



Did You Know?

- The Oklahoma Medicaid program's state plan amendment for an alternative drug payment model, the first of its kind, was [approved by the Centers for Medicaid and Medicare Services in 2018](#).
- Researchers from the State Medicaid Alternative Reimbursement and Purchasing Test for High-Cost Drugs project, or [SMART-D](#), helped Oklahoma research and develop the amendment.
- Total Medicaid outpatient drug spending in the U.S., before rebates, [grew 39 percent from 2014 to 2017](#).

Fresh Approaches to Addressing High Drug Costs

BY JOHN ARMSTRONG AND COLLEEN BECKER

The high cost of prescription drugs is a top priority for state legislators and insurance regulators, as new treatments that promise better results drive costs higher. According to the [Kaiser Family Foundation](#), Medicaid spending on drugs has risen sharply in recent years. One reason is that a large number of new drugs being approved by the Federal Food and Drug Administration (FDA) come with high costs to insurance formulary budgets. In 2018, a total of 59 new drugs were [approved](#), including 34 novel drugs for rare diseases.

One solution for containing costs that has been gaining traction in recent years is value-based pricing (VBP) of pharmaceuticals. Value-based purchasing agreements are created when drug manufacturers and purchasers negotiate costs of a

drug based on patient health outcomes or financial incentives. These alternative payment models, or APMs, have emerged as a possible way to constrain the upfront costs of these new drugs if the manufacturer guarantees their effectiveness. In these agreements, health insurers negotiate with private pharmaceutical companies to receive rebates, discounts or other incentives based on a drug's effectiveness in treating a disease. These agreements can take many forms, such as:

- Insurers requiring clinical results for patients in exchange for an agreed-upon price
- Giving refunds for adverse events caused by the drug
- Lowering the price of a drug for each subsequent prescription refill.

Alternative payment models may not directly affect consumer spending but are crafted as a top-down solution to manage insurers' overall health plan costs by adding new and more effective drugs to formularies (the list of approved treatments). The aim of these arrangements is to determine the benefits of specific drug treatments and set prices accordingly. For example, if a blood pressure drug does not perform as expected, the insurer would be entitled to additional rebates.

There are many types of APMs that determine what an insurer ultimately pays for a drug. Pricing can be based on the volume of drugs sold, the amount that the insurer is willing to pay, the clinical benefit in treating patients without negative side effects, or how the drug is being used in a patient's specific treatment plan. In these agreements, insurers have the goal of reducing costs and improving outcomes while manufacturers have the goal of gaining access to formularies and selling more of their product.

Insurance companies and pharmaceutical manufacturers must collaborate for months on these complex agreements because they involve massive amounts of health systems information, data collection and analysis. Since large quantities of patient data must be analyzed to successfully negotiate APM contracts, a significant investment by insurance companies is needed to build the necessary data collection infrastructure.

There are also many uncertainties about the legality of creating APMs. These include whether they would affect Medicaid's "best-price" rules for drug rebates by changing the lowest price paid in the market and whether they might count as illegal information sharing between pharmaceutical and insurance companies amounting to collusion. They might even be construed as "kickbacks"—gifts of monetary value from pharmaceutical companies to persuade insurers to use their drugs.

State Action

While there are already multiple private APM agreements, state Medicaid programs have recently started experimenting with their own value-based purchasing contracts for prescription drugs to control increasing state budget costs.

To begin the process, state Medicaid programs must apply for and receive approval from the Centers for Medicare & Medicaid Services (CMS). A state can submit a Medicaid [state plan amendment for CMS approval](#) or apply for a [Section 1115 waiver](#) that allows them to experiment with budget-neutral strategies that improve their health system.

In 2018, Oklahoma was the first state to have a [state plan amendment](#) approved by CMS. Researchers at the Center for Evidence-Based Policy's State Medicaid Alternative Reimbursement and Purchasing Test for High-cost Drugs (SMART-D) project aided in the process. SMART-D is an initiative that analyzes the options available to state Medicaid agencies to purchase and pay for high-cost specialty drugs under current federal law. Oklahoma's APMs cover four drugs: two long-acting antipsychotics, one intravenous antibiotic and one medication that manages epilepsy. Expected outcomes include reducing costly hospitalizations and improving medication adherence.

Although APMs have generated considerable interest, [according to Nancy Nesser](#), the pharmacy director of the Oklahoma Health Care Authority, the process of creating them was challenging. She told NCSL it took months to negotiate with drug manufacturers, who had little incentive to take on the risks associated with these contracts. Additionally, both sides had difficulty agreeing on the relevant health outcomes and measures to use, as well as how to define the value of each drug. With contracts now in place, an analysis of the results is due to be released in early 2020.

Not all state plan amendments or waiver requests receive CMS approval. For example, Massachusetts' [waiver](#) request to create a closed formulary that excluded coverage of certain drugs was recently denied because of conflicts with federal drug rebates.

Still, other states are exploring APMs. In November 2018, Michigan's [request](#) for a state plan amendment to create APMs with drug manufacturers was approved by CMS, though the details of that agreement are still being negotiated. Colorado followed Michigan in being the third state Medicaid program to [gain approval to negotiate supplemental rebates through APM contracts](#) in February 2019.

Federal Action

The Affordable Care Act took some of the first steps in promoting value-based (instead of volume-based) health care, such as providing bonus payments to physicians who provide quality care. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) also laid additional groundwork for APMs for providers who want to create innovative payment models. MACRA created the [Quality Payment Program](#), which oversees multiple value-based risk-sharing agreements that reward hospitals and physicians for high-quality care. This program focuses on providers and is not yet in the realm of drug purchasing.

Additional Resources

- [CMS Alternative Payment Models](#)
- [NCSL report, "Value-based Insurance Design"](#)
- [State plan amendments for alternative payment models, National Academy for State Health Policy](#)

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