Green Mountain Care Board
Prescription Drug Technical Advisory Group
December 14, 2020 Meeting Minutes

Attendance (Group Members and GMCB)
Jill Abrams, Assistant Attorney General & Director, Consumer Protection Division, Vermont Office of the Attorney General
Nate Awrich, Director, Pharmacy Supply Chain, UVMHN
Ena Backus, Director of Health Care Reform, AHS
Debbi Barber, R. Ph, VP of Managed Care Contracting & Payor Relations, Kinney Drugs
Emily Brown, Director of Rates and Forms, DFR
Devon Green, Vice President of Government Relations, VAHHS
Jeff Hochberg, Director, Smilin Steve Pharmacy Group & President of Vermont Retail Druggists
Nancy Hogue, Pharm. D., Director of Pharmacy Services, DVHA
Jim Hopsicker, Sr. Leader, Health and Pharmacracy Management, MVP Health Care
Helen Labun, Director of Public Policy, Bi-State Primary Care Association
Brian Murphy, Director of Pharmacy & Vendor Management, BCBSVT
Robin Lunge, Board Member, GMCB
Kevin Mullin, Chair, GMCB
Christina McLaughlin, Health Policy Analyst, GMCB
Lindsay Kill, Healthcare Data and Statistical Analyst, GMCB
Abigail Connolly, Executive Assistant, GMCB

Others Present
Kaili Kuiper, HCA
Eric Schultheis, HCA
Laura Pelosi, MMR
Jennifer Kaulius, UVMHN
Theodore Studdert-Kennedy, Otis & Kennedy, LLC
Lisa Hurteau, DVHA

Welcome & Introductions

Group members introduced themselves and Christina McLaughlin explained the goal of this advisory group is to propose to the legislature state solutions to help control prescription drug costs in Vermont. All materials and meeting information relating to the GMCB Prescription Drug Technical Advisory Group, please visit the Group's webpage here.

Vermont Medicaid Cost Containment Strategies
Nancy Hogue, Director of Pharmacy Services, DVHA

Nancy Hogue presented an overview of Medicaid's Prescription Drug Cost Containment Initiatives. Nancy shared Medicaid's drug spend for all pharmacy claims (including VPharm) and Medicaid Claims for FY 2019 versus FY 2020. Nancy noted that drug spend has trended upwards in terms of gross expenditures and drug spend is relative to the enrollment numbers, but you need to look at the PMPM to know how much was really spent per member. The rebates collected by Medicaid are also trending upward, which is mainly contributed to the federal rebate program because that is structured to provide a high-level of protection for Medicaid programs when drug prices increase. Nancy explained Medicaid serves a very young population mostly and tends to see the drugs that are attributable to that population, such as substance abuse disorder, ADHD, asthma, and high-risk children. The number one

drug spend for the past eight years has been for substance use treatment drugs. Nancy outlined the Hepatitis C treatment trend for 2020 on slide 6 and noted that there was a significant decline due to the COVID-19 pandemic this past year. Medicaid has seen a decline in short-acting and long-acting opioid drug utilization trends even when the claims volume is normalized per 1000 members per month to take variability out of the data for changes in enrollment. This data is also consistent with what the Department of Health is showing.

Nancy explained Vermont Medicaid spent about $11.5M gross for insulin this past year for over 13,000 prescriptions. While the gross cost per prescription is $832, Medicaid's copays range from $1-$3 with an average insulin copay of $2.38. Due to the way it is calculated, the newer insulin formulations have a higher net cost and most older products have higher rebates. When a brand drug first comes on the market, all drugs start with a base rebate of 23.1% of the Average Manufacturer Price (AMP), which is generally the price a manufacturer sells to a wholesaler. If a manufacturer raises the price of the drug faster than the rate of inflation, then there is a CPI calculation. The rebates increase if the drug's cost increases faster than inflation, which is based on CPI, or if the CMS rebate goes up based on the "best price" given to private companies. For FY 2020, 26.7% of Medicaid's drug spend is for specialty drugs, which was about $52M for gross paid. Nancy explained that specialty drugs have such a high impact because the average cost is so high.

For cost control strategies, Medicaid does not have the same tools other payers have. To shift utilization, they have preferred and non-preferred drug lists, step therapy, and quantity limits. Medicaid also uses supplemental rebates, which are negotiated as a state, and Nancy reminded the group that Vermont belongs to the Sovereign State Drug Consortium (SSDC), which includes 13 states. Medicaid also has a pharmacy cost management program which is a program the PBM operates on Medicaid's behalf to coordinate patient care with the specialist pharmacy, prescriber, and the member. Pricing controls has to do with how Medicaid pays the pharmacies according to a benchmark that approximates the acquisition cost. Medicaid also has a State Maximum Allowable Cost (SMAC), and value-based agreements, which are essentially a supplemental rebate based on the clinical efficacy of the drug. Nancy quickly reviewed the new high cost and ultra-high-cost drugs, which are mostly specialty. In summary, DVHA has successfully managed net cost of drug benefit programs since implementing Preferred Drug Lists along with state, federal, and supplemental rebates, and is now more focused on containing physician-administered and specialty drug costs. For more information, please see the presentation here.

Follow-Up

- Is there a relationship between the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) and the SSDC?
- Could Vermont create a regional financing pool with other Northeastern states for genetic gene therapies?
- For Medicaid, what percentage of the dollars is the average prescription coming from (i.e., a breakdown of the bulk of claims)?

Public Comment

There was no public comment.