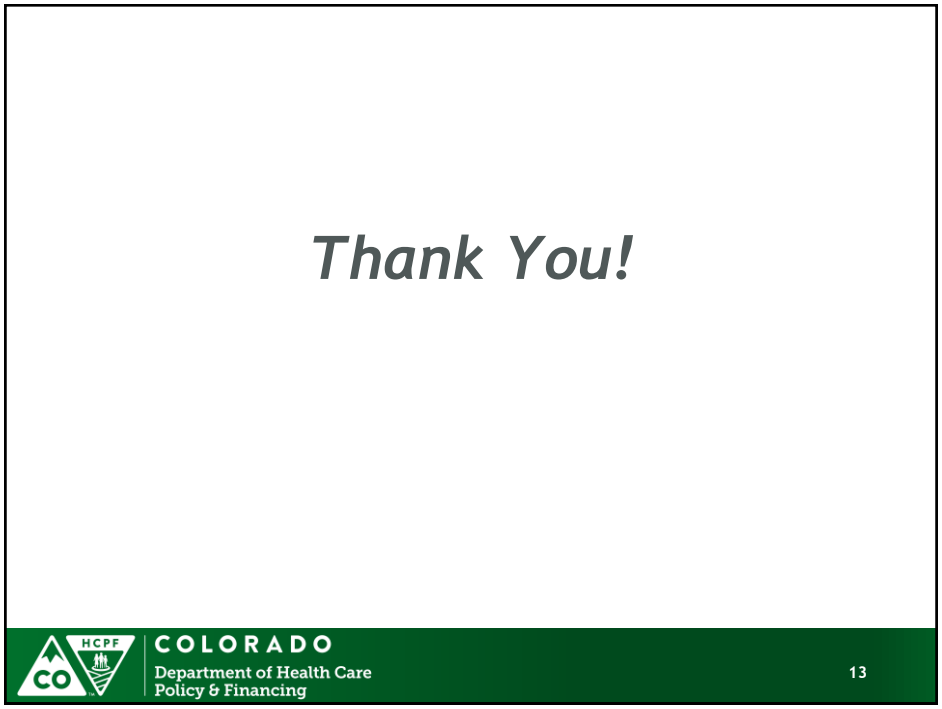
Thank You!
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