Rhode Island Health Care Cost Trends Steering Committee

September 21, 2023

Welcome

Agenda

1. Welcome
2. Approval of June Meeting Minutes
3. Co-Chair Update
4. Draft Pharmacy Legislation
5. VBP Subgroup Review of Compact Targets
6. CMS' AHEAD Model Announcement
7. Public Comment
8. Next Steps and Wrap-up

Approval of Meeting Minutes

Approval of Meeting Minutes

- Project staff shared minutes from the June 27th Steering Committee meeting in advance.
- **Does the Steering Committee wish to approve the June meeting minutes?**

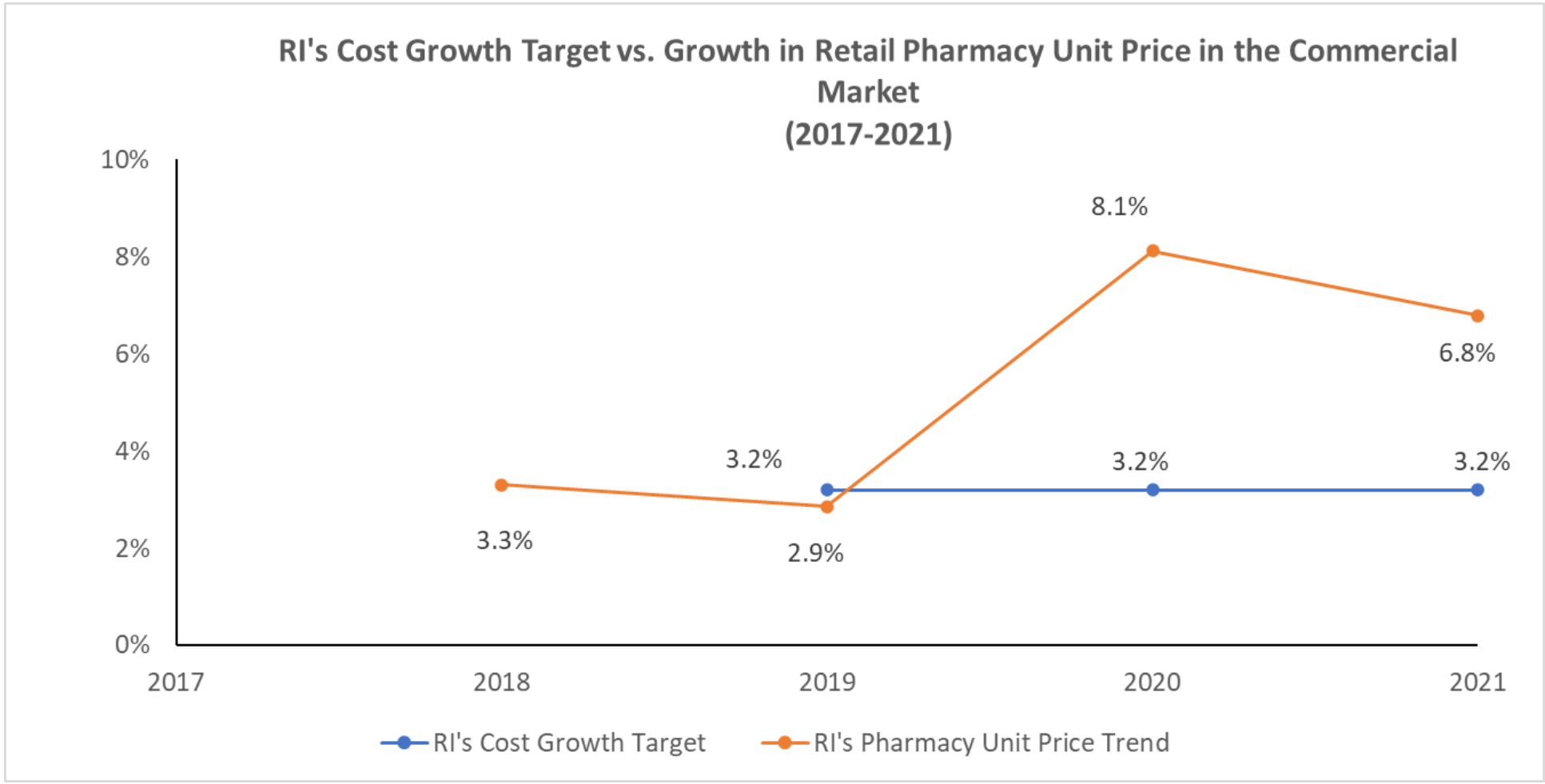
Co-Chair Update

New Cost Trends Co-Chair

- Effective immediately, Dr. Ed McGookin (President of Coastal Medical) joins Michele Lederberg and Cory King as co-chairs of the Cost Trends Steering Committee.
- Dr. Ed McGookin has spent 25 years at Coastal Medical, where he has a long track record at Coastal Medical of using data to improve primary care delivery and outcomes.
- Please join us in welcoming him to the Steering Committee.

Draft Pharmacy Legislation

Growth in Unit* Prices for Prescription Drugs Far Exceed the Cost Growth Target…



*Note: The 'unit' measure is a 30-day supply.
Source: Analysis of Rhode Island's All-Payer Claims Database

Why Constraining Drug Prices is Key to Affordability

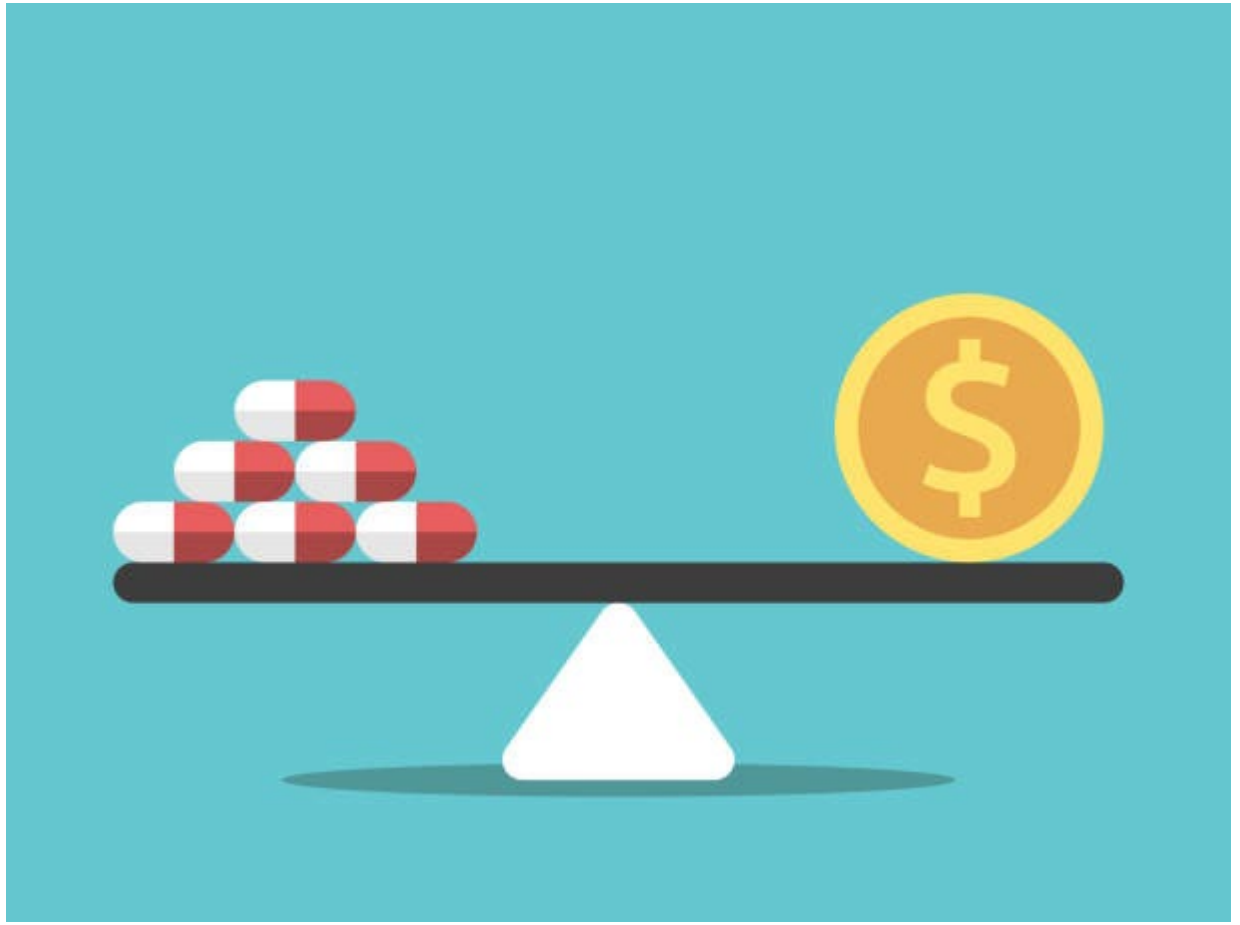
- 21% of Rhode Islanders (aged 19 to 64) reported **not filling** or **following a prescription** because of cost during a 12-month period.
- Patients are foregoing treatment or delaying retirement due to drug cost.
  - From the *NY Times*: "…(one patient)…plans to **delay her retirement** because she is worried about Humira's cost…The cost was **$88,766** in the past year."
  - Another patient "stopped taking Humira because of its price. She now relies on **free samples of a different drug**".

Source: "How a Drug Company Made $114 Billion by Gaming the U.S. Patent System", *New York Times*, January 28, 2023.

Why Constraining Drug Prices is Key to Affordability

Let's examine the price of Stelara*, a medication that treats Crohn's disease and psoriatic arthritis.

- In Rhode Island, the price of one 30-day equivalent (i.e., one month supply) of this medication is **$13,091.**
- This is HIGHER than one year of full-time family childcare for an infant in 2020 **($11,700)**.**



*Note: This reflects the unit price of Stelara based on analysis of Rhode Island's APCD data.
**Source: https://info.childcareaware.org/hubfs/State%20Fact%20Individual%20Sheets/Rhode%20Island.pdf

Pharmacy Activity Between 2019 and 2021

- From 2019 through 2020, OHIC and the Committee:
  - worked with Brown to perform APCD analyses that revealed increases in medical spending were influenced by retail and medical pharmacy cost growth, almost all of which was due to price increases,
  - engaged Trish Riley of NASHP, who presented two recommended pricing strategies: (1) penalizing manufacturers for unsupported price increases, and (2) international reference pricing.
- In 2021, participants voted to recommend legislation to address unsupported pharmacy price increases, but the recommendation was not acted upon.
  - Hospital representatives did not support the legislation, expressing concern with the impact on the prices hospitals are able to charge after purchasing discounted drugs under the federal 340B program.

Pharmacy Activity in 2023

- Due to the Committee's competing priorities (e.g., VBP), efforts to pursue a pharmacy cost mitigation halted between mid-2021 and late 2022.
- Earlier this year, the Steering Committee agreed to prioritize pursuit of a pharmacy cost mitigation strategy for 2023. This was informed by Rhode Island data that show that pharmacy costs have been a significant driver of spending growth in the state.
  - For example, analyses of the state's APCD showed that retail price paid per unit in the RI commercial market has grown at an 11.5% annual rate in just 2019 through 2021.
- During the summer months, OHIC has continued to manage two workstreams: 1) the cross-state pharmacy work group, and 2) the Steering Committee's 340B work group. We will now share information on both.

Multi-State Pharmacy Workgroup (1 of 2)

- In May, OHIC convened interested cost growth target states to develop a coordinated strategy on pharmacy price legislation.
- It did so in recognition of the fact that many states (through their APCD analyses) have identified pharmacy prices as a significant driver of cost growth.
- The Steering Committee has previously expressed support for a joint effort across states (and for RI, with its New England neighbors, MA and CT).

Multi-State Pharmacy Workgroup (2 of 2)

- OHIC held five monthly meetings between May and September. During these meetings, participants:
  - reviewed potential approaches under both a reference-based payment strategy and a price growth cap strategy, and
  - raised important considerations under both sets of strategies (e.g., data transparency provisions for the drug manufacturers on the number of drug sales in a state).
- Ultimately, OHIC drafted a legislative package containing proposals under both strategies to ensure some level of alignment with efforts in CT and MA.

340B Workgroup Goals and Objectives

- The Steering Committee previously supported the formation of a work group of 340B subject matter experts. To that end, OHIC convened a 340B Workgroup* twice during the summer. The main goals of the workgroup were to:

1. identify impacts the proposed legislative solutions would have on 340B drug discounts and pricing, and
2. recommend modifications to legislative proposals to mitigate their impact on 340B Covered Entities.

- Workgroup members provided feedback on both proposals, but wished to clarify that their feedback did not imply support for the proposals.

*The following organizations were represented in the Workgroup: Care New England, the Hospital Association of RI, Lifespan, Neighborhood Health Plan of RI, the RI Business Group on Health, and the RI Health Center Association.

Takeaways from 340B Workgroup Discussions

PENALTY ON EXCESSIVE PRICE INCREASES

- The definition of what is considered an excessive price increase should consider provisions that already exist in 340B, Medicare, and Medicaid statute around price increases that exceed inflation.
- The workgroup pointed out that this proposal would lead to state prices diverging from national prices, and could negatively impact local pharmacies that don't have national contracts that could be used to offset losses in RI.
- Workgroup members felt it would be important to model potential impact 4 to 5 years out.

SETTING PAYMENT LIMITS

- Without an exemption, the proposal would erode Covered Entities' margins from 340B.
- Implementing a 340B exemption would be difficult, since identification of 340B status is done at the back end and exemptions would have to be known at point of sale.
- There were concerns about Covered Entities having to develop the infrastructure to comply with the proposal.
- Even with a 340B exemption, hospital representatives were concerned about the proposal's impact on hospital finances (e.g., on non-340B drugs).

Draft Pharmacy Legislation

- The following slides provide an overview of the main components included underneath each pricing proposal.
- These documents were largely informed by, and expand upon, NASHP's model legislations.

Components of the Proposal to Penalize Excessive Price Increases

- **Establishing the benchmark increase:** Uses CPI-U to establish allowable price increases
  - The benchmark increase would be defined as the Wholesale Acquisition Cost in the base (or reference) year, adjusted annually by CPI-U
  - CPI-U is used to limit price Medicaid increases through the rebate program, and Medicare prices increases through the Inflation Reduction Act
  - Increases in the Wholesale Acquisition Cost that exceed this benchmark would be considered excessive
- **Targeted drugs subject to the penalty:** All drugs sold in the state, except for those subject to the state payment limit
- **Penalty:** 80% of excessive price increase

Does the Steering Committee have any comments or feedback on this proposal?

Components of State Payment Limit Proposal

- **Benchmarks for determining the state payment limits** would be calculated as an average of the following:
  - To-be-negotiated Medicare "Maximum Fair Prices"
  - Average international prices from a limited number of OECD countries (TBD)
  - Direct federal purchaser prices, represented primarily by the VA paid prices
- **Targeted drugs subject to the state payment limit**: Medicare Part B and D drugs as determined by CMS pursuant to the Inflation Reduction Act (IRA) + a state-defined list of up to 50 top-spend prescription drugs, with physician-administered drugs phased in over time
- **Regulated transactions**: All in-state payer and purchaser transactions

Does the Steering Committee have any comments or feedback on this proposal?

VBP Subgroup's Review of VBP Compact Targets

Discussion from VBP Subgroup (1 of 2)

- In April 2022, 21 members and affiliates of the Steering Committee's Value-Based Payment Subcommittee voluntarily signed a compact, committing their organizations to accelerate the adoption of advanced value-based payment models in the state.

- The compact specifically calls for adoption of three payment models:
  - **hospital global budgets** for facility and employed clinician professional services;
  - **prospective payment for high-volume and high-cost specialty care providers** who are not employed by hospitals, and
  - **prospective payment for primary care**.

- The document also includes six targets with associated implementation dates.

Discussion from VBP Subgroup (2 of 2)

- The compact's preamble states:
  - *"We, the undersigned members of the Steering Committee, agree upon the following principles, action steps, and targets to accelerate the adoption of advanced BP models in Rhode Island…we agree that [OHIC] should reconvene the signatories of this voluntary compact…to revisit this compact to ensure effectiveness in advancing payment reform and supporting cost containment efforts in Rhode Island".*
- OHIC convened the VBP Subgroup for this purpose. This group met in July and August, focusing first on the targets related to **hospital global budgets** and **specialty clinician VBP**. It is scheduled to meet once more in October.
- Cory will now summarize the discussions of the VBP Subgroup.

CMS' AHEAD Model Announcement

AHEAD Model (1 of 2)

- On September 5th, CMS announced the States Advancing All-Payer Health Equity Approaches and Development Model ("AHEAD model").

- While most details won't be released until December 2023, CMS characterizes the AHEAD model as a voluntary total cost of care model which will "test state accountability for constraining overall growth in health care expenditures [by]…"
  - "focusing resources and investment on **primary care services**…"
  - "providing hospitals with a prospective payment stream via **hospital global budgets**…"
  - "addressing **health care disparities**…and the needs of individuals… by increased screening and referrals to community resources like housing and transportation".

AHEAD Model (2 of 2)

- CMS will issue awards to **up to eight states** (including those states with which CMS already has agreements: MD, PA, and VT). Each state will have the opportunity to earn up to $12M for state implementation.

- States may apply during two different application periods (the first will open in late fall 2023; the second in spring 2024) and elect to participation in one of three cohorts with staggered start dates and performance years.
  - The model will conclude for all state participations in December 2034.

- CMS held a webinar on an overview of the model on Monday, September 18th.

Public Comment

Next Steps and Wrap-up

Upcoming Meetings

- October: TBD
- Quarterly meeting cadence to begin in 2024