Report to the Office of the Legislative Fiscal Analyst

Report on High Cost Medications

Prepared by the Division of Medicaid and Health Financing

June 1, 2018

UTAH DEPARTMENT OF HEALTH

EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed in Senate Bill 3, Item 59 by the 2018 Legislature:

> The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by June 1, 2018 on the following: (1) What are our estimated costs to Medicaid currently from Medications that cost more than $10,000 per month? (2) What is the estimated cost to Medicaid of the 1 year carve out that they are proposing and exactly which year were they proposing for the carve-out? And (3) Report on the possible options for a waiver or state plan amendment in which Medicaid would identify families who have a child that is receiving one of these very expensive medications and if that medical condition is a known genetic condition that can be identified by in vitro fertilization then Medicaid would offer and cover in vitro fertilization services to those families so they would know that any subsequent children that they wished to have would not be afflicted with the same medical condition.

Item 1: What are our estimated costs to Medicaid currently from Medications that cost more than $10,000 per month?

Over 12 months (May 2017-April 2018), medications costing more than $10,000 per month (total gross costs[1]) were identified from Medicaid's prescription pharmacy data. Medications were included if they were considered "new to market" in the last 3 years. Medications were excluded if they were billed through the physician office (J-code, medical claims), or identified for the medication management of Hepatitis C or Cystic Fibrosis, which had funding appropriated specifically for them in prior periods.

A total of 21 unique medications accounted for approximately $5,754,500 in pharmacy costs (2.4% of total gross costs) over 12 months. More specifically, high-cost medications account for 1.4% of the FFS pharmacy total gross costs and 3.8% of MCO pharmacy total gross costs over the 12 months of this analysis.

The medications are from the following drug classes:

Drug Group	Total Revenue
HEMATOLOGICAL AGENTS - MISC.	$2,044,500
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	$1,733,600
ENDOCRINE AND METABOLIC AGENTS - MISC.	$1,413,800
ANTIDOTES AND SPECIFIC ANTAGONISTS	$324,300
CARDIOVASCULAR AGENTS - MISC.	$238,300
Grand Total	**$5,754,500**

[1] Total gross costs includes copays, third party payments and Medicaid payments.

The Department cannot easily identify the cost of medications administered during an inpatient hospital stay without obtaining detailed records from each facility. This is due to the fact that facilities bill based on a revenue code (without detail.)

Note: Gross costs, as presented, do not account for the additional manufacturer rebates that may be collected on these medications.

Item 2: What is the estimated cost to Medicaid of the 1 year carve out that they are proposing and exactly which year were they proposing for the carve-out?

The estimated cost to Medicaid of the one year carve out that was proposed for SFY 2019 is $1,173,100 (General Funds).

Item 3: Report on the possible options for a waiver or state plan amendment in which Medicaid would identify families who have a child that is receiving one of these very expensive medications and if that medical condition is a known genetic condition that can be identified by in vitro fertilization then Medicaid would offer and cover in vitro fertilization services to those families so they would know that any subsequent children that they wished to have would not be afflicted with the same medical condition.

The State plan Attachment 3.1-A, Attachment #4c, Page 1 FAMILY PLANNING SERVICES AND SUPPLIES includes limitation language stating in vitro fertilization (IVF) is excluded from coverage as a family planning service.

Staff requested guidance from the CMS Regional Office in Denver on this topic. The response noted:

> IVF infertility services would fall under 1905(4)(c)-family planning services. Family planning policy says that if a state covers infertility services, then you would need to offer it to everyone. Since you would be proposing to only provide to women with genetic conditions, then it would be viewed as a violation of comparability.

The CMS response overlooked that the actual proposal is to cover the genetic testing and IVF only for those genetic conditions with significant medication costs.

Since covering IVF for only certain individuals is not an option through a state plan amendment, the state would need to obtain approval from CMS for an amendment to Utah's 1115 Demonstration waiver to offer this coverage.

According to the Kaiser Family Foundation (Medicaid Coverage of Family Planning Benefits: Results from a State Survey, Sep 15, 2016), no state Medicaid agency covers fertility treatments including IVF.