## Maintenance Level

# M2-ED Single Preferred Drug List

## Agency Recommendation Summary Text

The Health Care Authority (HCA) requests an increase of $122,922,000 ($36,347,000 GF-State) and 3.0 FTE in the 2018 Supplemental Budget to restore 85 percent of the assumed savings to be achieved through HCA implementing a single, standard preferred drug list (PDL) for the entire Medicaid population.

## Fiscal Summary

| Operating Expenditures | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|
| Fund 001-1 GF-State | $11,472,000 | $24,875,000 | $24,875,000 | $24,875,000 |
| Fund 001-C GF-Medicaid | $27,640,000 | $58,935,000 | $58,935,000 | $58,935,000 |
| **Total Cost** | $39,112,000 | $83,810,000 | $83,810,000 | $83,810,000 |

| Staffing | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|
| FTEs | 3.0 | 3.0 | 3.0 | 3.0 |

| Revenue | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|
| Fund 001-C GF-Medicaid | $27,640,000 | $58,935,000 | $58,935,000 | $58,935,000 |
| **Total Revenue** | $27,640,000 | $58,935,000 | $58,935,000 | $58,935,000 |

| Object of Expenditure | FY 2018 | FY 2019 | FY 2020 | FY 2021 |
|---|---|---|---|---|
| Obj. E – Goods & Services | $600,000 | $0 | $0 | $0 |
| Obj. N – Client Services | $38,512,000 | $83,810,000 | $83,810,000 | $83,810,000 |

## Package Description

**Background**

The enacted budget requires HCA to create, implement, operate and manage a single Medicaid preferred drug list (PDL) for both the fee-for-service (FFS) population and for implementation and use by HCA's contracted managed care organizations (MCO) who are providing medical care to the non-FFS Medicaid clients. A single preferred drug list also requires the alignment of all utilization management tools (e.g. prior authorization, quantity limits, step therapy, etc) across all programs. The budget proviso requires HCA to implement the single PDL by January 1, 2018 to maximize drug manufacturer "state supplemental rebates" (SSRs) for HCA Medicaid clients. The estimated savings assumed in the enacted budget to the state Medicaid program from expanding the current PDL to maximize manufacturer SSRs is $144,731,000, ($42,828,000 GF-State). Savings were based both on pharmacy benefit manager consolidation and a single, standard PDL, however the pharmacy benefit manager consolidation was lined-item vetoed. Although some savings may have been achieved by the pharmacy benefit manager

consolidation, it is unlikely to bring achievable savings up to the level assumed in the 2017-2019 biennium budget. For this reason, HCA has worked closely with Magellan to develop estimates and assumptions. The analysis indicates a more achievable savings of two percent rather than the original assumption of 10 percent.

To meet the new single PDL requirement, HCA signed a contract with a vendor to supply evidence-based drug monographs to be used by the Drug Utilization Review Board to create the PDL. HCA has also entered into a multi-state drug purchasing pool called TOP$ that offers pre-negotiated, manufacturer supplemental rebate contracts to state Medicaid programs who join the pool. Sufficient new funding was provided in the 2017-2019 biennium budget to accomplish these two necessary tasks as well as fund 3.0 additional FTEs to oversee and manage the required expansion of clinical and financial responsibilities necessary to produce and support a single Medicaid PDL for the entire State.

HCA has established a phased approach for implementing the single Medicaid PDL. January 1, 2018 HCA will require the contracted managed care plans to have a single PDL for thirteen drug classes. Additional drug classes will be added to the single PDL July 1, 2018 and January 1, 2019. Each week changes are made to the pool of drugs that are available for coverage, this includes new drugs to market, new generic drugs, new packaging of existing drugs, etc. HCA will need to communicate with the plan on how to cover these new drugs using the new PDL. Therefore, HCA intends to build an automated process to communicate the PDL changes to the MCOs and is working on a solution to that regard. There are several reasons for the initial phased in approach including:

- Short time-frame to create and implement a comprehensive PDL without major member and provider disruption;
- CMS requirement that capitated rates for the contracted managed care plans must be submitted to CMS 90 days before the beginning of the quarter for which they are effective.
- HCA was directed to carve the cost of the drugs out of the rate and create a process to reimburse plans for the costs of the drugs on a periodic basis. Phased implementation at six month intervals allows HCA adequate time to establish the new MCO capitated payment as more drugs are carved out of the MCO rate.
- Point of sale vendor is unresponsive to HCA's request to build an automated process to communicate the PDL requirements to the five contracted managed care plans.
- Costs for creating the automated process were not included in the budget appropriation;
- HCA must create an alternative method to produce a PDL file communicating changes to the PDL while we establish the long term automated process.

**Request**

This request proposes to restore 85 percent of the assumed savings; request $600,000 ($150,000 GF-State) to build the automated process, and obtain FTE authority for 3.0 FTEs as a technical correction. The budget step, SPDC Prescription Drug Costs, in the 2017-2019 biennium budget included the salary and benefits for these staff but not the FTE authority.

Joseph Whitley, Financial Services: 360.725.1303 or joseph.whitley@hca.wa.gov

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# Decision Package Justification and Impacts

## Performance Measure Detail:

**Activity Inventory**

H003 HCA Information Technology
H005 HCA National Health Reform
H007 HCA Take Charge and Family Planning Extension Clients
H008 HCA Children's Health Program Clients
H009 HCA State Program Clients
H010 HCA Apple Health
H011 HCA All Other Clients – Fee for Service – Mandatory Services
H012 HCA All Other Clients - Fee for Service - Optional Services
H013 HCA Supplemental Medicare Insurance Buy-In

## What specific performance outcomes does the agency expect?

This request ensures that HCA has secured the necessary positions for 3.0 FTEs to oversee and manage a much more comprehensive Medicaid PDL that will also be newly delivered through five independent MCOs as well as to HCA's current FFS recipients. This request also ensures that HCA is adequately funded for claims and premium payments so HCA will not exhaust the current appropriation and then be unable to pay pharmacies for recipient drug purchases or MCO plans for continued recipient coverage.

**Performance measures**

- Increased drug manufacturer rebate dollars for reducing total Medicaid drug expenditures
- Increased drug choice simplicity and improved care continuity for Medicaid patients
- Increased drug choice simplification and reduced administrative burden for prescribing providers

## What alternatives were explored by the agency and why was this option chosen?

The 2017-2019 operating budget, requires implementation and accrued savings starting on January 1, 2018. HCA considered several options for implementing the PDL.

1. Delay implementation of the single PDL until a comprehensive PDL was created by the Drug Utilization Review Board and there was a fully automated process to communicate weekly PDL changes to the contracted managed care plans.
    a. This option was not chosen because the work of creating a comprehensive PDL, aligning utilization management tools, making the necessary programming changes to the claims processing systems and effectively communicating the changes to members and providers was determined to be insurmountable for a successful January 1, 2018 start date. The possible risk of wide spread disruption in care and the inability of plans to respond to the volume of customer inquiries and requests for exceptions far out-weighed the potential increase in savings by starting January 1, 2018.

2. Implement a comprehensive PDL on January 1, 2018, using manual process to communicate weekly PDL changes until such a time an automated process was established.
    a. This option was not chosen for the same reason as listed above plus the additional risk of errors due to the use of a semi-manual process to communicate PDL changes to plans on a weekly basis.
3. Scale back implementation of the PDL on January 1, 2018 to a manageable number of drug classes targeting those classes with significant opportunity for savings using a manual process to communicate weekly PDL changes until such a time a fully automated process can be established.
    a. HCA chose this option because it could selectively target drug classes to implement January 1, 2018 that required little utilization management other than preferred or non-preferred consideration and also provided opportunity for savings through the collection of additional supplemental rebates. This option provided a "good-faith" effort for HCA to comply with the intent of the budget proviso while mitigating potential disruption in care to our members.

### What are the consequences of not funding this request?

HCA will be unable to establish an automated process for communicating weekly PDL changes to the MCOs and will be required to continue a semi-manual process with increased risk of errors that could reduce the opportunity for savings. HCA will run out of money to pay pharmacies or MCO plans for services delivered to state Medicaid recipients.

### How has or can the agency address the issue or need in its current appropriation level?

The current agency Medicaid appropriation is insufficient to cover projected future prescription drug expenses for Medicaid recipients. The agency also cannot address necessary system changes to fully automate the communication of the weekly PDL file to the health plans. Without obtaining the authority for 3.0 additional FTEs HCA will not be able to hire the appropriate staff necessary to oversee the creation, implementation and oversight of the PDL by the MCOs.

### Provide references to any supporting literature or materials:

http://www.magellanofnebraska.com/media/449178/p-31_single_formulary_white_paper.pdf

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## Base Budget

### If the proposal is an expansion or alteration of a current program or service, provide information on the resources now devoted to the program or service.

Currently, HCA Medicaid asks (by mail) drug manufacturers if they would like to provide a supplemental rebate to reduce the unit cost of their drug for 30 select therapeutic drug classes exclusively for the fee-for-service (e.g., non-MCO) Medicaid recipients. The new resources will allow the program to increase the number of drug classes eligible to receive supplemental rebates by three- or four-fold, and at the same time increase the number of Medicaid recipients eligible for the earning the manufacturer rebates by as much as four-fold.

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## Expenditure, FTE and Revenue Assumptions, Calculations and Details:

The expenditure figures represented in this request are derived from the updated savings assumptions achievable through HCA implementing a single, standard preferred drug list and operating as the single pharmacy benefits manager under the prescription drug purchasing consortium. The FTE request represents a technical adjustment for the salary and benefits funded in the 2017-2019 biennium budget devoid of FTE authority.

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## Impacts to Communities and Other Agencies

### Fully describe and quantify expected impacts on state residents and specific populations served.

Over 1.8 million Washingtonians who currently rely on Medicaid will be affected by this package because without additional funding they will be unable to have their MCO plan or pharmacy expenses covered. In addition, Washington State government will not fully benefit financially from overseeing and managing implementation and operations of State supplemental drug rebates from drug manufacturers.

### What are other important connections or impacts related to this proposal?

#### Does this request have?

| | |
|---|---|
| Regional/county impacts? | Yes ☒ No ☐ |
| Other local government impacts? | Yes ☒ No ☐ |
| Tribal government impacts? | Yes ☒ No ☐ |
| Other state agency impacts? | Yes ☒ No ☐ |

#### Does this request:

| | |
|---|---|
| Have any connection to Puget Sound recovery? | Yes ☐ No ☒ |
| Respond to specific task force, report, mandate or executive order? | Yes ☒ No ☐ |
| Contain a compensation change? | Yes ☐ No ☒ |
| Require a change to a collective bargaining agreement? | Yes ☐ No ☒ |
| Create facility/workplace needs or impacts? | Yes ☐ No ☒ |
| Contain capital budget impacts? | Yes ☐ No ☒ |
| Require changes to existing statutes, rules or contracts? | Yes ☒ No ☐ |
| Have any relationship to or result from litigation? | Yes ☐ No ☒ |

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### If "Yes" to any of the above, please provide a detailed discussion of connections/impacts.

The impacts of this package affect all Medicaid patients' use of specific prescription drugs, affects all Medicaid providers' choice of specific drugs for Medicaid patients, and impacts all the MCOs budgeting for prescription drug coverage of Medicaid patients covered by their plan. The proposal stems from a budget proviso in the 2017-2019 operating budget mandating the implementation of a single PDL for Medicaid. The proposal requires a State Plan Amendment to be submitted to CMS and that the contracts with MCOs be amended to reflect the terms and conditions of HCA's single PDL implementation.

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## Information Technology (IT)

### Does this request include funding for any IT-related costs, including hardware, software, services (including cloud-based services), contracts or IT staff?

☐ No 


☒ Yes Continue to IT Addendum below and follow the directions on the bottom of the addendum to meet requirements for OCIO review.)

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# 2018 Supplemental Information Technology Addendum

## Part 1: Itemized IT Costs

All costs are for contracted services provided by the P1 vendor CNSI.

| **Information Technology Items in this DP** (*insert rows as required*) | **FY 2018** | **FY 2019** | **FY 2020** | **FY 2021** |
|---|---|---|---|---|
| Vendor Costs - CNSI | $600,000 | $0 | $0 | $0 |
| **Total Cost** | $600,000 | $0 | $0 | $0 |

## Part 2: Identifying IT Projects

| | |
|---|---|
| Does this decision package fund the development or acquisition of a new or enhanced software or hardware system or service? | Yes ☐ No ☒ |
| Does this decision package fund the acquisition or enhancements of any agency data centers? (See OCIO Policy 184 for definition.) | Yes ☐ No ☒ |
| Does this decision package fund the continuation of a project that is, or will be, under OCIO oversight? (See OCIO Policy 121.) | Yes ☐ No ☒ |

If "Yes" to any of these questions, complete a concept review with the OCIO before submitting this budget request. Refer to chapter 12.2 of the operating budget instructions for more information.