Overview of the 340B Program & Insulin Utilization and Cost-Sharing in the Vermont Medicaid Program

Nancy J. Hogue, Pharm.D.
Director of Pharmacy Services, DVHA
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Agenda

- Brief Overview of 340B Program
- The Medicaid 340B Program Structure
- Insulin Utilization/Cost Share

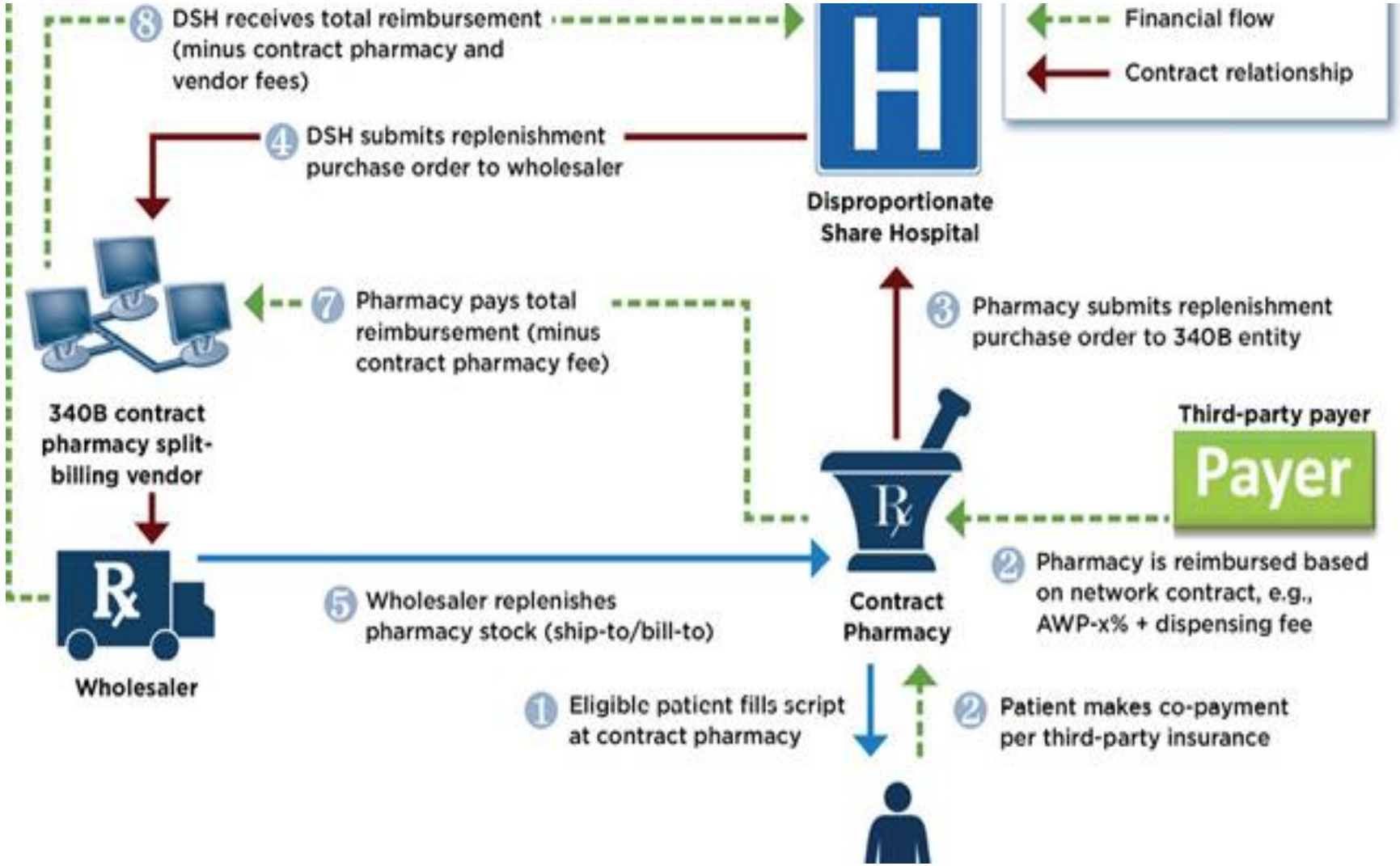
Creation of 340B Drug Discount Program

- The Medicaid Drug Rebate Program created by Omnibus Reconciliation Act (OBRA) of 1990
- Rebates paid to states based on a "best-price" calculations
- Did not consider the discounted prices or donated drugs that manufacturers were offering directly to federally funded clinics and public hospitals serving large numbers of low-income and uninsured patients.
- Continuing to offer these free or discounted drugs would have required the manufacturer to pass along that “best price” calculation to Medicaid.
- In 1992, Congressional hearings found that failing to exempt these voluntary discounts under the Medicaid Drug Rebate Program caused prices to rise significantly for these facilities.
- The Public Health Service (PHS) Act created the 340B program to help combat these unintended consequences.

340B Drug Discount Program

- Sets a statutory ceiling price for what drug manufacturers can charge 340B eligible health care providers, known as Covered Entities (CEs) for drugs provided to qualified patients.
- 340B ceiling price is set as difference between the drug's average manufacturer price (AMP) and its unit rebate amount (URA).
- HRSA calculates URAs based on the same formula used to calculate Medicaid drug rebates.
- HRSA allowed to disclose ceiling prices to covered entities but not to the general public.
- There is no "drug file" available to Medicaid containing 340B prices.
- Prime Vendor Program –Apexus negotiates additional discounts that are lower than the "ceiling price."

Typical 340B Drug Supply Chain-Contract Pharmacy



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Medicaid Rules and Guidance

- CMS requires states to develop specific 340B policies so that CEs are clear on how to participate with the state Medicaid program.
- CEs must assure that manufacturers are not charged a "duplicate discount".
- CEs must pass along their acquisition cost to states.
- Vermont Medicaid
  - Allows CEs to "carve-in" Medicaid through a special enrollment process.
  - Processes in place to avoid duplicate discounts
  - Must submit 340B acquisition cost
- Required to modify 340B in 2017 by CMS (Covered Outpatient Drug Rule 2345-FC)
- Also Legislative Report on 340B submitted May 2017
    - Removed DF for PADs and adjusted DF to align with COD Rule

Vermont Medicaid Enrolled CEs

HOSPITALS

- University of Vermont Medical Center
- Central Vermont Medical Center
- Southwestern Vermont Medical Center
- Springfield Hospital
- Rutland Regional Medical Center
- Brattleboro Memorial Hospital
- Fairview Hospital
- Berkshire Medical Center
- UMass Memorial Medical Center

HOSPITAL OUTPATIENT PHARMACIES

- UVMMC Outpatient Pharmacies (3)
- Rutland Regional Medical Center Pharmacy

FQHCs

- Community Health Center of Burlington INC
- Copley Professional Services Group DBA Community Health Services of Lamoille Valley
- Northern Counties Health Care
- Richford Health Center, INC.
- The Health Center (Plainfield)
- Northern Tiers Health Ctr for Health
- Notch Pharmacy
- Indian Stream Health Center

OTHER

- Planned Parenthood
- Other out-of-state entities are enrolled but have no utilization

Vermont Medicaid 340B Program

- Can present conflicts between a Preferred Drug List and 340B CE preferred products
- DVHA must monitor ceiling price submissions
- There is administrative burden on DVHA and CEs for reconciling the claims and avoiding duplicate discounts
- Impact on net cost to Medicaid is variable
- Currently repeating savings analysis

Vermont Medicaid - Insulin Utilization & Cost-Sharing

- Total Spend - $11.5 million (gross)
- 13,380 prescriptions per year
- $832 cost per prescription (gross)
- Medicaid co-payments are $1 - $3
  - No co-payments for children
  - Average co-payment is $2.38 for insulin
- Most older products have high rebates
- Newer formulations have higher net cost

"Shh. He's undergoing tweetment."

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