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February 1, 2016

Chairwoman Karen Spilka
Senate Committee on Ways and Means
State House, Room 212
Boston, MA 02133

Chairman Brian S. Dempsey
House Committee on Ways and Means
State House, Room 243
Boston, MA 02133

Senator James T. Welch
Senate Chair, Joint Committee on Health Care Financing
State House, Room 416A
Boston, MA 02133

Representative Jeffrey Sanchez
House Chair, Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

Mr. William F. Welch
Senate Clerk
State House, Room 335
Boston, MA 02133

Mr. Steven T. James
House Clerk
State House, Room 145
Boston, MA 02133

Dear Chairwoman Spilka, Chairman Dempsey, Chairman Welch, Chairman Sanchez, Mr. Welch, and Mr. James,

Attached is a report on potential Medicaid cost savings for prescription medications as required by section 182 of the Fiscal Year 2016 budget. I hope you find this report useful and informative. Please feel free to contact John May at 617-573-1763 should you have any questions about this report.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

MassHealth Report to the Legislature
Concerning Cost Savings on Prescription Drugs
February 1, 2016

LEGISLATIVE REQUIREMENT

Chapter 46 of the Acts of 2015 (the fiscal year 2016 budget) requires, in Outside Section 182, that "The office of Medicaid shall investigate and provide a report on potential cost savings for prescription medications including, but not limited to, the feasibility of joining a Medicaid multistate prescription drug bulk purchase consortium and pursuing new supplemental rebates from prescription drug manufacturers. The report shall include: (i) an update on existing supplemental rebates; (ii) recommendations to increase the amount of supplemental rebates received; (iii) estimated cost savings related to joining a Medicaid multistate prescription drug bulk purchase consortium; (iv) estimated administrative savings or other increased efficiencies related to joining a Medicaid multistate prescription drug bulk purchase consortium; and (v) opportunities for managed care organizations to receive similar rebates or discounts. The office shall file the report with the clerks of the house of representatives and the senate, the chairs of the joint committee on health care financing and the house and senate committees on ways and means not later than February 1, 2016." This report provides the information required by this section.

INTRODUCTION

MassHealth members who are enrolled in the MassHealth Primary Care Clinician Plan (PCCP) or in MassHealth fee-for-service (FFS) coverage receive their MassHealth prescription drug benefits MassHealth Pharmacy Program (also referred to in this report as PCC/FFS). MassHealth members who are enrolled in any of the six MassHealth participating managed care organizations (MCOs) receive their MassHealth prescription drug benefits through the MCO. These MCOs are responsible for coverage and payment of all medically necessary prescription drugs for their MassHealth member enrollees. This report addresses the PCC/FFS program for items (i) through (iv) and the MCO program for item (v).

MassHealth is continuously monitoring prescription drug costs and working to identify ways to reduce unnecessary cost while maintaining high quality of care. Both the PCC/FFS and the MCO pharmacy programs utilize a variety of industry-standard pharmacy management strategies including, but not limited to: utilization management techniques (e.g., formularies, prior authorization, step edits, and quantity limits); eligibility techniques (e.g., third-part liability cost avoidance); fraud/waste/abuse techniques (e.g., provider and member outlier profiling, overpayment recoveries, and opiate abuse surveillance); safety and clinical initiatives (e.g., duplicate therapies, polypharmacy, high dose limits, medication adherence, and care management referrals). All of these strategies contribute to significantly reducing unnecessary costs related to prescription drugs for the Commonwealth.

A condition to Medicaid coverage of manufacturer's drugs is that the drug manufacturer must enter into an agreement with the federal government to participate in the federally-mandated Medicaid drug rebate program as established by the Omnibus Budget Reconciliation Act of 1990 and modified by the Affordable Care Act in 2010. The federal statutorily-established Medicaid drug rebate program was intended to ensure state Medicaid programs receive the "best price," in the form of rebates, for prescription drugs compared to non-federal government purchasers. The rebate revenue must be shared with the federal government. In addition, state Medicaid agencies may enter into agreements for supplemental drug rebates with drug manufacturers which are over and above the federally-mandated rebates, subject to obtaining necessary approvals from the Centers for Medicare and Medicaid Services (CMS), including approval of the state's supplemental rebate agreement template (SRA template). States must also share the supplemental rebate revenue with the federal government.

In FY15, total pharmacy spending (the gross amount paid to pharmacies prior to any deductions for rebate or Federal Financial Participation) for the PCC/FFS program was $640,369,760. Gross rebate invoices to manufacturers in FY15 for the PCC/FFS program were $320,830,659. These rebates represented 50.1% of total pharmacy spending. By comparison, a 2011 federal report found that the national state Medicaid program average for rebates as a percentage of pharmacy spending was approximately 45%.[1]

The total gross rebate revenue invoiced to manufacturers in FY15 for all MassHealth Pharmacy programs, including both PCC/FFS and MCOs, was $591,069,186.

[1] Office of the Inspector General Department of Health and Human Services. Higher rebates for brand-name drugs result in lower costs for Medicaid compared to Medicare Part D. In: Office of the Inspector General Department of Health and Human Services, editor. http://oig.hhs.gov/newsroom/spotlight/2011/rebates.asp 2011.

SUPPLEMENTAL REBATES – CURRENT (i)

MassHealth solicits supplemental rebates in selected therapeutic classes in order to optimize the return to the Commonwealth. Once these opportunities are identified, MassHealth procures supplemental rebate agreements through a competitive bidding process. MassHealth currently has four supplemental rebate agreements in place[2], is evaluating bid responses from a fifth solicitation, and has five additional bid solicitations in preparation. The annualized gross value of the current supplemental rebate agreements is approximately $25 million. Please note that supplemental rebates fluctuate in value based on several exogenous factors, including the amount of the standard federal rebate, the price of the drug, and the volume of utilization. These somewhat unpredictable factors make supplemental rebate projections imperfect.

The MassHealth SRA template was last updated and approved by CMS in 2012. The CMS-approved template authorizes MassHealth to obtain supplemental rebates for prescription drugs covered for MassHealth members through the PPC/FFS program; it does not currently allow for supplemental rebates for drugs covered through an MCO. Modifications to the SRA template must be approved by CMS and are achieved through a process known as a State Plan Amendment (SPA). Although the SRA template requires CMS approval, individual agreements entered into using the template do not require separate approval.

SUPPLEMENTAL REBATES – RECOMMENDATIONS (ii)

In the near term, MassHealth is exploring opportunities to solicit supplemental rebate agreements from manufacturers. Examples of recent new supplemental rebate agreements secured by MassHealth include the epinephrine autoinjector EpiPen (April 2015) and the hepatitis agents Harvoni and Viekera (June 2015). MassHealth also has an agreement pending for the buprenorphine/naloxone product Suboxone that, when finalized, will be retroactive to January 1, 2016. MassHealth is also actively exploring opportunities to increase the number of agreements and the accompanying revenue by pursuing two areas identified by the Legislature: joining a multistate supplemental rebate cooperative (iii), and extending supplemental rebate agreements to include the MCO book of business (v). These concepts are addressed below.

MULTISTATE COOPERATIVES FOR SUPPLEMENTAL REBATE (iii)

Introduction: All insurers (public and private) who provide a pharmacy benefit must have several components to their pharmacy programs: Pharmacy network enrollment/management; claims processing; rebate invoicing/collection; formulary (which Medicaid programs often call a Preferred Drug List or PDL) development and management; prior authorization services; and clinical/provider call center. Many of these services are contracted out to one or several companies, typically a Pharmacy Benefit Manager or Administrator (PBM or PBA). For the MassHealth PCC/FFS program, MassHealth contracts with Xerox State Healthcare for network, claims, and rebate invoicing services, and utilizes University of Massachusetts Medical School for formulary, prior authorization, and clinical services. A limited number of companies (Xerox, Magellan, Goold, and Hewlett Packard) in the U.S. provide PBM/PBA services to state Medicaid agency fee-for-service programs.

[2] MassHealth also has a rebate agreement in place for diabetes test strips (which is not technically a supplemental rebate agreement, since it is not a drug).

Cooperatives: The three existing multistate cooperatives are affiliated with Magellan and Goold. These three cooperatives are:

- The Optimal PDL Solution (TOP$) – operated by Magellan
    - 8 states participating
- National Medicaid Pooling Initiative (NMPI) – operated by Magellan
    - 11 states participating
- Sovereign States Drug Consortium (SSDC) –operated by member states in cooperation with Goold; administered by the Department of Vermont Health Access (DVHA)
    - 10 states participating

TOP$ and NMPI: The cooperatives operated by Magellan are similar to each other but have slightly different supplemental rebate agreement contract duration terms and PDL development strategies. Magellan is a full-service PBM and typically offers the supplemental rebate agreement services as part of its suite of PBM services to its client states. Participating in either TOP$ or NMPI would require contracting with Magellan, which may involve additional administrative changes and costs.

SSDC: operates as a membership organization administered by an office in Vermont state government. Although Goold is also a full-service PBM, it provides technical and contracting support as a subcontractor to SSDC. Participating in SSDC would require enrolling as a member state in SSDC.

Joining any of the above cooperatives would also require CMS approval for a State Plan Amendment.

Potential Savings: Magellan reports participating states gain supplemental rebate revenue amounting to 3 to 6 percent of their gross pharmacy spend, while SSDC reports member states gain 4 to 5 percent of their gross pharmacy spend through supplemental rebates. MassHealth projects that its 11 current supplemental rebate agreements, when fully actuated, will produce $29 million gross annual revenue, which is approximately 4.4% of the projected spend for PCC/FFS pharmacy in FY17. While this figure is comparable to the Magellan and SSDC results, there may be potential upside benefit to MassHealth by joining one of the cooperatives since these may enable more ready access to supplemental rebates on a wider range of drug products, while allowing MassHealth to retain its existing agreements if they are more favorable than what is available through the cooperative. MassHealth has begun discussions with the cooperatives to evaluate whether there are additional savings to be gained.

Note: Strategies that reduce drug utilization or shift utilization to lower cost drugs generally diminish the potential to obtain large supplemental rebates. Consequently, one cannot automatically assume that higher supplemental rebates represent better pharmacy cost management. As part of deciding whether to pursue this option, MassHealth will need to assess the overall impact of the menu of rebate offerings in a multistate cooperative compared

to the rebate offerings and other savings we are able to achieve independently. This information is not publicly available, but MassHealth plans to pursue this information through discussions with the cooperatives.

MULTISTATE COOPERATIVES – ADMINISTRATIVE COSTS (iv)

The cost of joining a Magellan administered cooperative is not publicly available but could be discovered through a bid and negotiation process. As noted earlier, Magellan typically integrates the supplemental rebating services with its other PBM services. SSDC operates on a different business model, and its costs are publicly stated. SSDC requires a one-time accretion fee of $12,000 and an annual membership fee of $20,000. Certain other analytic and reporting services are available for an additional fee.

An advantage to joining a cooperative is the efficiency of an annual presentation of a menu of contracts the Commonwealth could decide to pursue. However, because of the requirement to establish MassHealth specific contracts for each supplemental rebate agreement, joining a multistate cooperative may not result in significant administrative savings for ongoing rebate contracting activities. MassHealth has begun discussions with the cooperatives to validate the relative potential administrative savings versus costs.

SUPPLEMENTAL REBATES – MANAGED CARE ORGANIZATION OPPORTUNITES (v)

MassHealth is in the process of updating its current SRA template to include the option of obtaining supplemental rebates on drugs covered through MCOs and plans to submit a SPA amendment for CMS approval. As noted above, the three cooperatives also address MCO pharmacy purchases in their SRA templates. Presently, there is little experience with supplemental rebates for MCO-paid pharmacy claims and no published data.

If the potential return from supplemental rebates for FFS programs (i.e., 3-6% of the spend) applies to MCO programs, then additional revenue could be available through MCO supplemental drug rebates, but this would be offset by foregoing revenue from some of the separate rebate agreements MCOs currently have in place. MCOs historically and currently receive rebates on pharmacy claims. These rebates are not supplemental rebates obtained by the state, but are rebates negotiated directly by the plan or by the plan's PBM, and are retained by the plan or PBM. Rebates that accrue to the plan are reported to MassHealth and are considered by MassHealth's actuary in the development of actuarially sound rate ranges. The imposition of additional, or different, rebates negotiated by the state rather than (or in addition to) the plan or its subcontractor could potentially impact the rebate revenue stream currently enjoyed by the MCOs. It is unclear what the net impact of applying the state's supplemental rebates would be on the MCOs' total rebate revenue and therefore on the actuarially sound rates that MassHealth is required to pay to the MCOs. MassHealth is working with its MCOs to conduct this analysis.

In addition, the MCOs operate under a different governance structure than the PCC/FFS program and consequently have different infrastructure and oversight than the PCC/FFS program. Formulary decisions by an MCO must be ratified by a Pharmacy and Therapeutics Committee and must comply with Division of Insurance rules, among other requirements. Extending state negotiated supplemental rebates to also include MCO-covered drugs would require harmonization of the various formularies or PDLs operated by the 7 plans (6 MCOs

plus PCC/FFS) within the regulatory framework. This is a complex undertaking by MassHealth in cooperation with its contracted MCOs. MassHealth has initiated these discussions with its MCOs and will continue them.

CONCLUSION:

MassHealth has re-invigorated its supplemental rebate program under the current administration and has achieved significant increases in rebate revenue as a result. MassHealth has been investigating joining a multi-state Medicaid rebating cooperative since the end of FY15 and continues to actively pursue this option. MassHealth expects to complete its analysis of the rebating cooperative opportunity by the early part of state fiscal year 2017. MassHealth is also taking steps to allow for the opportunity to negotiate rebates across books of business, including the PCC/FFS and MCO programs, in order to leverage the full purchasing power of MassHealth payers. MassHealth intends to continue pursuing more supplemental rebate opportunities as identified in this report as part of a broader strategy to contain costs, maintain high quality of care, and ensure the sustainability of the MassHealth program.