Ohio Revised Code

Section 5164.7515 Annual benchmark for prescribed drug spending growth.

Effective: October 17, 2019
Legislation: House Bill 166 - 133rd General Assembly

(A) Not later than July 1, 2020, the medicaid director shall establish an annual benchmark for prescribed drug spending growth under the medicaid program. If the director determines that prescribed drug spending in a given year is projected to exceed the benchmark for that year, the director shall identify specific prescribed drugs that significantly contribute to exceeding the benchmark.

(B) For a prescribed drug identified by the director under division (A) of this section, the director shall determine if there is a current supplemental rebate for that drug between the drug's manufacturer and the department or its designee. If there is a current supplemental rebate for the drug, the director may renegotiate the supplemental rebate agreement. If there is not a supplemental rebate for the drug, the director shall evaluate whether to pursue a supplemental rebate agreement for the drug with the drug manufacturer. In making that evaluation, the director may consider any of the following:

(1) The prescribed drug's actual cost to the state;

(2) Whether the drug's manufacturer is providing significant discounts or rebates for other prescribed drugs under the medicaid program;

(3) Any other information the director considers relevant.

(C)(1) If the director determines that a prescribed drug rebate agreement renegotiation is warranted under division (B) of this section, the director shall establish a target rebate amount. In determining the target rebate amount, the director may consider any of the following:

(a) Publicly available information relevant to pricing the prescribed drug;

(b) Information the department has that is relevant to the pricing of the drug;

(c) Information relating to value-based pricing of the drug for medicaid recipients;

(d) The seriousness and prevalence of the conditions for which the drug is prescribed;

(e) The drug's volume of use among medicaid recipients;

(f) The effectiveness of the drug in treating conditions for which it is prescribed or improving a patient's health, quality of life, or overall health outcomes;

(g) The likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(h) The average wholesale price, wholesale acquisition cost, and retail price of the drug, and the cost of the drug under the medicaid program, not including any rebates received for the drug under the program;

(i) In the case of generic drugs, the number of manufacturers that produce the drug;

(j) Whether there are pharmaceutical equivalents to the drug;

(k) Any other information the director considers relevant.

(2) In negotiating a new rebate agreement under division (B) of this section, the director shall seek to negotiate an amount that is equal to the target rebate amount under division (C)(1) of this section. The director shall not enter into a rebate agreement that is less than sixty per cent of the target rebate amount. If no rebate agreement is established or renegotiated under this section, the director may consider removing the drug from the medicaid program's preferred drug list and imposing a prior authorization requirement on the drug in accordance with section 5160.34 of the Revised Code.

(D) The director shall publish a list of the prescribed drugs it identifies as being responsible for increasing spending above the annual benchmark for prescribed drug spending growth.