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Medicaid Pharmacy Report State of Idaho

MERCER

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and

Bureau of Care Management
Idaho Department of Health and Welfare

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About the Authors

Mercer Government Human Services Consulting has experience with over 30 Medicaid managed care programs covering in excess of 30 million Medicaid lives across the country. This report was completed by members of Mercer's Government Pharmaceutical Practice. This specialty pharmacy group within Mercer is devoted to understanding the Medicaid arena so as to best assist states in assessing needs and achieving targeted goals within pharmacy Medicaid programs. Mercer's Government Pharmaceutical Practice is staffed with four pharmacists and numerous consultants and analysts with a unique understanding of Medicaid programs and data.

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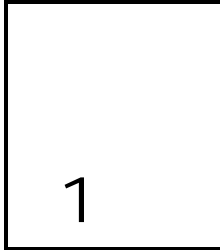
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Executive Summary

Background

Over the past few years, the Heinz Family Philanthropies has undertaken a number of groundbreaking studies assisting Governors and state legislators address the problem of skyrocketing prescription drug costs. At the request of Governor Kempthorne and the state legislature, the foundation provided the State of Idaho (State) with a grant to hire Mercer Government Human Services Consulting (Mercer) to perform a comprehensive analysis incorporating both a detailed examination of the State Medicaid pharmacy program and a concurrent study of the efficiency of provider practices within the State. This report exclusively presents the findings from the detailed analysis of the State's Medicaid pharmacy program completed by members of Mercer's Government Pharmaceutical Practice.

The situation in Idaho is not vastly different from what we have seen in other states — ever increasing costs that are significantly impacting the State's Medicaid budget. Solutions to address these increasing costs do exist, but also present a series of tough choices and decisions for legislators and policy makers. Our pharmacy consultant, Mercer, has identified several potential solutions, however, it should be recognized that certain programs overlap and affect similar therapeutic categories. Therefore, the cumulative savings may be mitigated, depending upon the programs that are implemented.

Medicaid expenditures for fee-for-service, outpatient prescription drugs have grown rapidly in recent years, motivating states to use various cost and utilization controls. In more recent years, this rise in prescription drug expenditures has also been accompanied by a decline in state revenue collections due to the economic situation. As a result, policymakers have been forced to consider how to contain the State budget, and therefore, Medicaid pharmacy programs have become a major cost containment target. Given the magnitude of budget deficits, many states are focused primarily on cost-containment strategies that produce immediate savings, such as reimbursement cuts, reductions in

services, and drug product selection through the use of preferred drug lists (PDLs). The bottom line is that States are confronted with a difficult challenge — how to achieve cost containment while maintaining adequate access and quality of care.

This independent analysis of the State's pharmacy program will serve to assess the current program structure and design, and assist the State's pharmacy department in the identification of additional opportunities to achieve further cost containment, without compromising the quality of care.

Approach

We completed this quality and cost-assessment analysis of the State Medicaid prescription drug program utilizing the following approach:

- documented current plan design, reimbursement arrangements with providers, and contractual arrangements with vendors;
- assessed and benchmarked findings and evaluated the performance of the pharmacy program;
- assessed Medicaid population characteristics and the effectiveness of the current pharmacy program;
- identified programmatic opportunities to strengthen the financial and quality aspects of the pharmacy program; and
- performed detailed analysis utilizing pharmacy claims data to forecast the impact of certain program recommendations.

We obtained benchmark data regarding other Medicaid pharmacy programs from public sources of information, Mercer's internal proprietary government pharmacy database, and discussions with contacts from other state pharmacy Medicaid programs. Additionally, we provided benchmark data and insight based on our experience and knowledge of best practices employed in the commercial sector in their management of the pharmacy benefit. To assist in forecasting the financial impact of particular program strategies, we utilized detailed pharmacy claims data supplied by the State, which included cost and utilization experience from January 2000 through November 2002.

Summary of Findings

In the ongoing effort to manage pharmacy expenditures and improve quality, we determined that the State's Medicaid pharmacy department has employed and follows a sound operational program. The pharmacy department is committed to understanding inefficiencies, identifying opportunities for cost containment, and driving towards a higher quality, more efficient program structure. Examples of this include the State's generic drug policy and procedures for the management of new generics, the State's monitoring and updating of existing contracts with external vendors for additional services and functionality, the recovery of Medicaid federal rebate funds, and the Enhanced Prior Authorization Program. In certain situations, State pharmacy staff have identified opportunities for improvement, but appear to be limited in their ability to make certain program modifications due to the current inflexibility within the claims processing

system. Based on discussions with State pharmacy staff, a majority of issues regarding current system inflexibility should be eliminated by December 2003 due to new requirements placed on the current claims processing vendor.

Although the operational program and committed resources within the Medicaid pharmacy department are sound, we did identify opportunities for consideration by the State. These opportunities are intended to achieve one, or a combination of, the following goals: cost containment, maintaining or improving quality, or alignment with best practices employed in other states, as well as best practices in the commercial sector. We understand the uniqueness and differences of a Medicaid pharmacy program (including regulations, patient mix, utilization patterns, and access issues) in contrast to that of a commercial pharmacy program, and understand the skepticism regarding the ability to replicate results in both of these environments. Therefore, in our analysis, we have given due consideration to the uniqueness of Medicaid program characteristics and to proven cost-containment strategies to identify only those opportunities that are likely to be successful in the public sector.

Summary of Opportunities

We identified the following opportunities:

- Currently, the State has a coverage policy that is considered standard and appropriate among Medicaid programs; however, we have recommended a few modifications that would mirror industry best practices.
- We believe the State has an adequate MAC program, but have identified additional opportunities to enhance this program.
- The reimbursement for brand name medications and the dispensing fees paid to pharmacies are not aggressive compared to current standards; we recommend various options for modification to the reimbursement formula.
- A number of opportunities exist for improvement in the retrospective drug utilization review (DUR) program.
- We recommend that the State improve the capture and entry of correct physician identifier information at the point-of-sale (POS) in order to improve the effectiveness of current and future DUR programs.
- We recommend the State enhance the clinical DUR edits at the POS.
- The State's pharmacy lock-in program is similar to programs enforced in other states; however, we believe there are opportunities to further enhance the methods utilized to detect and identify beneficiaries abusing the pharmacy benefit through reporting and profiling tools.
- Other opportunities for program enhancement address initiatives not currently implemented by the State, but identified as appropriate to achieve pharmaceutical cost control and/or improvement in the quality of care. These opportunities include such programs as dose consolidation, quantity limitations, specialty injectables, step therapy, and pill-splitting.

Those opportunities with the greatest potential magnitude of impact are presented in the table on the following page (Summary of Opportunities). An additional table of all

opportunities discussed in this report can be found in Appendix E, beginning on page 98. Some of the identified opportunities appearing in Appendix E are only focused on quality issues and therefore savings cannot be estimated; other identified opportunities may only result in minor or no cost savings for the State but are presented as considerations to align the Medicaid program with industry best practices.

Based on our analysis, the opportunities with the greatest potential are presented in the table on the following pages. However, it is important to recognize that estimated savings achievable from these opportunities are not always considered cumulative due to the overlapping nature of many of these initiatives. Additionally, since the inception of this study, the State may have implemented some of these initiatives, thereby further reducing the projected savings. Finally, opportunities that could or will result in a change in reimbursement to pharmacies must be evaluated individually, as well as from a global perspective. In particular, decisions that impact provider reimbursement must take into consideration political palatability and cumulative cost savings balanced against retention of adequate access to providers and services.

In addition, because of potential political pressure that may result if some or all of these changes are accepted, the governor and state legislators must determine which, if any of these changes, are acceptable to the public. In the end, however, these kinds of changes must be considered if states are going to have the ability to more effectively control skyrocketing Medicaid prescription drug costs, and fiscally prepare for the continued long term care cost crisis that looms.

For each opportunity, the report details background information, methodology for any savings projections calculated utilizing claims experience data, or explanation for any savings projections estimated based on industry knowledge and experience. We believe that valid opportunities exist for the State's consideration. However, it is important to note that the recommended opportunities will require state resources and time to implement. Therefore, the State must prioritize our recommendations and base final decisions on cost-containment targets, as well as the ability of the claims processing system to support each recommendation.

It is important to consider two final issues — the State needs to examine whether a similar formulary listing (or type of PDL) could be used by both Medicaid and the health insurance program for State employees and retirees, as such an initiative may result in additional savings. Additionally, the Heinz Family Philanthropies is completing a separate analysis on a prescription drug program to aid people age 65 and older. The State should give due consideration to this program upon completion of the analysis.

The opportunities presented in the following sections represent real savings that should be given adequate consideration. It cannot be stressed enough that the Governor and the Idaho State legislature needs to carefully weigh the kind of Medicaid prescription drug program it can afford, without adversely impacting taxpayers, and while continuing to

maintain access and quality of care for the Medicaid beneficiaries. The choices are tough, but no action is even more difficult.

This study, and other groundbreaking work initiated by the Heinz Family Philanthropies, is both a tribute and compliment to Teresa Heinz, chairman of the Heinz Family Philanthropies. Without her leadership spirit and guidance, we would not have the ability to tackle some of the nation's toughest health and domestic policy problems.

A very special thank you to our pharmacy and actuarial consultants at Mercer Government Human Services Consulting. Their valuable expertise and analytical assistance are one of the reasons why we value our partnership with them.

Finally, it is important to thank the bipartisan legislative leadership for their ongoing support and interest. This effort started because of recognition by both Democrats and Republicans that a better understanding of this complex problem was needed, as well as possible solutions. At a time of increasing national partisan politics, the Idaho State Legislature set aside partisan political interests to ensure that they received the best information to address and solve the prescription drug problems of the Idaho State Medicaid program.

Jeffery R. Lewis, President
Heinz Family Philanthropies
jlewis@heinzoffice.org

Summary of Opportunities

Opportunity for Consideration	Annualized Savings (Percent of Drug Spend)	Considerations/Advantages
Decrease reimbursement for brand name medications to AWP-13% or AWP-14% <ul style="list-style-type: none"> ▪ Current reimbursement is AWP-12% 	\$1M to \$2M (calculated) (1.0 – 2.0 percent) Only reflects savings for single-source brand medications	<ul style="list-style-type: none"> ▪ Potential threat of decreased participation by retail pharmacies ▪ Consider all program changes that could impact pharmacy reimbursement ▪ Mirrors recent changes made by other state Medicaid pharmacy programs
<i>Section 5, page 33</i>		
Decrease dispensing fee per claim by \$0.50 or \$1.00 <ul style="list-style-type: none"> ▪ Current dispensing fee is \$4.94 (retail) or \$5.54 (unit dose) 	\$1.1M to \$2.2M (calculated) (1.0 – 2.0 percent)	<ul style="list-style-type: none"> ▪ Potential threat of decreased participation by retail pharmacies ▪ Consider all program changes that could impact pharmacy reimbursement ▪ Mirrors recent changes made by other state Medicaid pharmacy programs
<i>Section 5, page 33</i>		
Implement more aggressive MAC list for oral generic products <ul style="list-style-type: none"> ▪ Increase breadth of list and aggressiveness of pricing 	\$2.4M to \$2.8M (calculated) (2.0 – 2.4 percent)	<ul style="list-style-type: none"> ▪ Consider all program changes that could impact pharmacy reimbursement
<i>Section 5, page 33</i>		
Implement a mail order program for specific medications and member populations	\$594K – \$1M (estimated) (0.5 – 1.0 percent) Variable and dependent upon utilization and medications shifted to mail order	<ul style="list-style-type: none"> ▪ Transient population ▪ Potential waste issues ▪ Reduces prescription volume for retail pharmacies ▪ Implemented in other Medicaid programs
<i>Section 4, page 14</i>		
Implement industry standard quantity limit program <ul style="list-style-type: none"> ▪ Prescription or dose limits placed on certain medications 	\$594K – \$2.4M (estimated) (0.5 – 2.0 percent)	<ul style="list-style-type: none"> ▪ Reduces fraud ▪ Minimizes overutilization ▪ Quality of care and cost containment ▪ Implemented in other state Medicaid programs
<i>Section 12, page 65</i>		

Summary of Opportunities (continued)

Implement a dose consolidation program <ul style="list-style-type: none"> ▪ Consolidating dosing frequency for certain medications ▪ Fewer doses dispensed for equivalent days supply 	\$305K – \$549K (calculated) (0.3 – 0.5 percent) Only a representative sample of medications evaluated; greater savings potential with additional medications	<ul style="list-style-type: none"> ▪ Adjudication system capability ▪ Improved medication compliance with lower frequency of dosing ▪ Implemented in other state Medicaid programs
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Section 11, page 61

Implement industry standard clinical step therapy program <ul style="list-style-type: none"> ▪ Requires the use of lower cost, first-line agents when clinically appropriate 	\$594K – \$1.1M (estimated) (0.5 – 1.0 percent)	<ul style="list-style-type: none"> ▪ Adjudication system capability ▪ Increases call volume ▪ Quality of care and cost containment ▪ Implemented in other Medicaid programs
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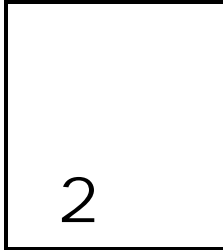
Section 14, page 72

Implement specialty injectable program <ul style="list-style-type: none"> ▪ Deliver certain injectable products to physician offices for direct administration ▪ Deliver certain injectables directly to home environment 	Highly variable — calculated at \$30K – \$164K (0.03 – 0.12 percent) (0.4 – 2.2 percent of injectable drug spend)	<ul style="list-style-type: none"> ▪ Transient population ▪ Physician impact — potential loss of revenue on certain medications administered in the office ▪ Aggressive discounts for certain injectable medications ▪ Increases return on federal Medicaid rebate dollars
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Section 13, page 68

Implement pill-splitting program for Zoloft®	\$188K – \$364K for Zoloft® program (calculated) (0.2 – 0.3 percent) Greater savings potential with additional medications	<ul style="list-style-type: none"> ▪ Potential pressure from advocacy groups and practitioners ▪ Implemented in other Medicaid programs
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Section 15, page 76



Introduction

Prescription drug spending is the fastest growing component within most Medicaid budgets, and therefore, has become a target to identify program inefficiencies and cost-containment strategies. The growth in prescription drug spending can be attributed to three factors, including:

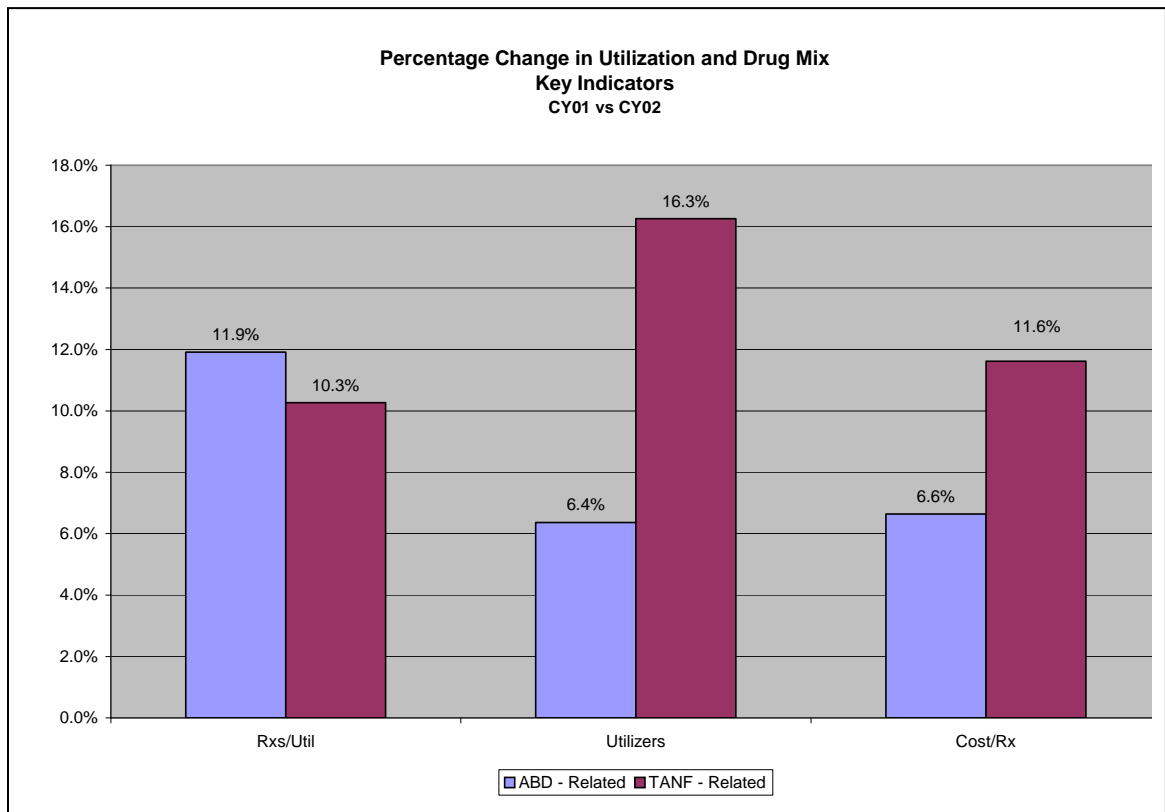
- increased utilization due to
 - modified clinical treatment guidelines,
 - greater reliance on drug therapy, and
 - an aging population; and
- drug mix changes due to
 - direct-to-consumer advertising,
 - delay of generic drug introduction and extensions of patent protection for highly utilized medications,
 - introduction of new, innovative biotechnology drugs,
 - introduction of medications with improved dosing schedules and delivery methods, and
- price inflation due to manufacturing price increases.

Between calendar years 2001 and 2002, the State experienced an increase in total pharmacy expenditures of approximately \$30 million and a 430,000 increase in the total number of prescriptions dispensed. These increases are driven not only by a combination of factors noted above, but also by population characteristics. For example, a large increase in the number of disabled or elderly beneficiaries would impact utilization and drug mix differently than a large increase in the number of young children. In order to best represent the influences of population characteristics, data was separated into two subgroups — individuals in categories of aid that are similar to typical Temporary Aid to Needy Families (TANF) beneficiaries and individuals in categories of aid that are similar to Aged, Blind, and Disabled (ABD) beneficiaries. The data in Figures 1 – 5 on the following pages represent utilization attributed to beneficiaries in each of the two subgroups.

Utilization changes are best tracked and represented by two key indicators — the number of prescriptions per utilizing beneficiary, as well as the number of utilizing beneficiaries. In Figure 1 below, data show that between CY01 and CY02, there was a large increase in the prescriptions per utilizer (Rxs/Util) for both the ABD-related group (11.9 percent increase) and TANF-related group (10.3 percent increase). Additionally, the TANF-related group experienced a greater increase in the number of utilizers (16.3 percent) as compared to the ABD-related utilizers (6.4 percent). This increase in both the number of individuals getting prescriptions filled and the number of prescriptions taken by each of these beneficiaries, explains the growth in prescription volume, as well as the overall increase in utilization.

The growth in total outpatient pharmaceutical cost to the State is a result of both increased utilization and changes in *drug mix*. The cost per prescription (Cost/Rx) value is a good indicator of changes that occurred within drug mix. As indicated in Figure 1, the ABD-related group experienced a 6.6 percent increase in Cost/Rx and the TANF-related group experienced an 11.6 percent increase in Cost/Rx from 2001 to 2002. This indication that beneficiaries received higher cost medications in 2002, could be attributed to any one of the drug mix factors noted above.

Figure 1



Another key factor that helps explain *drug mix* changes is the dispensing rates of generic versus branded medications. Figures 2 – 5 below, show the dispensing rates and changes that occurred between the two years for each population group.

Figure 2

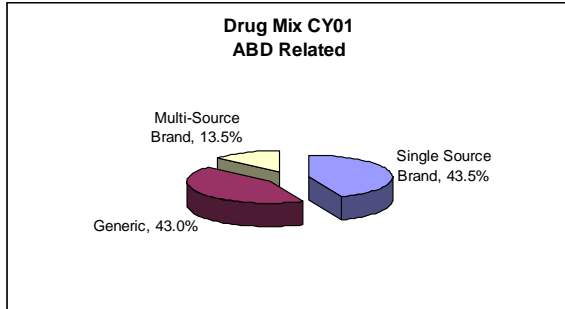


Figure 3

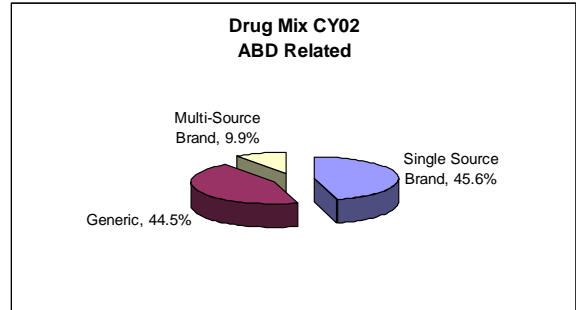


Figure 4

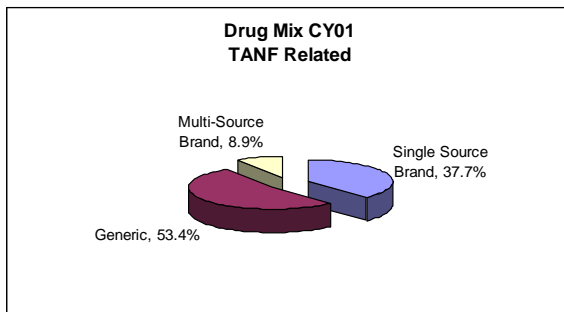
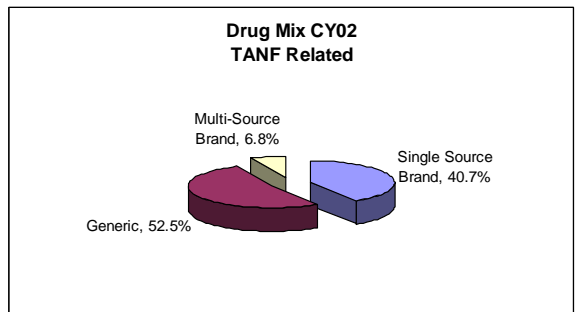


Figure 5



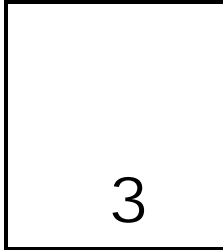
Although the ABD-related group showed an increase in the volume of generics dispensed (1.5 percent), which are lower cost alternatives, we see a continued growth in overall expenditures due to other utilization factors previously discussed. In contrast, the TANF-related group experienced a decrease in the volume of generics dispensed by 0.9 percent and a 3.0 percent increase in the dispensing of more expensive single source brand medications. Both of these factors directly contribute to the increased Cost/Rx represented in Figure 1 and to overall increases in expenditures.

This information explains some of the increases seen within the State utilization data, and is similar to utilization and cost increases we have seen in other states. However, as pharmacy expenditures continue to rise, the challenge will be in achieving a balance between cost containment, adequate access, and maintenance of a quality pharmacy program.

Therefore, in the State's ongoing efforts to manage the overall growth experienced in the pharmacy program over the past two years, the State enlisted our services to assist in an analysis of the Medicaid pharmacy program structure to identify additional opportunities for cost containment and quality improvement.

The efforts of this analysis are presented in this report, which is structured as follows:

- Section 3 *Methodology*, outlines the processes followed to complete this study.
- Sections 4 – 9 address current structure and operational programs, such as *Plan Design, Pharmacy Reimbursement, Financial Arrangement with Vendors, DUR edits, Prior Authorization, and Fraud and Abuse Programs*. Each of these sections is subdivided into Current Situation (to provide the reader with an understanding of the current pharmacy program in the State), Benchmarking (to provide an understanding of how the State's program compares to other state Medicaid programs or to the commercial sector), and Assessment and Opportunities for Consideration (which outlines our recommendations).
- Section 10, *Claims Data Fields*, is dedicated to discussing the capture and reporting of a specific data field within the pharmacy claims system, and outlines our findings and recommendations.
- Sections 11 – 15 are each dedicated to discussion of a specific pharmacy program initiative not currently implemented in the State, but identified as an opportunity for pharmaceutical cost control and/or improvement in the quality of care. In numerical order, the sections address *Dose Consolidation, Quantity Limitations, Specialty Injectables, Step Therapy, and Pill-Splitting*.
- Section 16, *Enhanced Prior Authorization Program and Supplemental Rebates*, documents the current status regarding this initiative and provides additional recommendations.
- In order to quantify the cost savings opportunities for *MAC, Dose Consolidation, Specialty Injectables, and Pill-Splitting*, it was important to perform detailed analysis utilizing claims data. Appendices A – D contain the full discussion and methodology for each detailed evaluation that was completed.
- Appendix E contains a table which outlines all our recommendations identified by the respective section of the report. This table also outlines savings potential (when quantifiable), defines savings as calculated or estimated, and provides key considerations regarding each program change.



Methodology

In order to complete this pharmacy program evaluation and the resulting report, we completed the following steps to gain an understanding of the current pharmacy program in the State:

- requested and received detailed pharmacy claims data from the State, including dates of service January 2000 through November 2002;
- received and validated data for reasonableness and completeness of files;
- reviewed public information, including the State Provider Handbook and the State pharmacy web site to obtain understanding of the pharmacy plan design, reimbursement schedules, utilization management programs, and any clinical interventions;
- obtained information regarding contracted vendors, including explanation of services provided and associated fees, contracted reimbursement rates, and copies of contractual language;
- obtained details of Idaho MAC program and pricing in order to complete the MAC cost savings analysis;
- conducted interviews with State pharmacy staff, including pharmacists and pharmacy analysts, to validate findings based on preliminary research and to further understand all components of the current pharmacy program;
- conducted interviews with State contracting staff to further understand services provided by contracted vendors;
- obtained information related to DUR program, including DUR program administrator, and a copy of the most recent the Centers for Medicaid & Medicare Services (CMS) DUR Annual Report; and
- obtained information regarding programs targeted at pharmacy fraud and abuse.

The information gathered from the steps above served as the foundation for all of our assessments, analyses, calculations, and final recommendations. Public sources of information used in this report are appropriately footnoted throughout the report. Other sources of information include our proprietary internal government pharmacy database, as

well as discussions with representatives of other state pharmacy Medicaid programs. We utilized and evaluated the detailed pharmacy claims data supplied by the State to:

- understand the State's current annual drug expenditures (drug spend) and prescribing mix;
- understand the key drivers of utilization; and
- calculate savings potential associated with specific program recommendations.

When appropriate, the detailed methodology we used to derive cost savings calculations are documented and supplied in the report.

We worked collaboratively with the State to understand the current pharmacy program, which assisted us in the identification of practical, programmatic recommendations, and strategies that address cost containment and quality improvement.

4

Plan Design Analysis

The basis of a pharmacy program begins with a well-structured plan design. The plan design offers third-party payers a means of managing certain components of the benefit. This section reviews, benchmarks, and suggests opportunities for consideration for the plan design components of benefit coverage and exclusions, prescription limitations, generic drug policies, cost sharing, and the use of alternative delivery options.

Benefit Coverage and Exclusions — Current Situation

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90), as amended in 1993, governs many of the options states have for the management of prescription drug expenditures. The laws established the federal Medicaid prescription drug rebate program and dictate provisions of drug exclusions, prior authorization programs, and state formularies. The rebate program denies federal Medicaid matching funds for the medications of any manufacturer that does not agree to participate in the program. In return for rebates, state Medicaid programs that provide pharmacy benefits are required to cover the participating manufacturers' outpatient drugs, with the exception of medications in the following ten categories:

- agents used for anorexia, weight loss, or weight gain;
- agents used to promote fertility;
- agents used for cosmetic purposes or hair growth;
- agents used for the symptomatic relief of cough or colds;
- agents used for smoking cessation;
- prescriptions vitamins and minerals, except prenatal vitamins, and fluoride preparations;
- non-prescription — or over-the-counter (OTC) — medications;
- barbiturates;
- benzodiazepines; and
- vaccines.

In accordance with these optional allowances, the State has excluded the following products from coverage:

- anorexiant and related products, amphetamines, chlorphentermine, dexfenfluramine salts, and optimal isomers of various amphetamines;
- ovulation stimulants;
- topical cosmetic agents;
- nicotine gum, sprays, inhalers, transdermal patches, and related products;
- legend (prescription status products), non-OTC multi-vitamins with or without minerals, and other legend vitamins;
- legend medications changed to non-legend status and generic equivalents;
- all diet supplements, including Fer-In-Sol[®] (Total Parental Nutrition (TPN) reimbursed through medical vendor); and
- Drug Efficiency Safety Implementation (DESI) drugs. (DESI drug products are defined as “less than effective” by the Food and Drug Administration (FDA) because there is lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established. CMS does not allow for reimbursement of these drugs.)

Therefore, according to OBRA ‘90, the allowance categories that the State continues to provide coverage for include barbiturates, benzodiazepines, and vaccines. The State Provider Handbook lists additional products that are included in the coverage policy. That listing of products appears below:

- covered vitamins: injectable B₁₂, Vitamin K and analogues, pediatric fluoride preparations, legend prenatal for pregnant or lactating women, legend folic acid, legend Vitamin D and analogues, and oral legend with folic acid in combination with B₁₂ and/or iron salts;
- covered non-legend products:
 - insulin;
 - disposable syringes and needles;
 - oral iron salts without additional ingredients; and
 - permethrin (for the treatment of head lice).
- for long-term care beneficiaries, all legend medications are covered plus insulin, oral iron, and permethrin (for the treatment of head lice).

Additionally, the State provides coverage for certain non-legend, OTC products for children in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Since the State does not provide coverage for OTC products for the bulk of the beneficiaries, the selected OTC products have been placed on prior authorization status so as to verify eligibility of the child prior to dispensing. Currently, there are approximately 41 OTC products that are available for EPSDT children in the State.

The State also provides coverage for certain diabetic related supplies; including, test strips, lancets, alcohol wipes, and blood glucose meters. However, these products are not eligible for electronic claims submission and must be billed via a HCFA 1500 form. In order to dispense and submit reimbursement for any of these products, the pharmacy

provider must have a Durable Medical Equipment (DME) provider number and submit the claim on the HCFA 1500 form. State pharmacy staff noted that a vast majority of pharmacy providers also have DME provider numbers.

All states have implemented certain limits and exclusions to the pharmacy benefit provided for Medicaid beneficiaries. The charts on the following pages provide comparative information on other states located within the same geographical region and provides benchmarking information on a national level, when applicable.

Benefit Coverage and Exclusions — Benchmarking

Pharmacy Plan Design ¹	Anorectics	Fertility Treatment	Cosmetics	Cough and Cold Preparations	Prescribed Smoking Deterrents	Prescription Vitamins and Minerals	Barbiturates	Benzodiazepines	Vaccines
Idaho	not covered	not covered	not covered	items available OTC	not covered	covered	covered	single source covered	covered
Montana	partial, PA ² required	not covered	not covered	not covered	partial coverage PA required	covered	covered	covered	covered
Oregon	covered	not covered	PA required	covered w/ restrictions	covered	covered	covered	covered	covered
Washington	partial, PA required	not covered	not covered	limited coverage	not covered	covered	covered	covered	covered
Wyoming	not covered	not covered	not covered	covered	not covered	covered	covered	covered	covered
All other states w/ FFS Medicaid	5 covered with no restrictions; 7 cover with PA required; 1 partial coverage; 4 partial coverage with PA required; 27 not covered 1 PA for ADD	42 not covered; 3 N/A	42 not covered; 3 N/A	4 covered with PA required; 8 partial coverage; 10 not covered 2 N/A 21 covered	6 covered with PA required; 4 partial coverage with PA required; 4 partial coverage; 13 not covered 17 covered; 4 N/A	predominately covered — difficult to determine	predominately covered — difficult to determine	predominately covered — difficult to determine	45 covered

¹ National Pharmaceutical Council, *Pharmacy Benefits Under State Medical Assistance Programs, 2001*.

² Prior Authorization

Benefit Coverage and Exclusions — Benchmarking (Continued)

Pharmacy Plan Design (Continued)								
	Experimental Medications	Insulin	Needles for Insulin	Syringe for Insulin	Blood Glucose Test Strips	Anabolic Steroids	Anxiolytics, Sedatives, and Hypnotics	Growth Hormones
Idaho	not covered	covered	covered	covered	covered as DME	covered	covered	covered, PA required
Montana	not covered	covered	not covered	not covered	not covered	covered	partial, PA required	partial, PA required
Oregon	not covered	covered	covered as DME	covered w/ restrictions	covered as DME	covered	covered	covered, PA required
Washington	not covered	covered	covered	covered	covered	partial coverage, PA required	covered, PA required	covered, PA required
Wyoming	not covered	covered	covered	covered	covered	not covered	covered	covered
All other states w/ FFS Medicaid	42 not covered; 3 N/A	2 covered w/ restrictions; 40 covered; 2 N/A; 1 not covered	4 covered w/ restrictions; 4 covered as DME; 5 not covered; 30 covered; 2 N/A	4 covered w/ restrictions; 4 covered as DME; 5 not covered; 30 covered; 2 N/A	2 covered w/ restrictions; 9 covered as DME; 7 not covered; 3 N/A; 24 covered	6 covered with PA requirements; 1 partial coverage; 1 partial coverage with PA requirements; 3 not covered; 29 covered; 5 N/A	6 covered with PA required; 2 partial coverage; 3 partial coverage with PA required; 30 covered; 4 N/A	22 covered with PA required; 5 partial coverage with PA required; 2 partial coverage; 1 not covered; 11 covered; 4 N/A

Benefit Coverage and Exclusions — Benchmarking (Continued)

Pharmacy Plan Design (Continued)

	OTC Products Covered	Injectables
Idaho	Permethrin, oral iron salts, insulin, and insulin syringes	Injectable medicines reimbursable through the Prescription Drug Program when used in home health care, extended care facilities, and through both the Prescription Drug Program and physician payment (when used in physicians offices)
Regional		
Montana	Insulin, laxatives, antacids, head lice treatment, H2 antagonist GI products, bronchosaline	Injectable medicines reimbursable through the Prescription Drug Program when used in home health care, extended care facilities, and through physician payment (when used in physician offices)
Oregon	Covered with restrictions: allergy, asthma, sinus products, analgesics, cough and cold preparations, digestive products, topical products, and smoking deterrent products	Injectable medicines reimbursable through physician payment (when used in physician offices), home health care, and extended care facilities
Washington	Digestive products (non-H2 antagonists) and contraceptives are covered w/o restrictions. Covered with restrictions: allergy, asthma, sinus products (selected items), analgesics (ASA and Acetaminophen), cough and cold preparations (selected items), feminine products (selected items), and topical products	Injectable medicine reimbursable through the Physician Drug Program when used in home health care, extended care facilities, and through physician payment (when used in physician offices)
Wyoming	Allergy, asthma, sinus products (some), analgesics, cough and cold preparations, digestive products (H2 antagonists), feminine products, antidiarrheals, antitussives, hyperglycemics, laxatives, pediatric and prenatal vitamins, sodium chloride for nebulizer, topical antifungals, and vaginal antifungals are covered w/o restrictions. Covered with restrictions: some OTC drugs — if they are alternatives to more expensive therapy, or they are unavailable by prescription order	Injectable medicines reimbursable under the Prescription Drug Program when used in home health care, extended care facilities, and through physician payment (when used in physician offices)

Benefit Coverage and Exclusions — Assessment and Opportunities for Consideration

Currently, the State continues to provide coverage for three categories of medication that, according to OBRA '90, are eligible for exclusion — barbiturates, benzodiazepines, and vaccines. Although eligible for exclusion, all states currently cover these drug categories. In general, the State has a coverage policy that is considered standard and appropriate amongst Medicaid programs. However, one area that the State is more restrictive than other programs is in the coverage of OTC products. In accordance with OBRA '90 regulations, the State is excluding from coverage all legend medications that have changed to non-legend status (OTC status). This strategy has likely served the State well in past years — ensuring that the State only pays for prescription products and, likewise, receives the accompanying federal rebate payment. However, as the marketplace changes regarding the shift of legend products to OTC status, the current strategy may need to be revisited.

For many years, other states have been employing strategies to aggressively promote and provide coverage for the use of OTC medications as alternatives to brand name products. Examples include promotion of OTC medications for headaches, diarrhea, constipation, temporary pain, vaginal infections, heartburn or upset stomach, antihistamines, and decongestants for cold symptoms. The purpose of employing an expanded OTC coverage list is to increase the number and availability of cost-effective alternatives for common, acute ailments. The success of an expanded program will be dependent upon several factors including; current prescribing practices, level of education and promotion dedicated to such a program, current utilization patterns, severity of illness within the population, willingness of the prescribing community to embrace the use of OTC alternatives, and the unit cost of available OTC products. It is important to ensure that the cost of an OTC product is not more expensive than the net cost of an equivalent legend product with the associated federal rebate.

Due to these complex factors, we were unable to quantify potential savings from such an initiative, but can comment that more states have begun to expand the OTC coverage list in an attempt to further manage pharmacy costs and encourage physicians to adopt cost-effective prescribing practices, while continuing to provide quality health care. Additionally, with the move of certain high utilization prescription products to OTC status; including, non-sedating antihistamines (loratidine) and proton pump inhibitors (omeprazole), the State should further evaluate a more aggressive OTC strategy.

State's initial reaction to opportunity: The State has evaluated the OTC prescription coverage and a study was completed by ISU in 2001–2002. Despite the minimal savings potential, the department plans to implement a limited coverage OTC program in 2004.

One final item for consideration is the current process used to bill for diabetic-related supplies. According to State pharmacy staff, these supplies are not eligible for electronic claims submission and are billed on a HCFA 1500 form. Since these are not electronically

billed, it is unclear to if these claims are submitted by the State for federal rebate dollars. We recommend the State institute a process to collect rebate dollars if such a process does not currently exist.

Prescription Limitations — Current Situation

Due to language in OBRA '90, state Medicaid agencies are restricted in their ability to manage the pharmacy benefit through drug exclusions. However, federal language does not place restrictions on a Medicaid program's ability to restrict the quantity of prescriptions or number of refills. CMS advises that any limitations placed on prescription medications should be done in an effort to control medical necessity or control utilization. These types of plan design prescription limitations are discussed and categorized below as days supply limitations, monthly prescription limitations, and early refill edit limitations.

Days Supply Edit

The intent of a days supply edit is to ensure that beneficiaries are not able to obtain medication beyond a standard monthly supply. Currently, beneficiaries in the State are eligible for no more than a 34-days supply with each prescription fill with two exceptions.

- Retail pharmacy can dispense 100 doses (not to exceed 100-days supply) for the following medications:
 - cardiac glycosides, thyroid replacement hormones, prenatal vitamins, nitroglycerin (oral or sublingual), fluoride and vitamin/fluoride combination, and OTC oral iron salts.
- Oral contraceptives can be supplied in quantities of one, two, or three cycles.

Monthly Prescription Limitation

In April 2002, a monthly prescription limit edit was scheduled for implementation. This would be an edit placed on the number of prescriptions a member could obtain each month, or every 30 days. The edit would be applicable to the fifth prescription that was attempted to be filled during that month, in which a reject would occur at the point of sale (POS) and require prior authorization review for medical necessity. During discussions with State pharmacy staff, it was noted that within four days of implementation of the edit in April 2002, the edit and program were terminated due to the volume of calls and complaints received by the State pharmacy department. Staff confirmed that currently, there are no limitations on the number of prescriptions that beneficiaries can fill each month.

Early Refill Edit

Early refill edits are used to set thresholds on the frequency of refills which are authorized and paid. The goal of this type of edit is to allow for convenience to the beneficiary, while maintaining refill controls to prevent potential fraud/abuse, waste, and unnecessary costs. Early refill edits also serve as a means of verifying compliance with the prescribed regimen. Utilizing the days supply field submitted at the POS by the dispensing pharmacy, each refill request is evaluated for adherence to the threshold. Therefore, if the

beneficiary has a 30-days supply of medication, and the edit is set at 75.0 percent, they will be eligible to refill the prescription after the 23rd day. Currently, the State has established their refill threshold at 75.0 percent. If a refill is requested before 75.0 percent of the medication has been used (according to a calculation based on days supply and date of original fill) the request triggers the edit and the prescription would be rejected at the POS. Subsequently, this prescription can be refilled at a later date in the month — after the 75.0 percent threshold has been met.

In the State, an early refill edit was implemented in February 2002, with a corresponding 75.0 percent threshold and a hard reject at the POS. Prior to February 2002, the same threshold existed but was a soft edit, or a warning message, at the POS; therefore, the edit could be easily overridden by the dispensing pharmacist. In conjunction with this hard edit implemented in February 2002, the State created two valid override codes. One override code is published on the web site and in newsletter communications, and is available for dispensing pharmacists to use if there is a documented case of dosing increases or continued treatment after starter therapy is initiated. For these situations, and in an effort to minimize the volume of calls received, the State has requested that pharmacy providers use this code only when appropriate, and only for these specific situations. All other requests for early refill must be reviewed and approved by Electronic Data Systems (EDS) or State pharmacy staff, who use a different override code than that which is provided to the retail pharmacies.

We questioned State pharmacy staff on the auditing procedures in place to ensure there is not misuse of the published override code. State pharmacy staff noted that a one-time audit was completed in late summer 2002 and results were sent to the surveillance and utilization reporting (SURS) unit; however, it was not noted if there appeared to be system-wide abuse of the edit based on this audit.

All states have implemented various prescription limitations within the plan design of their respective pharmacy program. The chart on the following page outlines prescription limitations for states with regional proximity to the State.

Prescription Limitations — Benchmarking

Pharmacy Plan Design

	Early Refill Edit? (Y/N)	Days-Supply Limit	Exceptions for Oral Contraceptives	Limits on Refills per Month? (Y/N)	Limits on Number of Prescriptions per Month? (Y/N)
Idaho	Yes; edit set at 75%	No more than 34-days, with exceptions: 100 doses not to exceed 100-days supply for maintenance medications	Available in 1, 2, or 3 cycles	No	No limitations on number of prescriptions per month

Regional

Montana	Yes; edit set at 75%	Maximum 34-days supply or 100 quantity, whichever is greater	None	No	No limitations on number of prescriptions per month
Oregon	Yes; edit set at 75%	Maximum of 34-days supply with exceptions, including 15 days supply for initial Rx for chronic conditions	Yes	No	No limitations on number of prescriptions per month OTC medications are limited to two prescription for each therapeutic class
Washington	Yes; edit set at 75%	34-days supply; 90 days supply for generics	Yes	2 refills per month, 2 refills for antibiotics or scheduled drugs	Limitation on the number of fills per month for specific therapy classes (see below); limitation of four brand name prescriptions per month with certain exclusions (see below)
Wyoming	Yes; edit set at 75%	Maximum 34-days supply or 100 quantity whichever greater (maintenance drugs exempt)	None	No	No limitations on number of prescriptions per month

Prescription Limitations — Assessment and Opportunities for Consideration

Days Supply Edit

Most states around the country have employed a standard limitation of a maximum of 34-days supply of medication per prescription fill. In the commercial setting, third-party payers have become more aggressive on this limitation — placing the restriction at a maximum of 30- to 32-days supply of medication. The savings that might result from this type of plan design modification is difficult to quantify, and indeed, may be minimal. However, it is known that certain best practices employed in the commercial setting drive similar efficiencies and cost containment within the Medicaid environment. In an effort to parallel some of these best practices, the State should consider making this modification to the pharmacy plan design.

State's initial reaction to opportunity: The State notes that the 34 day supply limit has been in place since the inception of the program and believes the modification to a 30-day supply limit will have no impact on savings and does not plan to pursue this strategy.

Monthly Prescription Limitation

Similar to the State program (that was quickly eliminated in early 2002), several states have placed restrictions on the number of prescriptions that can be filled in a given time period — typically 30 days. Often, particular therapeutic classes of medication (e.g., HIV/AIDS medications, behavioral health medications) and populations (e.g., beneficiaries in long term care facilities, beneficiaries with HIV/AIDS) are not subjected to this quantity restriction. Typically, when a beneficiary exceeds the limitation, there is a hard edit at the POS, and authorization must be received before additional prescriptions can be filled.

Currently, Washington is the only state in the geographical comparison region that has a limit on the number of refills allowed per month as well as a limit on the number of prescriptions that can be dispensed per month. Washington does not allow more than 2 refills per month for each individual prescription. Additionally, unless approval is obtained, they do not allow the member to obtain more than 2 refills for any medication classified as either an antibiotic or a scheduled, controlled substance medication. Washington is also the only state in the geographical comparison region that has imposed limitations on the number of prescriptions that can be filled or dispensed per month. They imposed a limitation of 4 prescription fills per month on certain therapeutic classes including; antibiotics, anti-asthmatics, schedule II and III drugs, antineoplastic agents, topical preparations, and propoxyphene and all propoxyphene combinations. Finally, Washington also has a limitation of 4 brand name prescriptions per month and excludes specific therapy classes such as antidepressants, antipsychotics, anticonvulsants, chemotherapy drugs, contraceptives, HIV/AIDS medications, immunosuppressants, and hypoglycemic rescue agents.

One important issue with a monthly prescription limitation program revolves around the potential of this strategy to result in decreased quality of care for those participants with co-morbid disease states who truly have a need for a large number of medications. If such restrictions are implemented, there must be a plan to ensure that there is not an increase in hospitalizations and emergency room visits as a direct result of the imposed limitations. Other states that have implemented such strategies have typically not studied how such limitations impact the quality of care.

Rather than imposing a hard edit at the POS, some states have implemented a retrospective review of individual medication profiles that exceeded a defined prescription limit within a defined time frame. Intervention letters are then sent to all providers for that specific beneficiary requiring each physician to respond with justification for the medication regimen. This type of retrospective review will be more politically palatable, and resembles more of a polypharmacy retrospective intervention, rather than a true monthly prescription limitation enforced at the POS. Likewise, this type of retrospective review does not deliver the level of savings achieved with a hard edit at the POS.

We believe that although there is a need to minimize misuse and overuse of unnecessary medications within the Medicaid population, the strategy of a hard edit at the POS runs the risk of compromising patient care and increasing administrative workload, with only a small cost containment benefit. A retrospective review program could be considered by the State. However, adequate resources and system functionality will be required to achieve program efficiency and success. Alternatively, there are many other POS options, as discussed throughout this report that can be implemented more quickly and which focus on both cost containment and quality of care.

Early Refill Edit

An early refill threshold requires that a member consume a set percentage of a prescription before an additional supply of the medication can be obtained. Across the country, certain state Medicaid programs and Medicaid managed care organizations (MCOs) have modified the early refill threshold edit to be more aggressive than the typical industry standard (which is 75.0 percent). For example, both the State of Utah and one large Medicaid MCO in the Commonwealth of Pennsylvania, which serves approximately 200,000 members, have set their threshold at 80.0 percent. However, other states and Medicaid MCOs have been reluctant to implement this edit and/or modify the aggressiveness above 75.0 percent because of population considerations, such as access to transportation.

We believe that an aggressive early refill edit helps to further manage unnecessary waste and utilization. With a more aggressive edit, additional savings may occur, but these savings are not quantifiable with retrospective data. Depending upon the flexibility of the adjudication system, a more aggressive edit could be selectively placed on certain medications that have a high potential for abuse (e.g., controlled substances and pain

medications). This may help deter fraudulent activities with controlled substances without placing undue burden on beneficiaries taking maintenance medications. Implementation of a more aggressive edit is somewhat dependent upon other utilization management and fraud/abuse programs in place. For example, the use of quantity limitations, step therapy programs, and polypharmacy monitoring and intervention programs work in unison and would likely identify and cost avoid any of the situations that would have been identified and potentially rejected through a single, early refill edit.

We recommend that the State consider implementing a more aggressive, early refill edit as a part of the overall strategy in managing the pharmacy benefit. If the State elects to enforce a more aggressive edit, we also recommend appropriate monitoring of complaints, accessibility, and medication compliance issues to ensure that this patient population is not disadvantaged by such an edit. Additionally, the State should maintain the current early refill override policies to allow dispensing pharmacists to exercise their professional judgment and authorize an override in appropriate situations. Finally, the State should continue to perform periodic audits to ensure that published override codes are not misused.

State's initial reaction to opportunity: The State notes that a 75 percent early refill edit has been operational for over one year and believes that modification of this threshold will have minimal savings impact; therefore, the State does not plan to pursue a more aggressive edit.

Generic Drug Policy — Current Situation

Mandatory generic substitution is a proven cost-control strategy in pharmacy benefit management. A vast majority of multi-source brand products can be dispensed with generic equivalents without creating quality of care or patient satisfaction issues. Currently, the State has a rule within the administrative code that requires the dispensing of a generic equivalent medication, when available, provided that the physician has not indicated that a brand name is medically necessary. In order to enforce this rule, brand name medications with an acceptable generic equivalent have been placed on prior authorization status. Authorization for these products is based on medical need, such as adverse reactions (clinically demonstrated, observed, and documented), that have occurred when the generic drug has been used. Likewise, in order for a beneficiary to receive the branded product, the physician must justify the request by submitting a MedWatch™ form and/or demonstrate that the beneficiary has tried and failed two other generic products.

There is an additional component of the current generic policy which works in conjunction with the SMAC program which allows the State to place prior authorization on certain newly released generic products. The rationale behind this policy is that when generic products first become available, there is typically a 180-day exclusivity period in which only one generic manufacturer can produce and supply the drug. During this time frame, the average wholesale price (AWP) of the newly released generic is less than the branded product, but after Medicaid federal rebates are accounted for, the net cost of the

branded product can still be significantly less than the cost of the generic. It is not until the exclusivity period passes, and additional manufacturers begin to supply the product, that the net cost of the generic becomes equivalent, or better than, the branded product. During discussions with State pharmacy staff, it was noted that during 2002, this prior authorization policy was applied to certain “blockbuster” products, such as fluoxetine — the generic for Prozac®.

As demonstrated in the following chart, a majority of states have implemented a mandatory generic drug policy within the plan design of their respective pharmacy programs.

Generic Drug Policy — Benchmarking

Pharmacy Plan Design	
	Mandatory Generic Substitution? (Y/N)
Idaho	Yes
Regional	
Montana	Yes
Oregon	Yes
Washington	Yes
Wyoming	Yes
National Benchmark	
All other states w/ FFS Medicaid	Dispensing of equivalent generic product required in 29 other states

Generic Drug Policy — Assessment and Opportunities for Consideration

The dispensing of generic medications has proven to be an effective strategy known to lower costs without impacting quality. Therefore, it is imperative that all third-party payers have policies in place to capitalize on the use of generic products now, and in the future. Currently, the State has a structured mandatory generic policy, allowing for exceptions only in cases of true medical necessity and/or dispensing of narrow therapeutic index (NTI) medications. NTI medications are those pharmaceuticals that have a narrowly defined range between risk and benefit, therefore, have a narrow difference between the minimum dose that might cause toxicity and the minimum effective dose. These medications often have erratic absorption and bioavailability issues, and require periodic blood level monitoring. As a result, the risk of mandating a generic product for NTI medications outweighs the potential cost savings. It is our opinion that the current State policy and procedures are appropriate and will continue to play a paramount role in the future as several high-volume brand name medications are scheduled to lose patent protection during 2003 to 2005.

Cost Sharing — Current Situation

Under federal law, states are permitted to impose “nominal” copayments, defined as ranging from \$0.50 to \$3.00 per prescription, on Medicaid beneficiaries. Currently, no copayments are assessed to Idaho Medicaid members. State pharmacy staff note that this option has been explored in the past with a final decision being made not to implement such a program. The following chart demonstrates the cost sharing programs implemented in other states located within the same geographical region.

Cost Sharing — Benchmarking

Pharmacy Plan Design	
	Copay
Idaho	none
Regional	
Montana	\$1.00 – \$5.00 per prescription, \$25.00 monthly cap
Oregon	\$2.00 generic, \$3.00 brand and \$3.00 per compound
Washington	None
Wyoming	\$2.00
Utah	\$3.00

Cost Sharing — Assessment and Opportunities for Consideration

Implementation of copayments has become more popular as state pharmacy programs continue to face budget deficits. Federal law prohibits charging prescription copayments for the following groups in the absence of a Medicaid waiver:

- children under 18;
- those in inpatient medical facilities;
- hospice care recipients; and
- categorically needy enrolled in MCOs.

Federal law also prohibits requiring copayments in the following circumstances:

- if the drug is for a medical emergency;
- if the drug is a pregnancy-related expense for an expectant mother; or
- if the drug is for family-planning purposes.³

In 2000, 28 states imposed some type of copayment for Medicaid prescription drug benefits. Most states had flat copayments while others had tiered copayments.⁴ Nominal

³ Department of Health and Human Services, Health Services, Health Care Financing Administration, 48 CFR 5730, February 8, 1983.

pharmacy Medicaid copayments cannot exceed \$3.00 per prescription. However, several states have obtained waivers that allow copayments of up to \$5.00 per prescription.⁵ As a result, states have implemented both flat and tiered copayments structures as a part of their overall pharmacy management strategy. However, due to Idaho's current eligibility criteria (i.e. income level), it is unlikely that they would be able to obtain a waiver to allow a \$5.00 copay.

The State of Georgia is one example of a state that uses tiered copayment structure. Georgia uses tiered copayments in combination with their PDL for Medicaid beneficiaries. In comparison to other regional states, Idaho and Washington are the only states which have not enforced copayments for prescription medications.

Opponents of cost sharing in Medicaid have expressed concern that beneficiaries may chose to discontinue their use of medications if faced with a copayment. Beneficiaries are likely to continue those medications that provide immediate symptomatic relief (e.g., antihistamines and heartburn medications) and discontinue the medications used for management of chronic disease states (e.g., high blood pressure, high cholesterol, and diabetes), since no ill-effects of the chronic disease are immediately experienced. Although much research has been conducted related to this topic, the evidence has been somewhat conflicting. In general, many studies have found that copayments did reduce the consumption of all medications; therefore, the general health status of the beneficiary declined, and there was a corresponding increase in the use of the other medical services.

Additionally, federal law prohibits providers from denying care or services to Medicaid recipients who are unable to pay copayments. The legal determination as to whether the beneficiary can pay the copayments rests wholly on the provider. At the POS, the retail pharmacist often just accepts responsibility for the copayment if the beneficiary indicates that they are unable to make the payment, otherwise the pharmacist would have to legally disprove the beneficiary. As a result, the retail pharmacies often absorb the copay amount every time a beneficiary cannot, or refuses to, furnish the copay. Accordingly, in many states that have implemented copayments, there has been significant opposition from the retail pharmacies and the corresponding state pharmacy associations. The end result might be the exodus of pharmacies in rural areas, which would result in inadequate access for the beneficiaries.

Any contemplation on implementation of beneficiary copayments should give due consideration to the following items:

- other reimbursement changes that will also impact retail pharmacies;
- establishment of regulations that clarify under what circumstances pharmacists can deny services to beneficiaries who refuse to pay copayments; and
- the need for the State to obtain a waiver to allow higher copayments.

⁴ Richard Cauchi, *Medicaid Survival Kit: 7. Pharmaceuticals*, National Conference of State Legislatures, May 2002, p. 7–10.

⁵ Richard Cauchi, *Medicaid Survival Kit: 7. Pharmaceuticals*, National Conference of State Legislatures, May 2002, p. 7-10.

At this time, we do not have a definitive recommendation for the State regarding copayments. Such a program must be evaluated with regard to the overall philosophy and strategy for management of the pharmacy benefit considering cost savings, impacts on quality of care, and administrative burden if a waiver is required. Additionally, the State must consider a copayment strategy as a potential impact on pharmacy reimbursement; therefore, should be evaluated amongst the other strategies that also impact reimbursement. We recommend that if the State elects to pursue a copayment strategy in the future, the State should also immediately launch an impact study to determine if copayment requirements reduce the use of particular medications and/or increase the use of other medical services.

Mail Order Delivery System — Current Situation

The basic premise of mail order is the delivery of an extended days supply (typically 90 days) of ongoing maintenance medication delivered directly to the home environment. This delivery option offers patients an added level of convenience, and for certain populations, such as elderly and disabled, this convenience may result in improved medication compliance and, ultimately, improved patient outcomes. Currently, in the State, all outpatient medications are supplied by retail pharmacies and there is no use of the mail order delivery option or alternative delivery system option. The following chart demonstrates the use of a mail order delivery program in other states located within the same geographical region.

Mail Order Delivery System — Benchmarking

Plan Design	
	Mail Order Program (Y/N)
Idaho	No
Regional	
Montana	No
Oregon	Yes
Washington	Yes
Wyoming	No

Mail Order Delivery System — Assessment and Opportunities for Consideration

Mail order service for prescription medications is well known within the commercial industry to result in tremendous unit cost savings due to aggressive discounting and minimal, or nonexistent, dispensing fees. To reduce medication waste and abuse, only ongoing therapy, or maintenance medications and/or supplies, should be dispensed through mail order.

Although large discounts are an attractive cost savings opportunity with mail order delivery, consideration must be given to certain characteristics of the Medicaid population. Due to their often transient nature — non-permanent telephone and home address — mail order delivery for Medicaid beneficiaries faces challenges not experienced in the commercial environment. In spite of this, several state Medicaid programs have implemented a mail order strategy including, Oregon, Washington, and Mississippi.

The State of Washington implemented a mail order program with Medco Health Solution's in February 2002. The program is voluntary and involves no expense to the beneficiaries. State representatives noted they were able to achieve lower discounts for brand and generic medications as well as lower dispensing fees than the current reimbursement arrangement with retail pharmacies. The State of Oregon has also implemented a voluntary mail order program, which has been operational for more than one year. However, more specific information on Oregon's program could not be obtained.

The State of Mississippi implemented a pilot voluntary mail order program for their Medicaid population in August of 2002 in seven counties. To encourage participation, the state sent out brochures to educate the beneficiaries. Though no special incentives are offered for participation in the mail order program, state representatives stated that mail order is promoted in the Medicaid brochures as a convenient option for Medicaid recipients who have transportation issues. Pharmacy representatives at each respective state did not provide any specific information regarding implementation barriers, quality of care issues, or calculated cost savings to date.

Currently, the State allows for beneficiaries to obtain 100 doses (not to exceed 100-days supply) for certain maintenance medications at retail pharmacies (refer to benefit coverage and exclusions section for medication listing). The reimbursement on such prescriptions is the standard AWP-12%. Use of a mail order delivery method could achieve discounts as high as AWP-19% to AWP-22% with no associated dispensing fee. In order to minimize waste and unnecessary costs that may result from the dispensing of more than a month's supply, the State could structure the program such that only certain types of maintenance medications (such as those listed above), and only those beneficiaries that are likely to remain in the Medicaid program (such as the disabled population), are eligible to receive mail order home delivery. For these chronically ill, disabled beneficiaries, mail order home delivery will likely be convenient and may improve medication compliance and clinical outcomes.

Opponents of a mail order strategy will include the retail pharmacies, which will lose the opportunity to fill and receive revenue from these medications in their stores, and perhaps certain advocacy groups. The ability to successfully implement this strategy will also be dependent upon the adjudication system and the ability to identify those beneficiaries and claims that should be filled through a mail order program.

Any contemplation on implementation of a mail order program should give due consideration to the following items:

- other reimbursement changes that will also impact retail pharmacies in the State; and
- limitation to certain patient populations and medications.

Quantification of savings resulting from a mail order program will be dependent upon program structure (medications allowed for mail order dispensing) and negotiated discounts and dispensing fees. Although savings attributed to a mail order program were not quantified by any of the states noted above, we are able to derive potential savings based upon unpublished information from national PBMs that support Medicaid managed care clients and other commercial clients throughout the country. Information from these sources indicate that anticipated savings would be approximately 0.5 – 2.0 percent of total drug spend annually. If a mail order program in Idaho was limited to particular medications and specific beneficiaries, the estimated savings could be estimated at 0.5 – 1.0 percent of annual drug spend. We believe that implementation of a mail order pharmacy program may save the State money while creating a delivery system that may be more convenient, and improve health outcomes, for particular recipients. Prior to implementation of such a strategy, the State must ensure the capabilities of the claims adjudication system to support appropriate edits.

State's initial reaction to opportunity: The State notes that the pharmacy department has reviewed the possibility of a mail order program and believes that the impact on the local providers is negative, with the potential to reduce access to rural pharmacy services. The State notes that it is important to balance the savings potential with potential for negative outcomes.



Pharmacy Reimbursement

When evaluating reimbursement arrangements between the State and contracted pharmacies, consideration must be given to all elements of the reimbursement formula; including, discounts on brand medications, discounts on generic medications, and dispensing fees per prescription. Likewise, any modification to the reimbursement formula will directly impact the profitability of contracted pharmacies within the State and will receive attention from the State’s pharmacy association. This section reviews, benchmarks, and evaluates savings potential if any of these key reimbursement components are modified.

Discounts and Dispensing Fees — Current Situation

Reimbursements to pharmacies for dispensing prescriptions have two components: acquisition costs and dispensing fees. Acquisition costs are costs incurred by the pharmacy to obtain medications. In addition, Medicaid is required to pay a “reasonable” dispensing fee to reimburse the pharmacy for the costs of preparing and distributing medications to the beneficiaries.

Currently, State reimbursement follows pricing logic in the EDS claims adjudication system based on the lowest of the following, plus a dispensing fee:

1. Federal Upper Limit (FUL) for multi-source medications;
2. SMAC;
3. Estimated acquisition cost (EAC); or
4. Pharmacy’s usual and customary (U&C) charge to the general public.

The EAC is the State’s best estimate of the price generally and currently paid by pharmacy providers for a particular medication in the package size of the drug most frequently purchased. The State calculates EAC as the AWP-12% for brand name drugs, and for any generic drugs that are not on the FUL or SMAC lists. When federal MAC limits (also known as FUL), as established by CMS, are announced, these prices will also become a part of the adjudication logic for generic products. Additionally, the State

creates and maintains its own SMAC list, as described below. The dispensing fee for State retail pharmacy Medicaid providers is \$4.94 per prescription. The dispensing fee for Medicaid “unit dose” providers is \$5.54 per prescription. Since the logic is based on “lower of” pricing, the reimbursement formulas are as follows:

Pharmacy Reimbursement Idaho Discounts and Dispensing Fees		
	Brand Name products (and any generics not on FUL or SMAC)	Generic products
Retail pharmacy	Lower of AWP-12% + \$4.94 or U&C	Lower of SMAC + \$4.94 or FUL + \$4.94 or AWP-12% + \$4.94 or U&C
Unit Dose Providers	Lower of AWP-12% + \$5.54 or U&C	Lower of SMAC + \$5.54 or FUL + \$5.54 or AWP-12% + \$5.54 or U&C

Per State pharmacy staff, unit dose providers are those “that provide medications in unit dose packaging and deliver the medication five times per week.” The State currently reimburses providers based on a provider type classification, and according to the EDS system, there are currently 19 pharmacies within the State that are classified as unit dose providers. Aside from the definition above, State pharmacy staff noted that the State is unsure of other criteria, or ongoing verification utilized by EDS, to ensure these pharmacies are providing unit dose services as stated. Additionally, staff note that there is no system edit that will stop payment if these providers are submitting claims on a weekly basis. State pharmacy staff note that due to the inflexibility and limited capabilities of the EDS system, the addition of an edit such as that mentioned above would result in the inability of the EDS system to handle other edits that are more critical.

In the states within the comparative region, as well as nationwide, there is a very broad spectrum of ingredient reimbursement rates and the corresponding dispensing fees. The chart below provides a sample of the variability in ingredient reimbursement rates regionally and nationally.

Discounts and Dispensing Fees — Benchmarking

Pharmacy Reimbursement ⁶

	Ingredient Reimbursement Rate	Dispensing Fee
Idaho	AWP-12%	\$4.94
Other States		
Most Other States	AWP-10 to 12%	\$2.50 to \$5.40
Alaska	AWP-5%	\$3.45
California		\$3.55
Minnesota	AWP-9%	\$3.65
Ohio	AWP-12.8%	\$3.70
Maine	AWP-13.0%	\$3.35
Florida	AWP-13.25%	\$4.73 (formulary) \$3.73 (non-formulary)
Michigan (1-4 stores)	AWP-13.5%	\$3.77
Indiana		\$4.90
Louisiana (independent stores)		\$5.77
Washington	AWP-14% brand <5 manufacturers AWP-50% generic >5 manufacturers	\$4.20 to \$5.20 (based on 3-tiered pharmacy volume)
Montana	AWP-15.0%	\$4.70 (in-state)
Oregon (non-institutional)		\$3.50
Louisiana (chain stores)		\$3.77
Michigan (5+ stores)	AWP-15.1%	\$3.77

Discounts on brand medications are represented by the “ingredient reimbursement rate”. To assess discounts on generic medications, it is important to have knowledge of the type of MAC program implemented (e.g., is the MAC a small subset of generic medications primarily utilizing only the FUL, or a MAC utilizing a unique list of generic medications which have more aggressive pricing than the FUL methodology). Please refer to the comprehensive evaluation completed on the State MAC program that appears in this section of the report.

⁶ Drug Topics February 3, 2003.

Discounts and Dispensing Fees — Assessment and Opportunities for Consideration

Changing reimbursement rates and dispensing fees are one of the more common strategies that have been employed across the country to help manage pharmacy expenditures. State Medicaid programs are attempting to bring reimbursement rates more in line with rates seen in the commercial or private sector. For brand name medications, reimbursement rates typically range from AWP-14% to AWP-16% with dispensing fees ranging from \$2.00 to \$2.50 per prescription. Such modifications to the reimbursement formula achieve immediate cost savings and; therefore, have gained popularity. In August 2001, a report released by the Office of the Inspector General (OIG) conducted an analysis of reimbursement rates versus the Actual Acquisition Cost (AAC) for medications. There was tremendous criticism of the methodology of this report; therefore, the OIG conducted a more thorough analysis, which was published in September 2002.⁷ The study found retail pharmacies had an AAC of AWP-17.2% for single-source brand drugs (drugs with no generic equivalent). As result of this study, several states have recognized the disparity between current reimbursement rates for brand medications and pharmacies AAC; therefore, many states have cut reimbursement rates, or considered such cuts, over the past year.

It is important to note that although implemented in certain states, this type of strategy has also led to some pharmacies exiting the pharmacy networks, stating inadequate reimbursement to continue operations. Pharmacies challenge such modifications to the reimbursement formula, stating that a greater level of consultation and time is needed to serve Medicaid beneficiaries; therefore, the higher reimbursement helps to compensate for the additional resources that are required. Modification of the reimbursement formula was a significant issue in the Commonwealth of Massachusetts and the State of Washington, with many pharmacies threatening to exit the network and refusing to service Medicaid beneficiaries at the lower reimbursement rate. The outcomes vary in each state, but in Massachusetts, the Commonwealth ultimately compromised with the pharmacy association and conceded part of the proposed decrease in reimbursement.

Discounts — Savings Opportunity

Currently the State reimburses pharmacies AWP-12% for single-source brand name medications. Utilizing claims experience from January through November 2002, we performed an analysis of the claims data to determine savings that would result from a modification of the State's single-source brand reimbursement rate to AWP-13% or AWP-14%. (We calculated annualized AWP expenditures of single-source brand products at approximately \$99.5 million.)

⁷ Department of Health and Human Services, Office of the Inspector General, "Medicaid Pharmacy—Additional Analysis of the Actual Acquisition Cost of Prescription Drug Products," September 2002, A-06-02-00041.

Based on the annualized utilization of single-source brand medications in 2002, it was determined that for each 1.0 percent modification of the reimbursement formula, the State is expected to realize approximately one million dollars in unit cost savings.

Pharmacy Reimbursement Brand Discount Analysis		
	Change to AWP-13%	Change to AWP-14%
Annualized Projected Savings	approximately \$1,000,000	approximately \$2,000,000

State’s initial reaction to opportunity: Reduction of ingredient cost reimbursement has been evaluated by the pharmacy department on multiple occasions. The State has chosen not to implement this strategy due to the negative impact on local providers.

Dispensing Fees — Savings Opportunity

Presently, the State pays a dispensing fee that is higher than commercial dispensing fees; paying \$4.94 to retail pharmacies, and \$5.54 to unit dose pharmacies. Utilizing claims experience from January through November 2002, we performed an analysis of the claims data to determine savings that would result from a reduction in the State’s dispensing fee payment by \$0.50 and by \$1.00.

Pharmacy Reimbursement Dispensing Fee Analysis			
	Current Dispensing Fee	New Dispensing Fee	Annualized Savings
Dispensing Fee Reduced \$1.00	\$4.94 Retail Pharmacy	\$3.94 Retail Pharmacy	\$ 2,184,483
Dispensing Fee Reduced \$1.00	\$5.54 Unit Dose Pharmacy	\$4.54 Unit Dose Pharmacy	\$ 20,574
		Total	\$2,205,057

Dispensing Fee Reduced \$0.50	\$4.94 Retail Pharmacy	\$4.44 Retail Pharmacy	\$ 1,092,242
Dispensing Fee Reduced \$0.50	\$5.54 Unit Dose Pharmacy	\$5.04 Unit Dose Pharmacy	\$ 10,286
		Total	\$1,102,528

Therefore, if implemented in calendar year 2002, a reduction in dispensing fees by \$0.50 (to \$4.44 and \$5.04) would have resulted in approximately \$1,102,527 annualized

savings. If the State reduced dispensing fees \$1.00 (to \$3.94 and \$4.54) the savings would have been approximately \$2,184,481.

The savings noted above represent savings from reimbursement changes achievable on single-source brand name medications during calendar year 2002; whereas, the dispensing fee savings is representative of all claims processed during CY02. Reimbursement savings that would be achievable on generic medications is discussed in the *MAC Pricing* section below.

In comparison to other states across the country, Idaho does not have an aggressive reimbursement formula for discounts and dispensing fees. Modification of any component (brand discounts, generic discounts, or dispensing fees) of the reimbursement formula will directly impact retail pharmacies. Therefore, a decision to modify the current formula and/or any of these components must take into consideration political palatability, existing relationships with the State pharmacy association, and cumulative cost savings. We recommend the State consider modification of the reimbursement formula to achieve desired cost savings while ensuring adequate access is maintained for beneficiaries.

State's initial reaction to opportunity: Reduction of dispensing fees has been evaluated by the pharmacy department on multiple occasions. The State has chosen not to implement this strategy due to the negative impact on local providers.

Maximum Allowable Cost — Current Situation

MAC pricing is a cost containment initiative used by program administrators to encourage pharmacy providers to purchase and use the most cost-effective generic products. A program using MAC pricing achieves this goal by establishing a ceiling price for selected generic drugs and multi-source brand drugs; therefore, determining provider reimbursement. It is well known that chemically-equivalent generic drugs (drugs with the same chemical entity) are usually available from a variety of manufacturers and/or distributors, all charging widely different prices. If a MAC program is not in place, there is no incentive for pharmacy providers to purchase generic drugs prudently when generic equivalent medications are available from multiple manufacturers. MAC reimbursement has become an industry standard pricing methodology accepted by pharmacy providers in the commercial and government marketplace.

The Idaho MAC list, or State MAC (SMAC) program, has been in place for many years and is currently maintained by the State Medicaid pharmacy staff. The SMAC list is a customized listing of generic products developed utilizing the following process:

- obtain AAC from two wholesalers;
- telephone three to four pharmacies (independent, chain, and hospital or home health care pharmacy, if applicable) to obtain their AAC;
- compare the AAC information learned from the various sources to two formulas (AWP-65%) and (AAC+10%); and
- establish a SMAC list price based on the comparison of the information gathered.

The State pharmacy staff note that there currently is no set schedule for updating existing SMAC list prices. State pharmacy staff currently maintains the SMAC list at the national drug code (NDC) level — rather than a generic code number (GCN) level. When adding new NDCs to the list, the State will often wait six to twelve months past the release of a generic product to determine the SMAC list price then add the NDC to the list. The rationale for this is to allow the State to capitalize on Medicaid rebates on single-source branded medications for a longer period of time. This situation typically occurs when a single-source branded medication first loses patent protection and continues for the 180-day exclusivity period. Other Medicaid programs across the country have employed a similar process, monitoring the price of newly released blockbuster generics until the net cost of the generic is less than the brand. Currently, State pharmacy staff note that the maintenance of the SMAC list requires less than a full time employee (FTE) pharmacist.

Maximum Allowable Cost — Benchmarking

Pharmacy Reimbursement	
	SMAC Program? (Y/N)
Idaho	Yes
Regional	
Montana	No, utilize federal MAC
Oregon	Yes, contracted to vendor
Washington	Yes, managed in-house
Wyoming	No, utilize federal MAC

We only had access to ingredient reimbursement rates and dispensing fees for each of the comparison states within the region and do not have specific knowledge on the MAC programs in Oregon or Washington. However, as a piece of the overall evaluation of the State pharmacy program, we performed an analysis of the Idaho SMAC that is maintained by the State’s Medicaid pharmacy staff to determine the breadth and depth of the list, to assess the competitiveness of Idaho SMAC pricing, and to assess the cost impact of an alternative MAC list. Highlights of this analysis, including key findings and conclusions are outlined below, with the complete methodology documented in Appendix A of this report.

Maximum Allowable Cost — Assessment and Opportunities for Consideration

In order to complete the comprehensive MAC evaluation, a comparison of the Idaho SMAC was performed against two external MAC lists — one National Proprietary MAC list and one Regional MAC list.

- In comparison to the two other MAC lists, the Idaho SMAC list has a much smaller breadth — containing substantially fewer numbers of NDCs represented on the list.

MAC Program Analysis	
	Number of NDCs* on each respective MAC list
Idaho SMAC	740
National Proprietary MAC	5,242
Regional MAC	5,338

* With State claims utilization

- The SMAC list offers aggressive discounts, but only for the small set of medications which appear on the list. The overall effective discount for products listed on the SMAC, with utilization during the evaluation time period, was calculated at AWP-52.1%.
- The SMAC list contains injectable products, which are not contained on either comparison MAC list; therefore, these products were removed from this evaluation and the reported savings is based solely on oral products.
- The SMAC is currently maintained by the State’s Medicaid pharmacy staff at an NDC level; whereas, other MAC lists are maintained at a higher product level (often at the GCN level).
- Based on State-specific utilization data, pricing analysis was performed and showed the potential savings if either the National Proprietary or the Regional MAC list had been implemented during the evaluation time period.

MAC Program Analysis			
	Total Expense*	Total Savings	Savings as % of Total Drug Spend
Idaho SMAC – Actual	\$15,405,058	N/A	N/A
National Proprietary MAC – Calculated	\$12,934,845	\$ 2,470,213	2.1%
Regional MAC – Calculated	\$15,602,193	\$ (197,135)	-0.2%

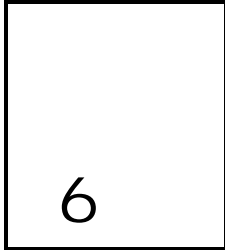
* Since a MAC list only represents a subset of generic products, the “total expense” value represents amount paid for only those generics in which there was claims experience during the evaluation time period.

Based on this analysis, we were able to conclude the following.

- The State has an opportunity for additional cost savings on **oral** products if a more aggressive SMAC is implemented, which can be achieved through either increased number of products represented on the SMAC list, more aggressive pricing on certain products, or a combination of the two.
- Based on our experience, estimated savings that may be achieved as a result of the implementation of a more aggressive SMAC is 2.0 to 4.0 percent of total drug spend annually, which is comparable to the findings of this analysis.
 - In order to achieve such savings, the State must implement a MAC program that is similar to the National Proprietary MAC.

As noted previously, a decision to modify the current formula and/or any of these components will directly impact retail pharmacies and must take into consideration political palatability, existing relationships with the pharmacy association and cumulative cost savings. The implementation of a more aggressive SMAC program is a strategy that will result in significant cost savings for the State. A more aggressive SMAC program can be achieved by either adopting an alternative MAC list from a third-party source or continued maintenance of the SMAC list by State pharmacy staff. If the State elects to adopt an alternative MAC list, a thorough analysis should be completed to evaluate the depth (aggressiveness of pricing) and breadth (number of NDCs) on the alternative list, and alignment of these NDCs with current utilization data to calculate savings potential. Additionally, we recommend the State investigate the option of customizing the SMAC list to include injectable products if they elect to adopt an alternative MAC list from any third-party source. If the State elects to maintain the current SMAC list, and not seek alternate sources, we recommend that the State Medicaid pharmacy staff develop a standard maintenance and updating process, including maintenance of the list at the GCN, rather than the NDC, level to ensure the list encompasses a larger number of NDCs.

State's initial reaction to opportunity: The State notes that the pharmacy department had previously identified the MAC List as a potential area of focus and, as of the date of this report, is in the process of developing and soliciting responses to an RFP for the provision of MAC program services.



Financial Arrangement with Vendors

Vendors providing pharmacy management services will charge third-party payers fees for standard services; such as, claims processing (which includes POS edits inherent in the adjudication system), rebate management, reporting, and other clinical programs, such as DUR services. This section reviews and, whenever possible, benchmarks the services provided by various vendors contracted with the State. The POS edits that are inherently part of the claims processing adjudication system are discussed in Sections 7 and 8 of this report.

Vendor Services — Current Situation

Currently, the State has an umbrella contract with EDS for the provision of the following services: claims processing of both medical and pharmacy claims, rebate processing for the federal drug rebate program, reporting, and extracting of utilization data. The annual fee is based on total volume of claims (paid and denied, but not reversals or adjustments), with a set fee for a specific range of claims volume. The annual fee for a volume of claims ranging from 6,521,568 to 7,173,725 is \$7,900,000. If claim volume exceeds this range, a separate calculation formula is utilized.

Claims Processing

In FY02, the annual fee paid to EDS for **all services** was \$7,900,000. (Per the detailed claims experience data provided by the State, the total volume of pharmacy claims during FY02 was 2,231,645.)

Rebates

The umbrella contract with EDS includes submitting and processing federal Medicaid rebates in the base contract price of \$7.9 million.

Reporting

The reporting of pharmacy utilization is also included in the base contract price of \$7.9 million. Additionally, the State indicated that other reports, which are not related to claims processing, are charged separately on a per-hour basis. The hourly charge can vary between \$82/hour to \$119/hour, for the current contract year, depending upon who is performing the work.

The State also noted that through an alliance with EDS and Heritage companies, the State has recently acquired license to use the *CyberFORMANCE TOOLKIT* software for data extraction. There are no ongoing fees for the first year beyond the initial acquisition cost. Ongoing fees for this software will not begin until September 2003 (the ongoing costs after September were not documented).

Drug Utilization Review (DUR)

The State currently holds a contract with Idaho State University, College of Pharmacy (ISU), for the provision of DUR services. Under this contract, ISU provides services to ensure the State is in full compliance with the DUR regulations, as set forth in OBRA '90, in order to receive federal funding. The State has contracted with ISU for DUR program services since 1993. (We did not evaluate CMS regulations as it relates to Medicaid program oversight, such as functions and role of the DUR Board.)

In August 2002, the Medicaid DUR coordinator completed a comprehensive evaluation of the DUR program provided by ISU — including ISU compliance with the contract provisions and fulfillment of OBRA '90 requirements. Services to be provided through the contract include, but are not limited to: DUR Board support, preparation of the CMS Annual DUR Report, completion of population-based, retrospective reviews (either on targeted medication or disease based), prospective DUR review (assisting the State in evaluation of the clinical evidence and relevance of on-line prospective DUR system edits furnished by First Data Bank (FDB)), data analysis and report preparation, and provision of drug information support. This evaluation concluded that the services provided by ISU were not meeting the State's needs.

As a result of this evaluation, the contract with ISU was rewritten to clearly outline services, roles, and responsibilities. For example, there is now a more structured process to identify and determine the retrospective studies and interventions that are to be completed. The process now revolves around relevance of the retrospective intervention, targeting the opportunities that could result in the most significant cost issues, and/or quality of care issues.

In order to understand the fees associated with the services provided by ISU, a representative from the State contracting department provided the following information, which outlines the total cost for the contract between the State and ISU for DUR services. The State noted that these contract fees are based on dedicated hours from various ISU staff needed to complete the services outlined in the contract.

Vendor Services — Contract with ISU		
Contract Period (October to September)	Contract Fees	Scope of Services
2000 – 2001	\$237,726	Same scope as previous year
2001 – 2002	\$249,342	Same scope as previous year
2002 – 2003	\$283,596	Change in scope based on evaluation

Additionally, the State is evaluating the capabilities of the Heritage *CyberFORMANCE TOOLKIT* software system to assist with the retrospective DUR program to best meet the State's needs.

Vendor Services — Benchmarking

Claims Processing

An administrative fee is usually paid to the claims processor on a per-claim basis. The claims processor can charge varying fees depending on numerous factors; including, volume of claims processed and electronic or paper processing. Based on experience with other Medicaid programs around the country, the fee typically paid to their respective claims processor for the processing of pharmacy claims is in the range of \$0.08 – \$0.15 per claim. (Typical fees for processing of medical non-pharmacy claims often exceed \$1.00 per claim processed.) In the commercial sector, organizations contract with pharmacy benefit management entities to manage all claims processing functions and the fee range is typically \$0.10 – \$0.20 per claim. This per-claim fee, in the commercial sector, also typically includes POS edits (all DUR edits, step therapy edits, and various quantity limitation edits) that are inherent in the adjudication system, retail network management, and commercial rebate management.

The State currently has an umbrella contract with EDS in which fees are not separated into fees for processing of medical claims versus pharmacy claims. Additionally, this umbrella contract includes other services provided by EDS, such as rebate processing, reporting, and extracting utilization data. As a result, it is not possible for us to benchmark and derive any meaningful analysis on the aggressiveness of this financial arrangement with EDS solely for pharmacy claims processing functions. However, we recommend that the State further evaluate their per-claim processing fees based on the benchmark information provided.

Rebates

The umbrella contract the State has with EDS includes submitting and processing of federal Medicaid rebates. As a national average, the rebates returned to states as a percent of total drug spend (annually) is reported to be approximately 18.0 – 20.0 percent in FY01¹² (information on FY02 could not be determined). As reported by State

representatives, EDS returned an average rebate of 20.5 percent during State FY02. This level of rebate return indicates a comprehensive recovery program.

Medicaid Drug Rebate Returned to State ⁸			
	Reported Rebate FY00	Reported Rebate FY01	Reported Rebate FY02
Idaho ⁹	17%	17.4%	20.5%
Regional ¹⁰			
Montana	18%	Not available	Not available
Oregon	19%	Not available	Not available
Washington	18%	Not available	Not available
Wyoming	17%	Not available	Not available
National ¹¹	17 – 18%	18 – 20%	Not available

DUR

In order to comply with federal OBRA ‘90 guidelines, each state covering prescription drugs must establish an outpatient, DUR program. States have the flexibility to construct their DUR program in various ways — either through outsourced contracts or using internal resources. As a component of the comprehensive DUR services review completed in August 2002 by State Medicaid pharmacy staff, the Medicaid DUR coordinator reviewed the structure of DUR programs in various other states and documented the following:

- “seven states run their entire DUR program internally;”
- “twenty four states use commercial firms;” and
- “two states contract with pharmacy associations.”

At this time, the State has elected to continue to subcontract DUR services to ISU for an annual fee of \$283,596. We do not have access to the DUR contracts established in other regional comparative states and; therefore, are not able to comment directly on the competitiveness of the contracted rates.

Vendor Services — Assessment and Opportunities for Consideration

Based on the contractual language between vendors and the State, we are not able to comprehensively benchmark the various contracted services and fees. However, we believe that the State has monitored and updated existing contracts, when appropriate, and

⁸ percent of total drug spend

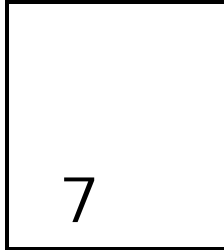
⁹ as reported by State representatives

¹⁰ National Pharmaceutical Council, *Pharmacy Benefits Under State Medical Assistance Program, 2001*

¹¹ http://www.kaisernetwork.org/health_cast/uploaded_files/10.16.01_NASMD_transcript

has negotiated reasonable contractual fees for claims processing and rebate management. As noted by State pharmacy staff, they will continue to evaluate the retrospective DUR program provided by ISU to ensure it meets the State's needs. However, since the State currently lacks reliable physician provider identification information for approximately 60.0 percent of the claims processed, and until the State improves the capture and entry of correct physician identifier information at the POS, the quality and success of any retrospective DUR program is greatly diminished. We consider this to be a key opportunity for improvement and likewise have dedicated Section 10 to this topic. We recommend that the State improve the capture and entry of correct physician identifier information at the POS in order to improve the quality of current and future DUR programs.

State's initial reaction to opportunity: The State notes that the DUR contract with ISU was revised several months ago to reflect improved performance.



Pharmacy Claims Processing Management Programs — DUR Edits

Within every claims processing adjudication system, various POS edits are inherent in order to alert the pharmacist to any potential medication issues prior to dispensing the medication. These POS edits help to promote safe, appropriate use of medications by providing both the dispensing pharmacist and the prescribing physician with important information about possible medication issues at the time of dispensing. This section reviews and evaluates the current POS edits present in the State adjudication system.

POS, DUR Edits — Current Situation

Currently, the State utilizes EDS for on-line claims processing services and the provision of POS, DUR edits. The State refers to such POS edits as ProDUR, or prospective DUR edits. A POS, DUR program should have the ability to perform on-line, real-time analysis at the point of dispensing to check all incoming prescriptions against the prescription profile using an integrated data source. A POS, DUR program should include edits that are both *non-clinical* and *clinical* in nature, as well as those that have a hard edit and those that have a soft edit. Prescription submissions that encounter a hard edit, will be stopped at the POS, requiring pharmacist intervention (review of the claim and possibly contacting the physician or call center) before the prescription is approved for payment. Medication issues that receive a soft edit include those in which there is only an alert, which can be overridden without further intervention.

Non-Clinical, DUR Edits

Discussions with the State pharmacy representatives revealed that several *non-clinical* edits are currently “turned on” in the EDS system as hard edits and likewise, may result in a rejection at the POS. These edits include:

- compound drug edit (rejects if NDC submitted for the compound is greater than \$20.00 and requests manual submission of claim);

- drug coverage edit (rejects if the NDC is a non-covered drug for both legend and non-legend products or if there is no manufacturer rebate);
- refill edits (rejects if invalid refills remain);
- NDC/drug on review edit (listing of products which the State requires review prior to dispensing and requires manual submission of claim with accompanying justification);
- medical supply NDC (diabetic supplies such as alcohol swabs, needles, and syringes must be billed as a DME product and submitted manually);
- days-supply edit;
- NDC/drug not allowed for nursing home client;
- early refill edit (established at 75.0 percent threshold);
- duplicate claim submission (edits on all data fields to determine if it is an exact duplicate entry); and
- invalid prescriber edit (checks for presence of characters in the data field).

Clinical DUR Edits

Currently the *clinical* edits “turned on” in the EDS system are as follows:

- maximum/minimum days supply edits (supplied by FDB drug file),
- high-dose/low-dose edit,
- drug-age edit, and
- therapeutic duplication edit.

In order to maintain the currency of the maximum/minimum days supply edit every two weeks, State pharmacy staff receive information from FDB regarding new NDCs and the suggested maximum and minimum days-supply edits. A pharmacist at the State reviews the suggestions for appropriateness and makes a recommendation to an internal committee to accept the suggestion or modify. This information must then be manually entered by State pharmacy staff since the FDB file through EDS does not automatically populate this information for these new NDCs.

The State only has two other clinical POS DUR edits — therapeutic duplication and drug-age conflicts. Additionally, State representatives noted that there have been difficulties in working with EDS to understand these two edits and to determine if the criteria used within the edit is meaningful.

POS, DUR Edits — Benchmarking

The types of *non-clinical edits* outlined above that are currently implemented would be considered standard within the industry with the exception of one of the edits — “NDC/drug on review” edit. State pharmacy staff noted that certain medications are placed on review by the State, including:

- those in which the State is requesting the submission of a manual claim in order to ensure proper billing, or
- medications that are subjected to prior authorization (Section 8), require justification from the physician, and require review by State pharmacy staff prior to dispensing.

Medications that require paper submission to ensure accurate billing include: blood factor products, interferons, Botox[®], and IVIG. When the retail pharmacist attempts to submit an electronic claim for one of these products, there will be a reject at the POS requiring submission of a paper claim. The pharmacist does dispense the medication to the beneficiary, but retrospectively submits a paper claim. Once the paper claim is received by State pharmacy staff, it is reviewed for quantity and days supply accuracy, and entered into the pharmacy claims system. Therefore, the sole reason for placing these specific medications on review is to ensure proper billing of dispensed units. Medications that are subjected to prior authorization are discussed in Section 8.

Within the claims adjudication industry, PBM organizations have set the standard in the types of *clinical*, *DUR edits* that should be applied at the POS using an integrated data source and include the following edits:

- drug-drug interactions,
- drug-disease interactions,
- drug-age contraindications, and
- therapeutic duplication.

These types of clinical edits may be soft or hard at the POS, reserving hard edits for those medication issues that could result in severe or life-threatening injuries for the beneficiary. In addition to these edits occurring at the POS, it is key that an integrated data source and complete prescription profile is utilized in order to maximize the identification of potential medication issues.

POS, DUR Edits — Assessment and Opportunities for Consideration

The current *non-clinical DUR edits* address the standard edits that should be present in the adjudication system; including, refill edit, days supply edit, and early refill edit. Some of the remaining edits (NDC drug on review, medical supply NDC) are more specific to the structure of the State program and are considered appropriate. One non-clinical edit of concern to us is the “invalid prescriber edit.” All prescriptions processed through EDS are editing on the prescriber field only to determine presence of a character within the field. There is no validation of the character entered or even of the string length of characters. We consider this to be a key opportunity for improvement and, likewise, have dedicated Section 10 of the report to this topic. Our recommendation regarding non-clinical DUR edits is that the State explores the implementation of a “high cost” claim edit. This type of edit is typical within claims’ processing systems, identifies any claim exceeding a certain dollar threshold, and serves to alert the pharmacist and the State to a potential medication issue for a beneficiary that may have special medication needs and require case management services. Savings from this type of edit cannot be quantified but adds to the quality of care.

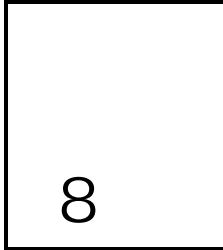
State’s initial reaction to opportunity: The State notes that a high cost claims review was completed in May 2002.

We also believe there are key opportunities for improvement regarding the *clinical edits* that are part of the State's on-line, DUR, POS program. As noted, the EDS edits do not include an on-line check at the POS using a centralized data source, for drug-drug or drug-disease interactions. Therefore, beneficiaries are at great risk for medication safety issues and potential adverse drug events.

We believe that the State's current clinical edits do not meet industry standards; thus, this is an important quality of care issue. We recommend that the State explore a means of enhancing the existing EDS system to, at a minimum, include integrated DUR checks at the POS for drug-drug and drug-disease interactions. Additionally, the State needs to work closely with EDS to further understand the existing clinical edits to ensure these are meaningful and appropriate. Savings that may result from improving clinical POS edits cannot be quantified, but are considered relevant.

Finally, it is important to note these DUR, POS programs are intended to support the pharmacist in screening and detecting important clinical medication issues, but do not take the place of the professional judgment of the pharmacist. Therefore, some clinical edits should be programmed as soft edits and others as hard edits. With any changes that occur to the claims adjudication system, a test environment should be established in order to validate the accuracy of all new edits.

State's initial reaction to opportunity: The State notes that enhanced clinical DUR edits are being integrated into the new pharmacy software release scheduled for December 2003.



Pharmacy Claims Processing Management Programs — Prior Authorization

This section continues the review of the POS edits that are inherent in the claims processing system — specifically prior authorization edits.

Prior Authorization — Current Situation

Prior authorization programs have been used in state Medicaid programs for many years, primarily targeting medications for which there is a high potential for misuse or abuse, medications that carry high price tags, or medications for which utilization should be closely monitored. In recent times, state Medicaid programs have begun to utilize the prior authorization process in conjunction with a PDL; subjecting any medication that does not appear on the PDL to prior authorization review. This section of the report only addresses how the State currently uses prior authorization — to help control the use of costly drugs or those which have misuse or abuse potential.

PA can often be separated into clinical versus administrative prior authorizations — depending on the criteria and/or requirements. Therefore, both administrative and clinical edits will reject at the POS if requirements are not met. Administrative prior authorizations are used in an effort to manage the prescribing or dispensing of certain medications, but do not require any clinical review or clinical information gathering for a decision to be made. Medications subjected to clinical prior authorization require the gathering of clinical diagnosis, previous medical history, or previous prescription utilization history to determine if a patient is eligible to receive the requested drug. Currently, the State utilizes both types of prior authorization programs to maximize their control over certain medications. The State currently subjects two different types of medications to prior authorization:

- medications for multi-source brand name products with A-rated generics that do not have a narrow therapeutic index; and
- medications requiring clinical review and authorization.

Administrative Prior Authorizations

As discussed previously, the State has a rule within the administrative code that requires the dispensing of an equivalent generic medication, when available, provided the physician has not indicated that brand name is medically necessary. In order to enforce this rule, brand name medications with an acceptable generic equivalent (multi-source brand name products) have been placed on prior authorization status. Therefore, the State has a prior authorization list for multi-source brand name products with A-rated generics that do not have a narrow therapeutic index. Additionally, the State does not utilize or recognize the “dispense as written” (DAW) field within the EDS claims processing system; therefore, a DAW override is not possible for these medications. In order to receive an override for this particular administrative prior authorization, the physician would be required to justify medical necessity by submitting a MedWatch form and/or demonstrating that the beneficiary has tried and failed two generic products.

This program began in March 2000 and currently, there are approximately 289 multi-source brand products that are subjected to this administrative prior authorization. Any product with a narrow therapeutic index is excluded from this listing. However, State pharmacy staff noted that there is no formal methodology followed in identifying and maintaining multi-source brand products contained on this list. It was noted that less than a FTE pharmacy technician and less than a FTE pharmacist are currently required to maintain this listing of multi-source brand products. Additionally, the State has not formally evaluated costs and any savings that result directly from this program and subjecting such multi-source brand products to prior authorization.

Clinical Prior Authorizations

Currently, the State has a listing of medications that are subjected to a clinical prior authorization requirement. When a prescription for a medication subjected to clinical prior authorization is entered at the pharmacy, the claim will reject at the POS, the pharmacy completes the appropriate prior authorization request form, sends the form to the physician who in turn completes missing information, and the completed form is then faxed to the State’s pharmacy department. A subset of medications has been subjected to this clinical review for many years and includes:

- Amphetamines and central nervous system (CNS) stimulants (e.g., Adderall[®], Dexedrine[®]);
- Growth hormones; and
- Retinoids (e.g., Retin-A[®], Renova[®]).

The second subset of medications which require clinical review and submission of appropriate prior authorization forms were added in calendar year 2002 and include:

- Anti-emetics (e.g., Zofran[®], Kyrtil[®], Anzemet[®], Marinol[®]) — February 2002;
- Non-sedating antihistamines (e.g., Claritin[®], Allegra[®], Zyrtec[®]) — May 2002;
- COX-II inhibitors (e.g., Celebrex[®], Vioxx[®], Bextra[®]) — May 2002; and
- Proton pump inhibitors (e.g., Prilosec[®], Prevacid[®], Protonix[®], Nexium[®], Aciphex[®], Prev-Pac[®]) — May 2002.

Depending upon the medication, the pharmacy department utilizes different prior authorization forms to process and review information provided and to make an authorization determination. Currently, the State performs all prior authorization functions (administrative and clinical) utilizing internal pharmacy department staff. Functions performed by the staff include the review of supplied information, authorization determination, and communication of authorization decision to both pharmacy and physician via fax. The program has been structured as a predominately faxed-based system in which providers have been trained and have learned to complete the appropriate paperwork and fax these requests directly to State pharmacy staff — rather than via telephone. As a result, there is not a need for a type of structured call center at the State. Finally, as a part of the prior authorization program, and in compliance with federal Medicaid law, the State has established an after hours/weekend emergency dispensing program in which pharmacists may dispense a 72-hour supply of a medication subjected to prior authorization if it is believed, within their professional judgment, that the member needs the medication immediately. State pharmacy staff note that the typical turnaround time for review of prior authorization requests is 24 hours (as is consistent with federal Medicaid law). State pharmacy staff are available during standard business hours Monday through Friday to accept prior authorization requests. It was noted that the entire prior authorization program (administrative and clinical) requires approximately 5 FTE pharmacy technicians. Based on our experience, this model and level of staffing resources committed to this program appears to be appropriate.

Prior Authorization — Assessment and Opportunities for Consideration

The current State policy and procedures regarding placement of multi-source brand products on prior authorization status are appropriate and will continue to play a paramount role in the future as several high-volume, single-source brand name medications are scheduled to lose patent protection during 2003 to 2005. We do not have further recommendations for the State regarding this administrative prior authorization process.

The rationale behind a well structured, clinically appropriate prior authorization program is that participants that truly need a particular medication will have little difficulty meeting the established criteria for medical appropriateness. The intent is to minimize or eliminate misuse or abuse of certain medications, while providing coverage for those patients that will benefit from such a therapy. An additional benefit of a prior authorization program is something referred to as the “sentinel factor,” which is the extent to which a prior authorization requirement discourages a physician or patient from prescribing and/or requesting the product if not clinically appropriate. Currently, the State has a few classes of medications subjected to the clinical prior authorization program. Other medications and medication classes that are typically subjected to clinical prior authorization in the commercial sector and within certain state Medicaid programs include:

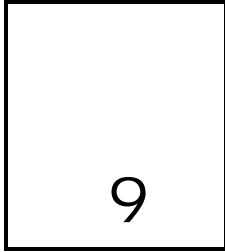
- agents for rheumatoid arthritis (Humira[®], Enbrel[®], Remicaide[®], Kineret[®]);
- agents to stimulate blood cells for anemia and chronic renal failure (Procrit[®], Epogen[®], Arnasep[®]);
- agents used in the treatment of hepatitis C (Pegasys[®], Peg-Intron[®], Rebetron[®], Intron-A[®], Peg-Intron[®], Infergen[®]);
- agents used in the treatment of respiratory syncytial virus (RSV) (Synagis[®], Respigam[®]);
- agents used in the treatment of erectile dysfunction (Viagra[®]);
- agents used in treatment of fungal infections (Sporanox[®], Lamisil[®]);
- agents used in the prophylaxis of vein thrombosis (Fragmin[®], Innohep[®], Lovenox[®]);
- agents used for nausea and vomiting associated with chemotherapy (Zofran[®], Kytril[®], Anzemet[®]);
- blood stimulating factors for patients receiving chemotherapy (Neulasta[®], LeuKine[®], Neupogen[®]);
- Amevive[®] for the treatment of psoriasis;
- Pulmozyme[®] for use in cystic fibrosis patients; and
- Singulair[®] for the indication of asthma.

The potential for cost savings with these medication classes is large. In one state, with which we consult, we evaluated the cost savings of a prior authorization program that was implemented and targeted at the first five therapy classes noted above. Based on utilization within that state, the estimated gross annual savings was approximately \$12 million or 1.3 percent of total drug spend. (This figure did not account for the administrative costs of the program; including, fees paid to a third-party vendor to accept calls and process denial and approval letters, or costs associated with development of prior authorization criteria.)

Since the inception of this study, the State may have already placed some of these medications on prior authorization status; however, we recommend that the State consider expanding the clinical prior authorization program. Prior to such an expansion, a workload evaluation should occur. The volume of faxes and phone calls received will be dependent upon current utilization and prescribing patterns in the State, an understanding of the clinical criteria for each medication, and communication with both beneficiaries and providers.

Based on the information available to us, we cannot definitely quantify savings for the State based on an expanded prior authorization list. However, we can comment that based on unpublished information from national PBMs that service Medicaid managed care and other commercial clients throughout the country, that the implementation of a prior authorization program for some or all of these medications could result in cost savings ranging from 0.5 – 2.0 percent of total drug spend annually.

State's initial reaction to opportunity: The State notes that they are currently moving to increase the number of medications subject to prior authorization through the Enhanced Prior Authorization Program.



Fraud and Abuse Programs

Fraud and Abuse Programs — Current Situation

One of the many challenges that all third-party payers encounter is the potential of fraud, abuse, and diversion of pharmaceutical products. Federal Medicaid law allows states to impose different types of limitations on pharmaceuticals provided that such limitations are necessary to discourage fraud and abuse. Based on interviews, the following fraud/abuse structured programs are in place for the State's Medicaid program:

- pharmacy lock-in program; and
- profiling of pharmacy providers.

The State's lock-in program is structured such that beneficiaries can be locked into a particular provider — either one pharmacy, or one physician — or locked into a combination of both a designated pharmacy and physician. Therefore, any beneficiary placed into this program and subject to the former lock-in requirement, must fill all prescriptions at a designated pharmacy, or receive services from the designated physician. If a beneficiary is locked into a combination program, they must receive services from both the designated physician and pharmacy. This section will primarily focus on the designated pharmacy lock-in portion of the program.

All functions of the lock-in program are managed by individuals employed in the State's Medicaid Bureau of Care Management. According to State Medicaid pharmacy staff, beneficiaries are identified for lock-in based upon detection of excessive use of medications, excessive use of controlled substances, or overlapping use of medications within similar therapy classes. Currently, the identification of beneficiaries that may be eligible for pharmacy lock-in comes from referrals from providers or concerned citizens. Any individual that detects abusive patterns is encouraged to refer this beneficiary to the Medicaid Bureau of Care Management. Upon identification, the profile and behavioral pattern for each beneficiary is reviewed and a decision is made regarding lock-in status in which Primary Care nursing staff work closely with State pharmacy staff to make an informed decision. Once placed in the program, beneficiaries are allowed to elect the

pharmacy in which they would like to be locked into and from which all prescriptions must be filled. Administratively, the EDS claims-processing system is programmed to reject all pharmacy claims that are not submitted by the designated pharmacy. The length of the lock-in period is terminal (24 months) and then lock-in status is re-reviewed. Currently, there are approximately 130 beneficiaries enrolled in any one of the lock-in programs (pharmacy lock-in, physician lock-in, or combination physician/pharmacy lock-in).

As noted, identification of potential lock-in candidates is currently based on referrals from any individual suspecting abusive behavior. However, it was noted that through the introduction of the Heritage software, the goal is to utilize the clinical rules within the software programs to increase the identification of abusive patterns to review potential abusive behaviors on a more structured and scheduled basis. The Bureau of Care Management is currently finalizing revised lock-in identification and criteria as part of an overall program revision.

SURs staff also noted that fraudulent patterns at retail pharmacies are reviewed quarterly. Upon further questioning, staff clarified that this review consists of comparing the “billed charges” submitted data field amongst provider pharmacies. SUR Staff participating in this interview did not elaborate further on this program.

Fraud and Abuse Programs — Assessment and Opportunities for Consideration

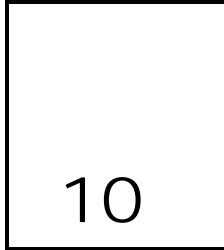
The State pharmacy lock-in program is similar to programs enforced in other states. However, we believe there are opportunities to further enhance the methods utilized to detect and identify beneficiaries abusing the pharmacy benefit. One such method is through the use of a retrospective claims review program. As previously discussed, retrospective DUR interventions are often used in this capacity to help detect specific polypharmacy issues, such as use of multiple pharmacies, multiple physicians, and multiple medications within the same therapy class. We recommend that State pharmacy staff utilize the reporting capabilities of *CyberFORMANCE* and Heritage software and establish predefined criteria to identify abusive beneficiary patterns on an ongoing and frequent basis.

With the additional capabilities that *CyberFORMANCE* offers, the State should consider opportunities to further enhance pharmacy provider profiling and detection of fraudulent behaviors. State pharmacy staff should maximize *CyberFORMANCE* to help monitor and detect pharmacies that are misusing or abusing the use of the *Early Refill* edit override code and/or the 72-hour emergency supply edit override code. Additionally, this tool should be used to assist the State SURS unit in identifying patterns that would warrant further auditing and investigation.

One additional area that is a target for fraud and abuse within other states is the payment of services for ineligible claimants. We did not discuss eligibility processing as a part of

this study, but recognize that Medicaid pharmacy programs are continually improving their eligibility updating policies and procedures and POS edits, to minimize abuse of the benefit. Additionally, we recommend that the State periodically review, or audit, the efficiency and accuracy of EDS in the uploading and maintenance of eligibility data supplied by the State.

State's initial reaction to opportunity: The pharmacy department agrees with this strategy, but has been restricted in their ability to implement enhanced fraud and abuse detection programs due to limited personnel.



Claims Data Fields

After receipt of the detailed pharmacy claims data from the State, it was apparent that two key fields, which are typically necessary for comprehensive monitoring and management of a pharmacy program, were either captured incorrectly, or not captured at all. Both fields relate to accurate identification of the prescribing physician — the “physician identifier” field and prescribing “physician Drug Enforcement Agency (DEA)” field.

Upon receipt and initial validation of the claims data, we discovered that the physician identifier field was populated with a variety of entries which did not appear to be valid State physician identifier values. During discussions with State representatives, we learned that the physician identifier field is not validated for accuracy of the input information, but only validated for content and the presence of a character in that field. Further analysis of the data showed that retail pharmacies have learned that there is not a validity check on this field and; therefore, input a variety of characters (e.g., %, /, <period>, ?, -) or other sequences. In order to fully understand the magnitude of this issue, we completed an analysis on the contents of this field identifying valid physician identifier values in the claims data, as compared against a prescriber license number file originally provided by the State. We calculated the accuracy of the claims data to that of the prescriber file for each calendar year of data supplied. We discovered that the presence of a valid/accurate matching physician identifier on the claims data has declined steadily over the three calendar years as demonstrated in the table on the following page.

Physician Identifier Analysis				
Year	Matching Claims	Claims with 777777	Non Matching Claims	Total Claims
2000 ¹²	808,678	141,001	897,039	1,846,718
	43.8%	7.6%	48.6%	100%
2001 ¹²	895,863	203,518	1,043,796	2,143,177
	41.8%	9.5%	48.7%	100%
2002 ¹³	814,430	241,213	1,002,813	2,058,456
	39.6%	11.7%	48.7%	100%

In the 2002 data, a valid physician identifier was present only on 39.6 percent of the claims; whereas, with 2000 data, a valid physician identifier was present on 43.8 percent of the claims. For each calendar year, the remainder of claims were populated with either 777777 or a variety of different characters. According to the Idaho Pharmacy Provider Handbook, pharmacies are instructed to submit the value of 777777 if the prescriber license number is unknown. Data shows an increase in the number of pharmacies submitting 777777 from 2000 to 2002. In all three years, pharmacies are consistently submitting nearly 49.0 percent of claims with erroneous characters populating the physician identifier field.

The physician identifier field is a key component of nearly all pharmacy management programs. The success of DUR programs, in general, will be impacted when this field is not captured in the claims data. Specifically, the success of DURs that focus on detecting polypharmacy (e.g., beneficiaries that seek out multiple physicians for the same medication or beneficiaries receiving unnecessary medications from one or more physicians) and DURs that focus on detecting fraud and abuse will be negatively impacted when this information is not available in the claims data. Additionally, the accuracy of any physician profiling activity will be negatively impacted due to the lack of complete physician identifier information. Therefore, in 2002, 60.4 percent of the claims will be ineligible for DUR or any physician profiling activity.

The second data field, which is not even captured in the State pharmacy claims data is the prescribing physician's DEA number. By federal and state pharmacy law, the DEA number is only required to be present and accurate for the dispensing of a controlled substance. In fact, according to the Idaho Board of Pharmacy Newsletter, September 2000, they encourage and even mandate that a valid DEA number be submitted by licensed pharmacies on all controlled substance prescriptions, and warn retail pharmacies that "knowingly entering incorrect information will be grounds for citation." Therefore,

¹² based upon calendar year evaluation

¹³ represents January – November 2002 (11 months of data)

the accuracy of the DEA, if it were to be captured in claims data, would have a probability of accuracy and completeness. Although this field is only mandatory for controlled substances, if this field were to be validated and captured at the POS, the ability to perform DUR and detect fraud and abuse would improve.

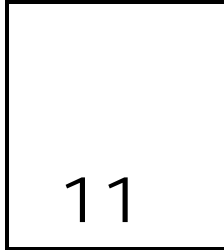
Recommendations

The success of several pharmacy management initiatives is dependent upon the ability to accurately identify the prescribing physician. Specifically, the accuracy and quality of DUR initiatives (either retrospective or prospective), and physician profiling activities will be negatively impacted due to the lack of complete physician identifier information on the pharmacy claims.

According to the State Medicaid Provider Handbook (3 – 49), “only valid prescriber license numbers, or the value of 777777 if the prescriber license number is unknown,” are allowed in the physician identifier field. However, the State is not currently editing this field for accurate entry during the adjudication process. We recommend that the State begin enforcement of a valid entry in physician identifier field with a corresponding hard edit for inaccurate submissions. Concurrently, we recommend that the State initiate a monitoring program on the use of the 7777777 entry by retail pharmacies to identify those pharmacies with an increase in the use of this entry with the implementation of the hard edit and validity check.

Although submission of an accurate DEA for controlled substances is currently a requirement published by the Idaho Board of Pharmacy, the State is not currently capturing or editing this data field. We recommend that the State edit and validate the submitted physician DEA field for controlled substance prescriptions during the adjudication process. Industry standards use two forms of validation on this field. One method is to enforce submission of a valid format. DEA numbers use a mathematical algorithm to ensure that the number entered is in the proper format. However, this is a published algorithm and it is known that fraudulent DEAs are often created to meet the mathematical criteria. Therefore, validating on the mathematical algorithm, increases the **accuracy** of the DEA number but does not ensure that the DEA number is **valid**. The second method of enforcement is to validate the DEA against a master DEA number file, typically provided by the claims processor. This type of file contains all valid and issued DEA numbers in the country and is available through sources such as the American Medical Association. Improving the accuracy of the DEA field (although only mandatory for controlled substances at this point), will result in improvement in the ability to detect fraud and abuse.

State’s initial reaction to opportunity: The State notes that the pharmacy department has previously identified this as an issue and noted that physician identifier information is being incorporated into the HIPAA release scheduled for October 2003.



Utilization Management Opportunity — Dose Consolidation

Background on Dose Consolidation

Within the industry, it is well recognized that certain medications are not prescribed in the most efficient manner — providing opportunities to improve quality and increase savings. The basis of a dose consolidation program is that certain medications are prescribed twice daily, but are suitable for once daily dosing. For instance, physicians may prescribe Accupril® 10mg twice a day when taking Accupril 20mg once a day is just as effective. These prescribing practices result in unnecessary costs and the potential for medication noncompliance.

It is well established in the pharmaceutical literature that medication noncompliance increases proportionally as the number of daily doses increases¹⁴. The consequences of medication noncompliance are far-reaching, both from an economic standpoint and in terms of morbidity and mortality. One approach to manage medication noncompliance is to reduce the number of doses taken each day. Through programs like dose consolidation, there is an increase in quality of care as medication compliance improves due to a decrease in the frequency of dosing; as well as a decrease in total cost as fewer doses are dispensed. However, only certain medications are appropriate for a dose consolidation program and they should have the following characteristics:

- medication is available in multiple strengths,
- medication is FDA approved for once daily dosing based on pharmacokinetic profile,
- medication is currently prescribed as multiple units per day (e.g., twice daily dosing), and
- the higher strength offers a price advantage that will result in cost savings when the dosing regimen is consolidated from multiple doses to a once daily dose.

¹⁴ Eisen SA, The effect of prescribed daily dose frequency on patient medication compliance, *Arch Intern Med* 1990 Sep; 150(9):1881 – 4

The savings that results from a dose consolidation program are achieved when the manufacturer of the medication sets parity, or nearly equivalent, pricing across medication strengths. In the previous example, the AWP per tablet of the 20mg version of Accupril is equal to the AWP per tablet of the 10mg version. Therefore, dispensing thirty tablets of 20mg Accupril (a 30-days supply) with directions to “take one tablet daily” will result in an ingredient cost that is approximately half the cost of a prescription for sixty tablets of 10mg Accupril (a 30-days supply) with directions to “take one tablet twice daily.”

In comparison to state government programs, dose consolidation initiatives in the commercial marketplace have experienced quick uptake; specifically, in MCOs that utilize national pharmacy benefit managers. Independent sources have evaluated medications that would be eligible for this type of program based on the criteria above. Eligible medications include those from various therapeutic classes; including, medications used in the treatment of chronic disease states, such as cardiovascular disorders (Angiotensin Receptor Antagonists, ACE Inhibitors, Calcium Channel Blockers, and Beta Blockers); high cholesterol (HMG-CoA reductase inhibitors); behavioral health disorders (SSRIs and Effexor[®]); arthritis/pain (COX-II inhibitors); and gastrointestinal disorders (PPIs).

In the government sector, two states that have implemented a dose consolidation program are Missouri and Minnesota. Missouri’s program was implemented in April 2003, in which a few select therapy classes and medications were initially targeted, with the remainder scheduled for implementation later in 2003. The listing of medications currently subjected to Missouri’s program can be located at <http://www.dss.state.mo.us/dms/dated/doseoptprod.pdf> Missouri Staff indicated that the list was developed using FDA guidelines and clinical practice standards and utilizes a hard edit of the POS. Missouri pharmacy staff noted that no resistance from providers was experienced and that to date savings from this initiative has met projected figures to date. Alternatively, Minnesota’s program does not utilize a hard edit, but is using a retrospective intervention program with retail pharmacies, in which profiles were mailed identifying opportunities for consolidation. Prior to publication of this report, we were unable to learn specific details of Minnesota’s program.

Dose Consolidation — Analysis and Findings

In order to assist the State in evaluating the potential impact of implementing a dose consolidation program, Mercer completed a comprehensive evaluation utilizing State claims experience data. A detailed section on the methodology and analysis used to complete this evaluation is located in Appendix B, which also contains our conclusions and recommendations. However, we have outlined the key findings if a dose consolidation program were implemented.

- Dose consolidation programs within the industry will vary in the medications that are targeted for consolidation.

- We reviewed the medications subjected to dose consolidation from three sources and selected a **representative** sample of medications that would be appropriate in a Medicaid population.
- Based on this representative list located in Appendix B, we analyzed the State's claims experience to determine cost savings potential.
- Had the State implemented a dose consolidation program for the medications on the representative list, during State FY02, we calculated an estimated savings potential between \$305,000 and \$549,000 annually. (However, this list of medications is not all-inclusive and State representatives noted a desire to add additional medications to this representative list.)
- The calculated savings range is dependent on the program structure — use of hard or soft edits to control quantities dispensed and the final list of medications targeted for dose consolidation.

Dose Consolidation — Implementation Considerations

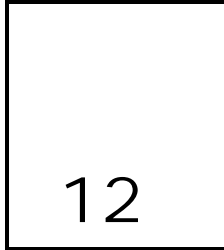
Implementation of a dose consolidation strategy will require coordination with the claims processor, as well as system capability/flexibility. In order to achieve optimal success for this program, we believe that a hard edit at the POS will be necessary to change physician prescribing habits. (However, a retrospective program similar to Minnesota's will not achieve the level of cost savings, but will be less invasive and more palatable). If the State elects to implement a dose consolidation strategy with hard edits, they must be accurately programmed into the system, and provide appropriate adjudication messaging at the POS to notify pharmacists of the consolidation policies and appropriate action steps. Likewise, the State will need to develop override policies and procedures, identifying populations and instances in which the consolidation interventions should not apply — such as the period of time when a member is initially prescribed a medication and is going through a dosage titration to determine the most effective individualized dosage. Finally, a communication strategy to all stakeholders will be necessary to ensure the success of the program. Communications to physicians regarding dose consolidation should emphasize FDA approval information and pharmacokinetic profile for each targeted medication and, likewise, emphasize the opportunity to improve medication compliance by moving to once daily dosing. Communications to retail pharmacies should focus on the established policies and procedures of the program and on counseling tips to encourage participants to adhere to the prescribed regimen. Communication to participants may also be necessary — depending on the structure of the program and if current prescriptions for the selected medications will be grandfathered or targeted for immediate dose consolidation.

Dose Consolidation — Recommendations

We recommend the State consider implementation of a dose consolidation program for particular drug classes, beginning with a phased-in approach for a few select drug classes, adding additional classes as the program matures. The impact of a dose consolidation program will be dependent upon program structure, coordination with the claims processor (including system capability and flexibility), communications with the provider

community, and development of override policies and procedures. The end result of a dose consolidation program will be an opportunity to decrease the number of doses a patient must take each day, as well as increase savings potential (estimated savings potential between \$305,000 and \$549,000 annually). We recommend the State consider a dose consolidation program as an additional option to help improve medication compliance and manage on-going drug spend.

State's initial response to the opportunity: According to the Department, dose consolidation initiatives were implemented in May 2002 through the pharmacy consultation program. The pharmacy consultation program occurs when a physician requests a clinical review of the beneficiaries medication profile. If a Department pharmacist identifies a dose consolidation opportunity, they will advise the physician at that time. The State also notes that implementation of this initiative has been limited due to availability of personnel; the software release scheduled for December 2003 will increase utilization of this program.



Utilization Management Opportunity — Quantity Limitations

Background on Quantity Limitations

A quantity limitation program is a utilization management strategy intended to prevent inappropriate medication use or excessive prescribing. This program can minimize overutilization, encourage proper clinical use of medications, and minimize the likelihood of an adverse drug event and potential hospitalizations. Therefore, a quantity limit program focuses on both quality of care and cost management. Quantity limit edits should be established such that they are consistent with FDA-approved dosing schedules, manufacturer's recommended maximum daily doses, and treatment guidelines. Typically, quantity edits are applied to medications that have a defined duration of treatment (e.g., oral Toradol[®], oral Diflucan[®]) or have the potential for inappropriate duration of treatment (e.g., abortive migraine therapy, short term sedative hypnotics). Depending upon the flexibility of the adjudication system, quantity limits can be enforced as:

- specific quantity per dispensing event (e.g., 16 tablets for a 30-days supply retail prescription of Imitrex[®] 50mg); or
- maximum daily dose per prescription event (e.g., comparison of the submitted days supply and submitted quantity to determine if daily dose parameters are exceeded).

As noted in the Clinical POS, DUR Edit Section, the State currently has maximum/minimum days-supply edit turned on in the adjudication system; however, this edit does not also edit on the days supply field. Therefore, pharmacies can circumvent the current edit by splitting the prescription so as not to exceed the maximum daily dose. An industry standard claims adjudication system should compare both days supply and submitted quantity.

Quantity Limitations — Assessment and Findings

Medications that appear on a quantity limit list can vary — depending on the breadth of the list and the flexibility of the adjudication system. Often, vendors such as national

pharmacy benefit managers offer similar quantity limit programs that include many of the same medications and predetermined quantity limitations. Therapy classes typically included on quantity limit lists include: antihistamines, certain antibiotics and antifungals, sedative-hypnotics, influenza medications, migraine headache medication, anti-emetics, narcotics such as Oxycontin[®], erectile dysfunction medications, certain oral inhalers, and certain behavioral health medications.

Quantity limit programs are well accepted by various stakeholders and providers within the commercial sector. However, numerous states have also adopted this cost containment strategy. For example, within the comparison region, Oregon currently has quantity limitations in place for anti-emetics, certain sedative hypnotics, and pain medications, such as Toradol[®]. Washington has implemented quantity limits on the various migraine headache medication therapies and Wyoming has also imposed quantity limits on migraine headache therapy, Sonata[®], Toradol, Oxycontin, and Viagra[®].

Based on unpublished information from national PBMs that service Medicaid managed care clients throughout the country, the implementation of a quantity limit list that spans the therapeutic classes noted above, plus oral inhalers, typically results in cost savings ranging from 0.5 – 2.0 percent. The savings potential is dependent upon current utilization and prescribing patterns, medications subjected to these edits, use of a hard edit at the POS, and use of both quantity per dispensing event edits, as well as quantity per day edits. Based on an annual drug spend of \$118,878,341 in FY02 it is anticipated that the State could realize savings between \$594,000 and \$2,378,000 annually with the implementation of a quantity limit program. In addition to this estimated savings, the potential for adverse drug events is decreased, simply by minimizing excessive quantities dispensed and available to the beneficiary. As a result, there is an anticipated decrease in medical costs with the improved quality of care.

Quantity Limitations — Implementation Considerations

The savings potential that may result from the implementation of an extensive quantity limit list is dependent upon the ability of the EDS adjudication system to support additional edits in the system. The savings potential will increase if the program is implemented with hard edits at the POS requiring approval for any claim submitted which exceeds the predefined limitation.

In order to gain physician acceptance of this program (with the accompanying hard edits), the initial list of medications subjected to quantity limitations should be developed using current medical literature and input from practicing providers within the State. Review and approval of such a list could be assigned to the State Pharmacy & Therapeutics Committee that will be formed by July 2003.

The success of a quantity limit program with hard edits at the POS will be dependent upon understanding of the program by the provider community. Communication efforts should emphasize the value of such edits as a means to further improve the quality of care and reduce drug misadventures. Accurate messaging at the POS will assist pharmacists in

understanding that the quantity submitted exceeds the defined limit established by the State. Equipped with such information, the dispensing pharmacist can evaluate the prescription, dispense a lower quantity of medication while adhering to the original directions for use, where appropriate, or contact the prescribing physician and request a change in dosing frequency or amount prescribed per day. Communication via newsletters and information posted to the State web site should provide the information needed by pharmacists to explain to the beneficiary at the POS the need to call the physician for dosing clarification. Pharmacists should become accustomed to informing beneficiaries that this program is a part of the whole process of ensuring they receive the right medication, at the right dosage, for the correct duration — which helps to ensure that their disease state is properly treated, while minimizing the risk of side effects and other adverse reactions.

After development of such a quantity limit list, the State must also give consideration to developing appropriate override policies and criteria for these edits. Additionally, the State will have to determine which entity (State pharmacy staff or a contracted vendor) will be responsible for receipt of override requests. If edits are established according to accepted and published guidelines, override requests should be minimal. However, these estimated internal costs should be factored out of the estimated savings expected from such a program. Likewise, these estimated savings do not account for fees that would be charged by EDS to provide this program, or accept override exception requests.

In discussions with State representatives in May 2003, it was noted that functionality to support additional edits, such a quantity limits per dispensing event and per dose, may become available in the EDS claims processing system in December 2003. This enhanced functionality will result from EDS' system modifications that must occur in order to support the implementation of the Enhanced Prior Authorization Program (discussed in Section 16).

Quantity Limitations — Recommendations

We recommend the State implement a robust quantity limit program utilizing hard edits at the POS in December 2003, providing EDS system functionality. In the interim, State pharmacy staff should begin developing this list of suggested medications and the corresponding quantity limitations (either daily limitations or limitations per dispensing event) for approval by the State P&T Committee and Medical Director. Finally, in the selection of medications that will be subjected to quantity limitations, consideration must be given to the status of medications on the Enhanced Prior Authorization program in order to ensure consistent, coordinated pharmacy management efforts.

Based on FY02 drug spend it is estimated that the State could realize savings between \$594,000 and \$2,380,000 in calendar year 2004 with the implementation of a quantity limit program in December 2003.

State's initial response to opportunity: The pharmacy department believes they have placed quantity limits on a vast majority of the available pharmacy products.

13

Reimbursement Opportunity — Specialty Injectables

Background on Specialty Injectables

The development and delivery of biotechnology products, including injectable or infusion medications, has emerged as one of the newest, fastest growing markets within the pharmaceutical industry. Pharmaceutical manufacturers have a robust development pipeline — as they continue to study and market such biotechnology products — that allows for a shift away from hospital-based product administration and care to ambulatory-based care. Most of these products generally, but not exclusively, require injection or other unique methods of administration, and special handling, and/or refrigeration.

The traditional delivery and billing of these products is via one of the following methods:

- participants receive prescriptions from physicians for self-injectables, and receive the medication through the retail pharmacy;
- physician administers these products in their office and bills using healthcare common procedure coding system (HCPCS) J-codes and standard office administration fees; or
- home infusion vendor delivers (may or may not administer) and bills this product via a standard medical claim.

When the participant receives the medication through the physician’s office, the third-party payer is obligated to reimburse the physician at a much higher price than would have been paid had these products been purchased through retail pharmacies and/or reimbursed through the pharmacy benefit with an associated discount.

As a result of the explosive growth in this marketplace over the last five years, a new approach termed “specialty pharmacy” has emerged. Currently, there are over 100 biotechnology products on the market, with hundreds more in the pipeline — targeted for use in the outpatient- or ambulatory-care setting. Numerous vendors and entities have capitalized on this market (and growing industry) need and developed capabilities and services to manage specialty pharmaceutical products; including, inventory and delivery

of the product, coordination of care, and adherence to best practice guidelines. The end result is cost control and improved quality of patient care by capitalizing on services offered by these vendors; including, extensive patient education and counseling, active monitoring of compliance with prescribed regimen, customized dosing by clinicians, reduction in medication waste and hoarding, and 24-hour customer support and access to trained clinicians.

Specialty pharmacy services is a concept that can be provided by different entities; including, a stand alone specialty vendor; an established pharmacy benefit manager providing specialty vendor services; or teaching hospitals, clinics, retail, or home health pharmacies located within the State that are willing to provide specialty vendor services; including, discounted prices, coordinated care activities, patient education, and case management activities. During interviews with State pharmacy staff, we noted that currently, the State does not have any special contracts with outpatient providers for the delivery and/or dispensing of such high-cost, specialized products. However, as noted in the MAC analysis section, the State does apply aggressive MAC pricing to specific injectable medications.

Specialty Injectables — Analysis and Findings

In order to assist the State in evaluating the potential impact of implementing a specialty injectable program and calculate potential unit cost savings at retail pharmacies, we completed a comprehensive evaluation utilizing State claims experience data, as well as product lists from 2 national specialty injectable vendors. A detailed section on the methodology and analysis used to complete this evaluation is located in Appendix C, which also contains our conclusions and recommendations. However, we have outlined the key findings and conclusions in the following section.

- Based on the traditional delivery methods for injectable products, opportunities exist to capitalize on unit cost savings and patient care management in both physician offices, as well as retail pharmacies.
- Many of the specialty medications are currently billed through physician offices using HCPCS J-codes. The scope of this savings evaluation focused only on unit cost savings for injectables processed through retail pharmacies, as that is what is captured in the outpatient processing of pharmacy prescriptions. Therefore, depending on the utilization and administration of these products in physician offices, additional savings would be expected.
- The 2 national specialty injectable vendors offer discounts of AWP-14% for these injectable products with either a \$0.00 or \$2.50 dispensing fee for a majority of products on their list.
- The State is currently reimbursing retail pharmacies at AWP-12% plus a \$4.94 dispensing fee, and is likely reimbursing physicians for any specialty injectables administered in the physician's office at full AWP (or with a small discount) plus an in-office "drug administration" fee.
- The SMAC price assigned to select specialty injectables is significantly more aggressive than the discount offered from either specialty vendor.

- Based purely on injectable unit cost utilization, through retail pharmacies during FY01 – FY02, we estimated annual savings potential between \$32,000 and \$74,000. During the time period January 2002 – November 2002, we estimated annual savings potential between \$114,000 and \$164,000. Injectable drug spend was approximately \$7,382,000; therefore, potential savings ranging from 0.4 to 2.2 percent of injectable drug spend.
 - If such a program were implemented to include specialty injectables delivered and billed in a physician office, the result would be additive unit cost savings, as well as increased recovery of federal rebate dollars that are currently not collected when a prescription is billed through the physician office using HCPCS J-codes.
- As new biotech injectables come to market, there will be an increased opportunity for unit cost savings and return of federal rebate dollars.
- The benefit of a specialty vendor includes not only unit cost savings, but also coordination of patient care, appropriate dosing and utilization, reduction in medication hoarding and waste, side effect management, overall improved outcomes, and increased rebate potential.

Specialty Injectables — Implementation Considerations

If the State considers a specialty injectable program, consideration must be given to the fact that the Medicaid population is transient and; therefore, the delivery of medications and coordination of care will be challenging. However, members with chronic disease states in which these injectable medications are used, are likely to continue to receive Medicaid services for many years. As a result, the opportunity for intervention with this population may begin in the physician office — as a primary means to educate and acclimate the member to this delivery method. Over time, product delivery and coordinated care may be able to shift away from the physician office to more home delivery through the specialty vendor.

If the State elected to adopt a specialty injectable discount program offered by a third-party vendor, a full procurement would be required. The costs associated with this process are not included in the savings calculation. Additionally, if the State elected to adopt a specialty injectable discount program offered by a third-party vendor, the program should be designed to ensure continuation of the aggressive MAC pricing for those select injectable products included on the Idaho SMAC list.

Specialty Injectables — Recommendations

We recommend the State consider this program as an opportunity for cost savings, as well as a method to ensure the consistent delivery of quality patient care for certain injectables and the corresponding chronic disease state. The savings calculated through this evaluation only apply to injectables currently dispensed through retail pharmacies; far greater savings would be expected from claims processed through HCPCS J-codes. Therefore, a phased in approach of such a program would be ideal for the State; with an initial focus on injectables currently billed through the physician office. A specialty vendor should offer services that integrate directly with the physician office — removing

the burden of paper claim billing, but offering the convenience of product delivery by the specialty vendor to the physician office for administration to the patient. Products with high claims volume could initially be targeted with other products implemented over time. The end result of any form of specialty injectable program will be an opportunity for unit cost savings, as well as a method to ensure consistent delivery of quality patient care for selected disease states that utilize such injectables.

State's initial response to opportunity: The State notes they have briefly evaluated this initiative and have scheduled implementation of a similar program in late 2003 or early 2004. However, this initiative has received lower priority than other initiatives based on cost savings potential.

14

Utilization Management Opportunity — Step Therapy

Background on Step Therapy

A step therapy program is a management strategy focused on encouraging initial utilization of clinically appropriate, first-line agents that are often less expensive, but equally effective to second- or third-line agents. This type of step therapy edit optimizes appropriate drug therapy while controlling costs by defining how and when a particular drug or drug class should be used, based on defined clinical algorithms and a beneficiary's prescription history. If expected response is not received from an adequate therapy trial of a first-line medication, then the beneficiary would be eligible for newer, more expensive, second-line therapy. Step therapy program criteria are based upon treatment guidelines defined by best practices that are widely accepted within the medical community.

Ideally, this type of program applies this clinical algorithm on-line at the POS. As the prescription is processed, the system automatically reviews the beneficiary's medication profile for previous use of first-line agents in correspondence with the criteria of the algorithm. If the criteria are met, the prescription automatically processes in real time, omitting the need for a manual review. (This review is provided seamlessly as the prescription is filled and is different from a prior authorization that automatically rejects the claim at the POS, subsequently requiring a phone call or fax for approval.) However, if the predefined criteria are not satisfied, a reject message is transmitted back to the dispensing pharmacy, authorization is denied, and the process is similar to standard prior authorization in which a phone call must be initiated by the dispensing pharmacy to a call center or to the appropriate authorization entity (in this case, the call would be received by State pharmacy staff).

Step Therapy — Analysis and Findings

Step therapy programs are commonplace within the commercial environment, particularly in areas with high managed care penetration. Within their client base (which includes

employer groups, Medicaid managed care plans and commercial managed care plans, and other third-party payers), national pharmacy benefit managers have calculated savings that result from implementation of an automated step therapy program. Savings estimates are reported between 0.5 – 3.0 percent of total drug spend — depending on current utilization, the therapeutic classes targeted, and number of edits implemented. Medications and medication classes that are typically subjected to a step therapy program, include:

Therapy Class Subjected to Step Therapy	Drugs impacted
Angiotensin II receptor antagonists (used to treat hypertension)	Atacand [®] , Avapro [®] , Avalide [®] , Cozaar [®] , Hyzaar [®] , Micardis [®] , Diovan [®]
DMARD anti-rheumatoid agents (used to treat juvenile arthritis and rheumatoid arthritis)	Enbrel [®] , Arava [®] , Kineret [®] , Humira [®]
Non-sedating antihistamines (used to treat allergies/asthma)	Claritin [®] , Allegra [®] , Zyrtec [®]
COX-II inhibitors (used to treat arthritis/pain)	Celebrex [®] , Vioxx [®] , Bextra [®]
Antibiotics (used to treat infection)	Third generation cephalosporins and Zyvox [®]
Branded medications when generic alternatives within the therapy class exist	Branded NSAIDS, branded ACE Inhibitors
Medications used for insomnia	Sonata [®] , Ambien [®]
Pain medications	Duragesic [®] , Ultram [®] , Actiq [®]
Medications used for acne	Accutane [®]

A large percentage of the reported and estimated savings can be attributed to the use of an automated POS system that reviews beneficiary prescription drug history and eliminates the need for manual review. Therefore, our analysis focuses on an automated step therapy model.

Based on unpublished information available from national PBMs, the savings from an automated step therapy program has been calculated between 0.5 – 3.0 percent of total drug spend – depending on medications subjected to the program, other overlapping management programs, and utilization patterns. Currently, the State has management programs for COX-II inhibitors and non-sedating antihistamines, and since the inception of this study, may have initiated a management program for other therapy classes noted above. Therefore, the savings potential for the State using an automated step therapy program would be mitigated and may only achieve savings of 0.5 – 1.0 percent of drug spend.

The State is currently administering a form of manual step therapy for one therapy class currently subjected to prior authorization — COX-II inhibitors. All new prescriptions for COX-II agents must be reviewed and approved by the State pharmacy department. During this approval process, beneficiary prescription drug history for prior drug therapy is manually reviewed. Likewise, there are labor and infrastructure costs associated with this manual review and approval process. The State currently has no products subjected to automated step therapy, as this type of edit is dependent on the capability and flexibility of the claims processing system. In discussions with State pharmacy staff in May 2003, it was noted that automated functionality to support step therapy should become available in the EDS claims processing system in December 2003. This enhanced functionality will result from EDS' system modifications that must occur in order to support the implementation of the non-preferred drug initiative (discussed in Section 16).

Within the government sector, the State of Missouri has also successfully implemented a step therapy program. Therapy classes include second generation antihistamines, ACE Inhibitors, COX-II inhibitors, Forteo[®] for the treatment of osteoporosis, and HMG CoA reductase inhibitors and Zetia[®] for elevated cholesterol. Certain therapy classes in this program were implemented in December 2002 with others implemented during the first and second quarter of 2003. The program automatically checks the patient history at the POS and rejects the claim if the predefined criteria are not met and returns a message to the pharmacist. Prior to the implementation of each therapy class subjected to the step therapy requirements, Missouri prepared communications for each physician with patients that would be impacted by this program. This communication explained the program and step criteria and notified physicians of the date of implementation. Missouri pharmacy staff indicated that this process helped to minimize confusion and resistance that might have been received from the provider community.

Step Therapy — Implementation Considerations

The savings potential that may result from the implementation of step therapy is dependent upon either the ability of EDS to support an automated POS program, or on the resources available within the State pharmacy department to continue with the current manual approval process. The automated step therapy approach occurs at the POS, is less disruptive to beneficiaries, imposes less administrative burden on providers and is accordingly more cost effective. However, the savings range noted on the previous page does not take into account costs that would be charged by EDS for this service. If EDS cannot provide this functionality, and the State elects to continue utilizing the manual review process, adding additional therapy classes, we recommend that an internal analysis be completed to estimate the costs associated with a manual review process. This analysis should determine how operating costs will impact estimated savings potential if additional therapy classes are added.

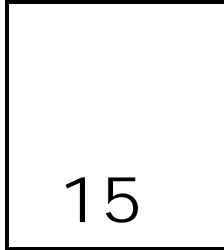
The success of either an automated or manual step therapy program is also dependent upon the communication and understanding of the program by the provider community. Detailed POS messaging will assist pharmacists in understanding that the beneficiary did not meet predefined criteria. Additional communication, such as newsletters, will assist

all providers in understanding the defined step therapy criteria, as well as understanding the processes that should occur when a claim rejects as a result of not meeting the criteria. Communications should also establish the credibility of the program by referencing the current practice guidelines and literature utilized to establish the criteria.

Step Therapy — Recommendations

We recommend the State implement an automated step therapy program in December 2003 with the availability of the EDS functionality. In the interim, the State should continue to manually review the COX-II inhibitor class. State pharmacy staff should begin to identify additional therapy classes which will be subjected to step therapy, as well as development of the corresponding clinical criteria and exceptions policies. In the selection of medications that will be subjected to step therapy edits, consideration must be given to the status of medications in the Enhanced Prior Authorization program in order to ensure consistent, coordinated pharmacy management initiatives. Based on our estimates, implementation of an automated step therapy program in the State may realize annual savings between \$594,000 and \$1.1 million (0.5 – 1.0 percent of drug spend).

State's initial response to opportunity: The pharmacy department notes that step therapy was implemented as a function of expanded prior authorization and the pharmacy consultation program in May of 2002 and continues to function as a non-automated program.



Pricing Opportunity — Pill-Splitting Program

Background on Pill-Splitting Programs

The goal with a pill-splitting strategy is to capitalize on the financial pricing of particular medications via the splitting of tablets. Such a strategy should result in cost savings without an impact on the quality of care. Pill splitting is a well-established medical practice — common in the prescribing and dispensing of medications for both pediatric and geriatric populations. Medications considered for this type of utilization management program must be easily split in half (i.e., a scored tablet) and the price of a higher strength tablet must be similar to a lower strength tablet (equity pricing amongst dosage strengths). Products that would qualify for pill splitting are those where slight differences in dosing caused by manual splitting of the tablets do not pose a threat to the beneficiary's well being or quality of care (i.e., NTI medications). This type of program should be structured such that the prescribing physician and the dispensing pharmacist are encouraged to utilize the higher milligram strength tablet with the intention that each tablet will be split in half, thus reducing the quantity of medication dispensed. Therefore, to provide a 30-days supply of medication, a quantity of 15 tablets would be dispensed.

Opponents of this type of program argue that requiring patients to split the pills themselves could result in patient confusion or inappropriate dosing, and therefore, may result in other medical problems. To help alleviate this realistic issue, the State could require the dispensing pharmacy to split the tablets before dispensing, and reimburse them an additional fee for each prescription that required splitting of the tablets prior to dispensing. Within the commercial industry (in which standard dispensing fees are \$2.00 – \$2.50), an additional reimbursement fee for this service can range from \$1.50 to \$3.50 per prescription.

In comparison to state government programs, pill-splitting initiatives in the commercial setting have experienced quick uptake, specifically in MCOs and in environments with high managed care penetration. Several independent sources have evaluated medications that would be eligible for this type of program based on the criteria noted above. Eligible

medications include those from various therapeutic classes, including medications used in the treatment of hypertension, elevated cholesterol, and depressive disorders. However, in the government sector, the implemented programs have focused on only one therapy class and one medication — Zoloft, which is used primarily in the treatment of depressive disorders. The primary reason that this medication has been singled out within the government sector is the high utilization amongst the covered population, resulting in the potential for significant impact. The following table represents the financial rationale for using Zoloft in a pill-splitting program.

Medication	AWP Cost* per Unit	AWP Cost* for 30 tablets
Zoloft 25mg	\$ 2.11	\$63.30
Zoloft 50mg	\$ 2.15	\$64.50
Zoloft 100mg	\$ 2.18	\$65.40

*AWP cost reflects most recent pricing as supplied by First Data Bank.

As illustrated, the higher strengths of Zoloft are equity priced; therefore, splitting the higher strengths (100mg or 50mg tablets) would result in significant cost savings.

One study published in the *Journal of Managed Care Pharmacy*¹⁵ examined the effects of a pill-splitting program for cholesterol reducing medications. Although the population was not a Medicaid population, the authors found that in addition to unit cost savings there was no significant difference in clinical effect of the medication, medication compliance or beneficiary satisfaction. Therefore, this program did not seem to negatively impact clinical or beneficiary satisfaction outcomes.

Despite the lack of evidence and outcomes studies specifically in Medicaid populations, 3 states moved forward with a Zoloft pill-splitting program — Illinois, Nebraska and Washington. Nebraska implemented a program in April 2000 which includes a hard edit at the POS. Pharmacies are required to split the tablets and are paid \$0.15 per tablet that is split. Therefore, for a standard 30-days supply in which the pharmacist split fifteen tablets to achieve thirty doses, the State would reimburse the pharmacy an additional \$2.25 per prescription. The standard dispensing fee in Nebraska is currently \$3.20 per prescription. Nebraska pharmacy representatives noted that no formal studies have been conducted to assess outcomes associated with this program, but also noted that they have been in close contact with the provider community, have not received negative feedback, and are considering expansion of the program to other appropriate medications. The Illinois program was implemented in 2002 and has the following characteristics: no additional dispensing fee reimbursement (current dispensing fee is \$3.54), and a hard edit at the POS that prevents the dispensing of more than thirty tablets of the 50mg strength of Zoloft. Pharmacy representatives for Illinois stated that due to the infancy of the program, quality outcomes studies have yet to be conducted. Finally, the state of Washington has a voluntary pill-splitting program for Effexor[®], Paxil[®], Serzone[®], and Zoloft. In

¹⁵ *Journal of Managed Care Pharmacy* 2002; 8(6):453 – 458

Washington, the edit is soft at the POS and pharmacists are not paid an additional dispensing fee for splitting tablets.

Pill Splitting — Analysis and Findings

In order to assist the State in evaluating the potential cost savings impact of implementing a pill-splitting program, we completed a comprehensive evaluation utilizing State claims experience data. A detailed section on the methodology and analysis used to complete this evaluation is located in Appendix D, which also contains our conclusions and recommendations. However, we have outlined the key findings if a Zoloft pill-splitting program were implemented.

- The largest utilization in the State claims experience is with the 50mg and 100mg strength Zoloft tablets, with minimal utilization of the 25mg strength.
- The greatest savings opportunity for the State is to implement a pill-splitting program focused on the splitting of 100mg tablets for the purpose of dispensing as a 50mg dose.
- Depending on the program structure (use of hard or soft edits to control quantities dispensed), the success of this program will vary.
- For a Zoloft 100mg pill-splitting program, including an additional dispensing fee of \$2.50 for each prescription in which 100mg tablets were split prior to dispensing, we calculated an estimated savings potential between \$188,000 and \$364,000 annually.

Pill Splitting — Implementation Considerations

Implementation of a pill-splitting strategy will require coordination with the claims processor, as well as the EDS system capability/flexibility. In order for this type of program to be successful, the claims processor must be able to ensure that hard edits will be accurately programmed in the system and provide appropriate adjudication messaging at the POS notifying pharmacies of the pill-splitting policy and appropriate action steps. The State will also need to develop override policies and procedures, defining the populations that should not be subjected to this type of intervention. Likewise, the claims processing system must allow for override flexibility, otherwise administrative hassles will result and additional costs incurred.

The State will also need to make policy determinations on additional pharmacy provider reimbursement. The State should be sensitive to the fact that resistance in the provider community will occur if the dispensing pharmacies do not believe the reimbursement is adequate or fair. Naturally, advocacy groups may feel that beneficiaries will get confused and voice opinions against such a program; therefore, a comprehensive communication strategy is a key component of this type of program. Communication on program implementation must be disseminated to the entire provider community as well. Finally, prior to implementation, the State should consider impact on Medicaid rebates resulting from a lower number of units utilized of both Zoloft 50mg and 100mg tablets.

Pill Splitting — Recommendations

Although the savings associated with a Zoloft pill-splitting program are minimal (\$188,000 to \$364,000), we believe this is a program opportunity that will continue to be relevant in the future. Therefore, we recommend that the State focus on implementing other pharmacy management opportunities in the next 6 to 12 months, reserving this strategy for the future.

State's initial reaction to opportunity: The State notes that a pill-splitting program for Zoloft has been reviewed and rejected due to initial negative response from providers.

16

Utilization Management and Pricing Opportunity — Enhanced Prior Authorization Program and Supplemental Rebates

Background — PDLs and Supplemental Rebate

For many years, PDLs (formularies) have been used in the commercial market to manage pharmacy benefit costs. Likewise, during the past few years PDLs have become an effective tool for states looking to control their overall prescription drug expenditures. A PDL is a condensed listing of clinically-effective medications within selected therapeutic classes that is developed by clinical experts. In order to comply with federal Medicaid regulations, a PDL must be established by a committee that is appointed by the state’s governor and must include physicians and pharmacists; the list must include all drugs of those manufacturers that have a rebate agreement with the federal government, unless a drug does not have a “significant, clinically meaningful therapeutic advantage over other formulary drugs.”¹⁶ For state entities, drugs which are not on the list can be provided to beneficiaries through the prior authorization process, thereby allowing for continued access to all drugs covered under Medicaid. Those states that have implemented PDLs have also successfully leveraged pharmaceutical manufacturers to pay supplemental rebates (rebates above the required federal Medicaid rebate payment) in exchange for inclusion on the PDL. Although supplemental rebate payments are still the subject of pending litigation and appeals, supplemental payments are considered a key component of a PDL program at the state level.

In developing a PDL, the appointed committee reviews drugs by therapeutic class (drugs with similar clinical indications and/or chemical composition). Based on each drug’s effectiveness, safety, clinical outcome data, and cost considerations, several medications from each class are typically selected for inclusion on the PDL. A PDL program has

¹⁶ Social Security Act, Section 1927(d)(4).

proven to be valuable in moving market share to particular pharmaceutical products, as evidenced in Michigan and Florida. Additionally, according to a survey conducted by the National Conference of State Legislatures, 32 states are contemplating the creation of PDLs, or altering their existing PDLs, during the 2003 legislative session.¹⁷

Several states have embraced the use of a PDL as the cornerstone of their pharmacy management program. However, full development and maintenance of a PDL is an ominous task. In order to minimize the administrative burden associated with the startup of a PDL, several states that have written and/or passed PDL legislation within the past 2 years, are also considering the purchase and use of an existing PDL, or developing a custom PDL, by utilizing the standard formulary base from a pharmacy benefits administrator or a pharmacy benefits manager. One such initiative includes the multi-state coordinated effort that was developed in Michigan with assistance from the program administrator, First Health. To date, five states have agreed to join this initiative in which all states will use the same PDL, and will negotiate more aggressive, supplemental rebates due to increased marketshare leverage.

The State's Current Situation

During initial interviews with the State pharmacy staff, they indicated an intention to contract for drug class reviews with the Oregon Health Policy and Research and the Oregon Health and Science University Evidence-based Practice Center. These drug class reviews would serve as the foundation for a State PDL. However, at the time of initial interviews, the States' pharmacy staff did not know when a formal PDL would be developed. Therefore, in an effort to control escalating pharmacy costs, the State implemented a *voluntary*, preferred agent program in March 2003. Through this program, the State requested voluntary compliance in prescribing preferred agents from designated drug classes. In the first phase of this voluntary initiative, the therapy classes from which the State selected preferred agents included *Long Acting Opioids* (treatment of moderate to severe pain), *Triptans* (migraine headache therapy), and *Proton Pump Inhibitors* (gastrointestinal disorders). Communication from the Medical Director to the provider community clearly stated that the "ability to maintain a voluntary approach to the Preferred Drug Initiative will depend upon the prescribers' willingness to use, whenever possible, the preferred medications in a therapeutic class." In May 2003, additional therapy classes added to this voluntary initiative include *Urinary Incontinence Agents and Skeletal Muscle Relaxants*.

In discussions with the State pharmacy department representatives in May 2003, it was noted that this voluntary program had not produced measurable results regarding the prescribing of preferred agents. Therefore, it was confirmed that the State will be implementing a *mandatory* program, which will be similar to a PDL, but the initiative is now called an "Enhanced Prior Authorization Program". Representatives confirmed the following scheduled events regarding this program:

¹⁷ NCSL, "2003 State Health."

⁹Idaho *MediCaid* Provider Newsletter, March 2003.

- purchase of the evidence-based information and therapy class evaluations conducted to date, and in the future by Oregon;
- establishment of a State P&T Committee by June 20, 2003; and
- submission of an Advanced Planning Documents to obtain enhanced funding to pay for the necessary enhancements to the EDS POS claims processing system to support the initiative.

The State P&T Committee will consist of experienced clinicians that will be responsible for utilizing the evidence-based clinical reviews from Oregon to make final recommendations on medications that will be subject to this program. Additionally, the P&T Committee will be responsible for ongoing review and determination of prior authorization status for certain drug classes.

The claims processing functionality from EDS that is necessary to support this enhanced prior authorization program at the POS is scheduled to be fully operational by December 2003. In the fall of 2003, P&T Committee members will make a final determination on the medications that will be subject prior authorization for the following therapy classes:

- statins (high cholesterol),
- triptans (migraine headaches),
- COX-II inhibitors (pain and arthritis), and
- Proton pump inhibitors (gastric disorders).

Through the use of this prior authorization program and accompanying supplemental rebates that are expected to be negotiated with pharmaceutical manufacturers, the State has projected overall saving of 8.0 percent. (This savings projection takes into account the fees associated with the use of the Oregon evidence-based reviews.) In comparison, in the first year after implementation of a PDL in Florida, the program achieved a 6.7 percent savings of total drug spend annually. In Michigan, program savings are expected to reach 10.0 – 12.0 percent based on both supplemental rebates and market shifting to lower cost alternatives.

Enhanced Prior Authorization Program — Assessment and Recommendations

We agree with the State and support the full implementation of this Enhanced Prior Authorization program as it will help to provide a long-term solution to controlling pharmacy costs without eliminating access to medically necessary medications. We have listed below the general recommendations/considerations to the State as they move forward with this initiative.

We recommend that due consideration be given to the process that will be used by the State P&T Committee in the final selection of medications that will be subjected to prior authorization. In conjunction with the evidence-based therapy class evaluations, consideration should be given to needs and characteristics of ethnic and aged populations

within the state; consideration of once-daily versus multiple dosing regimens that will impact medication compliance; consideration to excluding certain therapy classes from the initiative (e.g., HIV/AIDS medications, oncology); and consideration of current prescribing patterns and practices within the state.

Aside from the medications represented in the Enhanced Prior Authorization program, consideration must also be given to the State's costs of implementing, administering, and/or monitoring the associated prior authorization review program. If the approval process is managed in-house by State pharmacy staff, consideration must be given to implementation costs (education and training on the process to providers and recipients), and initial investments in labor, information systems, and telephonic infrastructure, to support the process. If the approval process is managed by a contracted vendor, primary consideration must be given to implementation costs and ongoing monitoring of the vendor to ensure adherence to established standards (including federal Medicaid regulations) and to the quality of services provided.

Additionally, in the development of the clinical rules and edits that will be programmed into the EDS claims processing system, the State should align pharmacy utilization management strategies (e.g., step therapy, pill splitting, provider education programs) to correspond with this program. Through the application of consistent utilization management strategies and physician education efforts, savings can be maximized.

The initial and ongoing success of this program can be maximized through a comprehensive communication strategy with all stakeholders — physicians, pharmacies, and beneficiaries. Communications should include initial provider bulletins regarding this program and the associated P&T processes in order to help gain buy-in from the physician community and mitigate concerns regarding “cookbook” medicine. Once final decisions regarding those medications that will be subject to this program occurs, this information should be communicated to the provider community. When physicians are provided with this level of information, they may be more likely to accept this effort and only request prior authorized agents when medically necessary. There must also be communication regarding the process for appeals and requests for these medications subjected to prior authorization. In an effort to assist the dispensing pharmacists in adapting and accepting this program, the EDS system should provide on-line, POS adjudication messaging to the dispensing pharmacist, including alternative therapy options. One final message that should be communicated to all stakeholders is that the State will provide a process that will continue to allow access to any prior authorization medication if it is determined to be medically necessary to meet the beneficiary's needs.

Finally, consideration should also be given to implementing a single coordinated drug list for multiple state agencies, such as public employees, department of justice, and Medicaid. This type of coordinated effort has the potential of yielding additional savings based on the ability to leverage prescribing patterns for an even larger population. Two states that have implemented such a strategy are Washington and Georgia. In Washington, the state employees, Medicaid, and Labor and Industry groups have a

unified PDL that currently encompasses six therapy classes of medication. The medications on the PDL are reviewed every six months by the P&T Committee and additional therapy classes will be added to the PDL through 2004. Georgia, supported by its pharmacy benefit manager, Express Scripts, Inc., established a PDL for its Medicaid, public employees, and the Board of Regents groups. Georgia has learned that achieving increased market concentration (a significant percentage of plan participants within a physician's office or a pharmacy) creates opportunities to enhance program and administrative efficiencies. Efficiencies are maximized by aligning drug coverage strategies, as well as utilization and clinical management strategies — thereby enabling the PBM to educate providers and participants collectively, and more effectively. The anticipated results are improved outcomes that translate into program savings; however, at this point, actual savings calculations for the Georgia program have not been made public knowledge.

Appendix A

Maximum Allowable Cost (MAC) Comparison

Methodology and Analysis

Several sources and methodologies of MAC pricing exist. As a result, the overall discounts achieved by an individual MAC list can vary substantially. We compared the State's current SMAC list (current as of December 2002) against two other MAC lists to provide an indication of the aggressiveness of the SMAC list, as well as potential savings opportunities that would be gained from implementing an alternative MAC list. Through this analysis, it is important to evaluate both the breadth and the depth of the MAC list, the effective (or aggregate) discount of the MAC list, and overall savings potential.

The two comparative MAC lists include a National Proprietary MAC list, utilized by other Medicaid fee-for-service (FFS) programs, and a Regional MAC list. The National Proprietary MAC list was established utilizing defined criteria and methodology, and designed to meet the needs of a Medicaid-provider community through the use of more conservative pricing as compared to a MAC list developed by a national pharmacy benefit manager, which is utilized in the commercial setting. The Regional MAC list was provided to us during a recent pharmacy study and is utilized in the commercial setting.

Currently, the State Medicaid pharmacy staff maintains the SMAC list at a National Drug Code (NDC) level, whereas, the National Proprietary MAC list and Regional MAC list are available at the generic code number (GCN) level. The NDC is a unique 11-digit number assigned to every medication. A list maintained at the NDC level indicates that a MAC price is set for every medication, and the price is set specific to the manufacturer, the package size, and the strength of that product. GCN level indicates a grouping that rolls up numerous product NDCs representing the chemical entity under one GCN. Using GCN level maintenance of a MAC list results in grouping medications with the same generic name and similar strengths, regardless of the manufacturer; thereby providing greater maintenance efficiency and accuracy.

In order to complete the comparative analysis, we took the GCN level MAC lists and expanded each to create a comprehensive NDC-based listing. From each respective MAC NDC list, we utilized State claims experience for the most recent time calendar year of data (time period of November 28, 2001 – November 28, 2002), to determine the total number of aggregated NDCs that appear on each list.

MAC Program Analysis	
	Number of NDCs* on each respective MAC list
Idaho SMAC	740
National Proprietary MAC	5,242
Regional MAC	5,338

* with State claims utilization

This data provides high level information on the breadth of each MAC list, showing that the National Proprietary MAC list and the Regional MAC list include a significant number of NDCs, as compared to the current Idaho SMAC list. However, this data in itself, does not account for differences in the aggressiveness of the lists, does not represent the true breadth of the individual MAC lists, nor does it account for product alignment amongst the lists. Both aggressiveness and breadth will most accurately be reflected in calculations of the average MAC effective discount; the effective discount and product alignment will be reflected in calculation of the total amount saved.

In order to further evaluate the aggressiveness and breadth of the SMAC list in comparison to the alternative MAC lists, the following assumptions and data manipulation occurred.

- Due to the variance in the NDCs represented on each list, there were numerous instances in which a particular NDC did not have a price on one of the alternative MAC lists. In these situations, the State pricing methodology (standard AWP-12%) was applied. (This assumption was used in order to create consistency with overall savings calculations.)
- In this type of analysis, with retrospective repricing of the amount paid values, there may be situations in which the product appears on the current MAC list, but MAC price was not applied at the time of claim adjudication. For example, a newer generic was added to the current MAC list in November 2002, but there was utilization for this product in February that was not subjected to MAC pricing because a MAC price had not been established in February. Therefore, if the submitted amount paid for that claim was less than the quantity times the current SMAC price, then the submitted amount paid value field was utilized in the calculations. (In this type of analysis, in which we are applying current pricing to retrospective utilization, it is best to use the submitted amount paid to allow for the most accurate representation of total amount paid so as not to overstate potential savings.)
- Although numerous injectable medications appear on the current SMAC list, they were removed from consideration for two primary reasons. First, a vast majority of

these products are not included in typical MAC lists, nor are they included in either comparative MAC list. Second, the data reflected numerous quantity submission issues that would have resulted in an incorrect AWP price. (Incorrect quantity submission is a common occurrence in the adjudication of injectable medications, as pharmacies often submit the number of micrograms or milligrams contained in the vial, when the price is actually based on a per vial or kit basis.) Removing the injectables from the analysis created a more realistic comparison and savings calculation between the SMAC list and alternative MAC lists for **oral** products.

After completing this data manipulation, we then calculated the average MAC effective discount and overall savings attributed to each MAC list.

MAC Program Analysis

	Total Amount Paid*	Total Savings	Savings as a % of Drug Spend	MAC Effective Discount
Idaho SMAC	\$15,405,058	N/A	N/A	52.1%
National Proprietary MAC	\$12,934,845	\$2,470,213	2.1%	43.8%
Regional MAC	\$15,602,193	\$ (197,135)	-0.2%	52.8%

* Since a MAC list only represents a subset of generic products, this total amount paid value represents amount paid for only those generics for which there was claims experience during the evaluation time period.

The calculated savings figure is represented as the difference in total amount paid with the current Idaho SMAC list versus total amount that would have been paid with implementation of either of the alternative MAC lists for the defined time period.

MAC Conclusions

Through this analysis, we were able to determine that currently the State Medicaid SMAC program is aggressive in the pricing of medications that appear on the MAC list — therefore achieving an effective MAC discount of AWP-52.1%. However, the number of **oral** product NDCs listed on the SMAC list is minimal in comparison to the other lists. The National Proprietary MAC list effective MAC discount is calculated at AWP-43.8%, but the National Proprietary MAC list has greater number of NDCs than the SMAC list. (As noted previously, the National Proprietary MAC is intended to be less aggressive than commercial MAC lists offered by national pharmacy benefit managers.) The effective MAC discount will vary among lists as it is dependent on the number of products on the list, the aggressiveness of the pricing and the product alignment with current utilization.

Based on our analysis, had the National Proprietary MAC list been implemented during the time frame of November 28, 2001, through November 28, 2002, the State would have realized savings of approximately \$2.47 million (approximately 2.0 percent of total drug spend) on **oral** MAC list products.

Based on Mercer’s experience, the National Proprietary MAC list has a similar level of aggressiveness (both number of products and price aggressiveness) to other Medicaid

FFS MAC lists. Therefore, based on State-specific utilization, use of a Medicaid focused FFS MAC list from a third-party vendor may result in savings of approximately 2.0 to 4.0 percent of total annual drug spend.

In comparing the SMAC list to the Regional MAC list, it was determined that the MAC effective discounts are nearly the same; however, if the Regional MAC list had been in place during the defined time period, the State would have paid approximately \$200,000 more. A closer look at the data shows that even though the Regional MAC list average effective discount is as aggressive as the SMAC list (approximately AWP-52%), and the Regional MAC list has a larger number of NDCs on the list, there are a subset of products that are either not on the MAC list or do not have aggressive pricing on the Regional MAC list. Since the calculation of savings is dependent on the utilization, every situation noted above would result in the State paying more for the generic products had the Regional MAC list been implemented; therefore, resulting in a negative savings reflected in the chart above. Key drugs driving this result include albuterol, cephalexin, clozapine, and famotidine — all of which either were not MAC'd or had a less aggressive price on the Regional MAC list, as compared to the Idaho SMAC list. This particular analysis exemplifies the need to go beyond the surface of effective MAC discounts and determine product alignment when evaluating the financial impact of a MAC program. Therefore, if the State elects to investigate the possibility of utilizing an alternative MAC program, we recommend that a complete analysis incorporating utilization data be performed.

As noted, we eliminated injectable products contained on the SMAC list; including, blood factor products, decompression, enoxaparin, immunoglobulin, and Synagis[®] from this evaluation, due to quantity submission errors. Submission errors result in the inability to calculate true costs and savings associated with the pricing of these injectables. Although savings from injectable products that are currently on the SMAC list cannot be calculated based on the data supplied, we can comment that the addition of injectables to the SMAC list likely results in significant savings to the State. Therefore, the savings calculations represented above reflect only the savings attributed to MAC pricing of **oral** products. We recommend that if the State elects to adopt an alternative MAC list from any third-party source, they should investigate the option of customizing the list to include such injectable products.

(Note: the savings calculation represented does not take into account the costs of contracting with a third-party vendor to provide a SMAC program for the State; nor does it take into account internal State labor (pharmacist) costs that would be saved as a result of management of the program by a third-party vendor.)

Appendix B

Dose Consolidation

Methodology and Analysis

Dose consolidation programs within the industry will vary in the medications that are targeted for consolidation. Some third-party payers elect to target specific therapy classes or a particular subset. The purpose of this analysis was to select a subset of medications that would be appropriate for dose consolidation within the Medicaid population and alert the State to potential unit cost savings associated with such a program.

In order to complete this analysis, we performed the steps listed below.

- Identified medications that would be included in this analysis from three sources — the dose consolidation program offered by a national pharmacy benefit manager, the dose consolidation program offered by the State of Missouri, and medications listed as eligible for dose consolidation as published in the *Journal of Managed Care Pharmacy* (*J Managed Care Pharm* 2002:146 – 151). From these lists, we selected a representative sample of medications for this evaluation (listed on page 90).
- Based on this representative list of medications, we extracted all corresponding drug data fields (strength, AWP, NDC) from the First Data Bank National Drug Data File (FDB NDDF); resulting in a list at the NDC level.
- Utilization data was extracted for the time period of July 1, 2001, to June 30, 2002, for these corresponding NDCs. Any claim in which the quantity exceeded the days supply by a factor of 1.75 but less than or equal to 2.5 was assumed to be a product prescribed for twice daily dosing. Any claim in which the quantity exceeded the days supply by a factor greater than 2.5 was assumed to be a product prescribed for three times a day dosing. Although savings can result from consolidating situations with three daily doses, this analysis was confined to only those claims that meet the twice-daily dosing criteria. (Less than 7.0 percent of the targeted NDCs were assumed to be dosed in excess of two doses per day.)
- A savings percentage was projected by taking the average cost per unit dispensed times two (to reflect the cost per day dose that was actually dispensed in the twice daily dosing scenario), compared to the average cost per unit that could have been

dispensed (to reflect consolidation to once daily dosing). Subsequently, the ingredient cost of the identified NDCs targeted for consolidation was multiplied by this savings percentage to obtain an estimated dose consolidation savings. (These steps were necessary to ensure that an equivalent ingredient cost discount was applied to the NDC targeted for consolidation.)

- Additionally, in the savings percentage calculation, we assumed a constant dispensing fee and; therefore, dispensing fee does not impact savings estimates.

Dose Consolidation Conclusions

Forty unique drugs (representing 217 NDCs) were considered as targets for this dose consolidation analysis (as listed in Appendix A). Utilization data showed that during the defined time period, the targeted NDCs were utilized by 4,195 members, which accounted for 14,506 prescriptions. The total discounted ingredient cost for these prescriptions with the existing dosing was \$1,494,540.

Based on the stated methodology and targeted medications, potential savings from a dose consolidation program during the defined time period are reflected in the following chart.

Number of NDCs Impacted	Amount Paid	Number of Prescriptions	Annual Ingredient Cost Savings with Varying Levels of Success		
			50% Success	65% Success	90% Success
217	\$1,494,540	14,506	\$305,000	\$396,500	\$549,000

We have displayed varying levels of potential savings because the success of this strategy will be dependent on program structure. For example, if a dose consolidation program is not mandatory with hard edits at the point of sale (POS), then the success of getting physicians to prescribe once daily dosing instead of twice daily dosing could be as low as 50.0 percent. However, if the State implements a program that includes a hard edit at the POS for the targeted medications, in which the quantity cannot exceed the days supply (without prior approval), a higher success rate of 90.0 percent or more would be expected.

Representative Listing of Medications Evaluated for Dose Consolidation Program

Drug Label Name*	Drug Label Name*
ACCUPRIL®	MEVACOR®
ACEON®	MINOXIDIL®
ACYCLOVIR®	MONOPRIL®
ADALAT®	NADOLOL®
ALTACE®	NIFEDIPINE
ATACAND®	NORVASC®
AVAPRO®	PAXIL®
BISOPROLOL®	PLENDIL®
CELEBREX®	PRAVACHOL®
CELEXA®	PREVACID®
COZAAR®	PRILOSEC®
DIOVAN®	PRINIVIL®
EFFEXOR®	PROCARDIA®
ENALAPRIL®	PROPRANOLOL®
FLUOXETINE®	PROZAC®
HYZAAR®	REMERON®
INDERAL®	SULAR®
LESCOL®	TOPROL®
LIPITOR®	UNIVASC®
LISINOPRIL®	VIOXX®
LOTENSIN®	ZEBETA®
LOVASTATIN®	ZESTRIL®
LUVOX®	ZOCOR®
MAVIK®	ZOLOFT®

* Medications selected based on three published resources — dose consolidation program offered by a national PBM, the dose consolidation program offered by the State of Missouri, and medications listed as eligible for dose consolidation as published in the *Journal of Managed Care Pharmacy (J Managed Care Pharm 2002:146 – 151)*.

Appendix C

Specialty Injectable

Methodology and Analysis

To assist the State in evaluating the potential impact of implementing a specialty injectable program that would be considered industry standard, we completed the following steps:

- Obtained two specialty product lists, with associated discount percentages and dispensing fees, from two national specialty injectable providers;
- Mapped each product list to an NDC product level utilizing First Data Bank (FDB) drug information;
- Removed any NDCs from the product lists that were **not** injectable formulations (some specialty injectable vendors also include high cost specialty oral products on their list);
- Extracted State retail pharmacy claims experience, at the NDC level, for corresponding specialty injectable products for fiscal year 2002 (July 1, 2001 – June 30, 2002). From the claims experience data, removed all injectable products that currently appear on the Idaho SMAC list (including Benefix[®], DDAVP[®], Gammagard[®], Intron-A[®], Lovenox[®], Novoseven[®], Recombinate[®], and Synagis[®]); and
- Compared total amount paid under current reimbursement rates, to what would have been paid, if a specialty injectable program had been implemented for injectables processed through a retail pharmacy during this time period.

Additionally, the claims experience showed that on a number of occasions, the quantity that was submitted by the pharmacy was incorrect and therefore, calculated an incorrect AWP price. This is a common occurrence in the adjudication of injectable medications, as pharmacies often submit the number of micrograms or milligrams contained in the vial, when the price is actually based on a per vial or kit basis. As a part of this analysis and methodology, obvious pricing issues were corrected. Where these errors were discovered, obvious quantity issues were corrected so as to avoid over inflation of applied discounts.

Specialty Injectable Conclusions

Data shows that for injectables processed through retail pharmacies, Idaho is currently reimbursing at a calculated **average** discount of AWP-12.4%. In comparison, the two specialty vendors offer discounts of AWP-14% for most injectables on their list. Data also shows the State’s average dispensing fee is \$4.84 for these prescriptions (standard dispensing fee is \$4.94, but certain prescriptions carried a \$0.00 dispensing fee); whereas, the program offered by vendor A does not charge a dispensing fee, and the program offered by vendor B charges a dispensing fee of either \$2.50 or \$12.50 per prescription, depending on the injectable product.

Specialty Injectable Annual Savings

	Savings	% of Drug Spend	Effective Discount*	Average Dispensing Fee
Specialty Vendor A	\$74,080	1.0%	14.0%	\$0.00
Specialty Vendor B	\$31,893	0.4%	14.0%	\$5.53

* Average discount for NDCs evaluated with Idaho claims utilization July 1, 2001, through June 30, 2002.

The goal of this analysis was to alert the State to potential **unit cost savings** associated with the use of aggressive discounts and dispensing fees for specialty injectable products dispensed through retail pharmacies. However, the benefit of a contracted specialty vendor includes unit cost savings, as well as savings that result from monitoring and improved medication compliance, patient education, reduction in medication hoarding and waste, side effect management, improved outcomes and an overall improvement in the quality of care provided. Additional key services offered by specialty vendors include coordination of patient care and case management by trained staff, access to call center resources, and access to on-call clinicians.

Based purely on unit cost savings and utilization of injectables dispensed through retail pharmacies, during July 1, 2001, through June 30, 2002 we estimated the potential savings to the State through use of a third-party specialty vendor would have been between \$31,000 and \$74,000. We also evaluated savings, using this same methodology, during the time period of January 2002, through November 2002. The estimated potential savings ranged between \$114,000 and \$164,000. Total amount spent on specialty medications at retail pharmacies was approximately \$7,382,000. Therefore, savings potential ranging between 0.4 – 2.2 percent of injectable drug spend. This exemplifies the fact that the impact of specialty drug pricing is variable and highly dependent upon utilization of these high cost injectables. Accordingly, there will be great variability in the savings potential. Additionally, it is important to note that these savings estimates do not take into account the cost of contracting with a third-party vendor to provide such a program for the State; nor does it take into account internal State labor costs that would be incurred to oversee and manage such a vendor relationship. However, the industry

standard is that specialty vendors typically do not charge an upfront or start up fee for establishing and providing these services.

It is important to recognize that through this methodology, we only evaluated the potential savings resulting from this type of program for injectables dispensed through **retail pharmacies** and did not evaluate utilization associated with Healthcare Common Procedure Coding System (HCPCS) J-codes and administration of injectables in a physician's office. Depending on the utilization and administration of these products in physician offices, the potential for additional savings is tremendous — including both discounted ingredient costs and recovery of federal Medicaid rebate dollars. Specialty vendors offer services in which the physician can still administer the product in their office, but the dose is ordered directly from the vendor, adjudicated through electronic claims processing, and delivered directly to the physician's office for subsequent administration to the patient. Unlike claims submission through J-codes, this process allows for discounted pricing to be applied electronically to the claim and captures all standard outpatient pharmacy data fields, allowing for more accurate monitoring and reporting, including the submission of accurate utilization units to recover Medicaid rebate dollars. This particular service offered through specialty vendors provides the State with a good opportunity to a first step in the implementation of a specialty injectable program.

It is also worthwhile to note that the current discount applied to select injectables on the Idaho SMAC is significantly more aggressive than the discount offered from either vendor. Accordingly, if the State elected to adopt a specialty injectable discount program offered by a third-party vendor, the program should be designed to ensure continuation of MAC pricing for those injectable products included on the SMAC.

Appendix D

Pill-Splitting

Methodology and Analysis

Given that Zoloft® has been successfully implemented within the government sector, we elected to evaluate the cost savings opportunity for the State with a Zoloft pill-splitting program. Utilizing claims experience from fiscal year 2002, we quantified Zoloft utilization for the 25mg, 50mg, and 100mg product strengths.

Zoloft Utilization FY01 - 02					
Drug Name	Amount Paid	AWP Cost per unit	Number of Prescriptions	Average Days Supply	Percent of Total Zoloft Prescriptions
Zoloft 25mg	\$ 98,042.29	\$ 2.11	1,500	28.7	5.5%
Zoloft 50mg	\$ 856,825.35	\$ 2.15	12,028	30.9	40.5%
Zoloft 100mg	\$1,305,250.20	\$ 2.18	16,166	34.9	54.0%
Total	\$2,260,117.84	N/A	29,694	N/A	100.0%

The largest utilization in the State claims experience is with the 50mg and 100mg strength tablets, with minimal utilization of the 25mg strength. Therefore, the greatest savings opportunity for the State is to implement this strategy focused on the splitting of 100mg tablets for the purpose of dispensing as a 50mg dose. The table below displays the potential cost savings with varying levels of success in dispensing a quantity of fifteen 100mg split tablets instead of thirty 50mg tablets.

Ingredient Cost Annual Savings with Varying Levels of Success					
Drug Name	Amount Paid	Number of Prescriptions	50% Success	65% Success	97% Success
Zoloft 50mg	\$ 856,825.00	12,028	\$203,000.00	\$263,900.00	\$393,900.00

We have displayed varying levels of potential savings, because the success of this strategy will be dependent on program structure. For example, if a pill-splitting initiative is not mandatory with hard edits at the POS, then the success of getting physicians to prescribe Zoloft 100mg, half-tablet daily could be as low as 50.0 percent. However, if the State requires splitting of a 100mg tablet and implements a program that includes a hard edit at the POS that prevents the dispensing of greater than fifteen tablets of Zoloft 50mg, then a higher success rate (greater than 90.0 percent) would be expected. In discussions with the State of Illinois, the reported success rate with their Zoloft 100mg pill-splitting program is over 97.0 percent.

The savings figures above account for ingredient cost savings and the standard dispensing fees for the State (\$4.94 per prescription), but do not account for additional reimbursement. Although the State’s current dispensing fee reimbursement is high at \$4.94, we believe that the success of the program will be dependant upon the cooperation of retail pharmacies. Therefore, in an effort to gain their buy-in, additional compensation may be required. The table below illustrates the additional fees that the State might pay if the program is structured to provide additional compensation of \$2.50 per prescription in which the pharmacist split the pills prior to dispensing.

			Additional Dispensing Fee Costs		
Drug Name	Number of Prescriptions	Average Additional Dispensing Fee	50% Success	65% Success	97% Success
Zoloft 50mg	12,028	\$ 2.50	\$15,035	\$19,545	\$29,168

Pill-splitting Conclusions

Overall savings as a result of implementing a pill-splitting program for Zoloft 100mg, with an additional \$2.50 dispensing fee reimbursement, is represented in the table below.

			Annual Savings with Varying Levels of Success Attributed to Splitting Program of Zoloft 100mg		
Amount Paid	Number of Prescriptions	Average Additional Dispensing Fee	50% Success	65% Success	97% Success
\$856,825	12,028	\$2.50			
Ingredient cost savings			\$203,000	\$263,900	\$393,900
Additional Dispensing Fee Costs			\$ 15,035	\$ 19,545	\$ 29,168
Annual Net Savings			\$187,965	\$244,355	\$364,732

Depending on the program structure (use of hard or soft edits to control quantities dispensed), the success of this program will vary. For a Zoloft 100mg pill-splitting program, including an additional dispensing fee of \$2.50 for each prescription in which 100mg tablets were split prior to dispensing, we calculated an estimated savings potential between \$188,000 and \$364,000 annually.

Appendix E

Opportunities for Consideration

Report Section	Opportunity for Consideration <small>(Note: See the State’s initial reaction to these opportunities throughout the body of the report.)</small>	Annualized Savings (Estimated or Calculated) (Approximate Percent of Total Drug Spend)	Considerations/Advantages
Plan Design — Section 4	Evaluate expansion of coverage of OTC products	Highly variable Dependent on net cost of OTC versus prescription therapies	<ul style="list-style-type: none"> ▪ Marketplace changes will likely result in continued movement of products from prescription to OTC status
Plan Design — Section 4	Modify Days Supply Limitation <ul style="list-style-type: none"> ▪ Decrease benefit to allow for a 32 days supply of medication (currently 34 days supply allowed) 	Minimal	<ul style="list-style-type: none"> ▪ Minimal member impact; minimal provider impact ▪ Mirrors industry best practices
Plan Design — Section 4	Modify Early Refill Edit <ul style="list-style-type: none"> ▪ Increase threshold edit to 80.0 percent (currently at 75.0 percent) 	Minimal savings	<ul style="list-style-type: none"> ▪ Minimal member impact; minimal provider impact

Report Section	Opportunity for Consideration (Note: See the State's initial reaction to these opportunities throughout the body of the report.)	Annualized Savings (Estimated or Calculated) (Approximate Percent of Total Drug Spend)	Considerations/Advantages
Plan Design — Section 4	Implement a mail order program for specific medications and member populations	\$594K – \$1M (estimated) (0.5 – 1.0 percent) Variable and dependent on utilization and medications shifted to mail order	<ul style="list-style-type: none"> ▪ Transient population ▪ Potential waste issues ▪ Reduces prescription volume for retail pharmacies ▪ Implemented in other Medicaid programs
Pharmacy Reimbursement — Section 5	Decrease reimbursement for brand name medications to AWP-13% or AWP-14% <ul style="list-style-type: none"> ▪ Current reimbursement is AWP-12% 	\$1M to \$2M (calculated) (1.0 – 2.0 percent) Only reflects savings for single-source brand medications	<ul style="list-style-type: none"> ▪ Potential threat of decreased participation by retail pharmacies ▪ Consider all program changes that could impact pharmacy reimbursement ▪ Mirrors recent changes made by other state Medicaid pharmacy programs
Pharmacy Reimbursement — Section 5	Decrease dispensing fee per claim by \$0.50 or \$1.00 <ul style="list-style-type: none"> ▪ Current dispensing fee is \$4.94 (retail) or \$5.54 (unit dose) 	\$1.1M to \$2.2M (calculated) (1.0 – 2.0 percent)	<ul style="list-style-type: none"> ▪ Potential threat of decreased participation by retail pharmacies ▪ Consider all program changes that could impact pharmacy reimbursement ▪ Mirrors recent changes made by other state Medicaid pharmacy programs

Report Section	Opportunity for Consideration (Note: See the State's initial reaction to these opportunities throughout the body of the report.)	Annualized Savings (Estimated or Calculated) (Approximate Percent of Total Drug Spend)	Considerations/Advantages
Pharmacy Reimbursement — Section 5	Implement more aggressive MAC list for oral generic products <ul style="list-style-type: none"> ▪ Increase breadth of list and aggressiveness of pricing 	\$2.4M to \$2.8M (calculated) (2.0 – 2.4 percent)	<ul style="list-style-type: none"> ▪ Consider all program changes that could impact pharmacy reimbursement
Financial Arrangement with Vendors — Section 6	Enhance the quality and frequency of current retrospective DUR interventions (either with ISU or Heritage tools)	Highly variable	<ul style="list-style-type: none"> ▪ Improves quality of care ▪ May result in cost containment
Pharmacy Claims Processing Management Programs — Section 7	Implement high cost claim edit in non-clinical POS DUR edits	Highly variable	<ul style="list-style-type: none"> ▪ Assists in the identification of potential fraud or abuse; identifies need for case management services ▪ Mirrors industry best practices
Pharmacy Claims Processing Management Programs — Section 7	Enhance POS clinical DUR edits	Highly variable	<ul style="list-style-type: none"> ▪ Improves quality of care ▪ May decrease the occurrence of adverse drug events and associated costs
Pharmacy Claims Processing Management Programs — Section 8	Enhance number of medications subjected to clinical prior authorization	\$594K – \$1M (estimated) (0.5 – 1.0 percent)	<ul style="list-style-type: none"> ▪ Incremental workload for State pharmacy department ▪ Impacts providers and members
Fraud and Abuse Programs — Section 9	Enhance programs to detect fraudulent and abusive patterns <ul style="list-style-type: none"> ▪ Maximize the use of Heritage reporting tool 	Highly variable	<ul style="list-style-type: none"> ▪ Improves quality of care ▪ Cost containment measure

Report Section	Opportunity for Consideration (Note: See the State’s initial reaction to these opportunities throughout the body of the report.)	Annualized Savings (Estimated or Calculated) (Approximate Percent of Total Drug Spend)	Considerations/Advantages
Claims Data Fields — Section 10	Capture physician identifier information on pharmacy claims	Highly variable	<ul style="list-style-type: none"> ▪ Improves accuracy and quality of DUR interventions ▪ Improves accuracy and quality of physician profiling
Dose Consolidation — Section 11	Implement a dose consolidation program <ul style="list-style-type: none"> ▪ Consolidating dosing frequency for certain medications ▪ Fewer doses dispensed for equivalent days supply 	\$305K – \$594K (calculated) (0.3 – 0.5 percent) Only a representative sample of medications evaluated; greater savings potential with additional medications	<ul style="list-style-type: none"> ▪ Adjudication system capability ▪ Improves medication compliance with lower frequency of dosing ▪ Implemented in other state Medicaid programs
Quantity Limits — Section 12	Implement industry standard quantity limit program <ul style="list-style-type: none"> ▪ Prescription or dose limits placed on certain medications 	\$594K – \$2.4M (estimated) (0.5 – 2.0 percent)	<ul style="list-style-type: none"> ▪ Reduces fraud ▪ Minimizes overutilization ▪ Quality of care and cost containment ▪ Implemented in other state Medicaid programs
Specialty Injectables — Section 13	Implement specialty injectable program <ul style="list-style-type: none"> ▪ Deliver certain injectable products to physician offices for direct administration ▪ Deliver certain injectables directly to home environment 	Highly variable — calculated at \$30K – \$164K (0.03 – 0.12 percent) (0.4 – 2.2 percent of injectable drug spend)	<ul style="list-style-type: none"> ▪ Transient population ▪ Physician impact — potential loss of revenue on certain medications administered in the office ▪ Aggressive discounts for certain injectable medications ▪ Increases return of federal Medicaid rebate dollars

Report Section	Opportunity for Consideration (Note: See the State's initial reaction to these opportunities throughout the body of the report.)	Annualized Savings (Estimated or Calculated) (Approximate Percent of Total Drug Spend)	Considerations/Advantages
Step Therapy — Section 14	Implement industry standard clinical step therapy program <ul style="list-style-type: none"> ▪ Requires the use of lower cost, first-line agents when clinically appropriate 	\$594K – \$1.1M (estimated) (0.5 – 1.0 percent)	<ul style="list-style-type: none"> ▪ Adjudication system capability ▪ Increases call volume ▪ Quality of care and cost containment ▪ Implemented in other Medicaid programs
Pill Splitting — Section 15	Implement pill-splitting program for Zolof [®]	\$188K – \$364K for Zolof [®] program (calculated) (0.2 – 0.3 percent) Greater savings potential with additional medications	<ul style="list-style-type: none"> ▪ Potential pressure from advocacy groups and practitioners ▪ Implemented in other Medicaid programs

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Government Human Services Consulting

Jeffrey R. Lewis
President Heinz Family Philanthropies
jlewis@heinzoffice.org

Mercer Government Human Services
Consulting
3131 E. Camelback Road, Suite 300
Phoenix, AZ 85016-4536
602 522 6500