



Coordinated Contracting of Prescription Drugs:
A Fiscal and Policy Strategy for the
State of Rhode Island – The Rhode Island Blueprint

A project of the Heinz Family Philanthropies
Teresa Heinz, Chairman

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The Honorable Donald L. Carcieri
The Honorable Joseph A. Montalbano
The Honorable William J. Murphy
State House
Providence, Rhode Island 02903

Dear Governor Carcieri, Speaker Murphy, and Senate President Montalbano:

At the request of the state legislature, the Heinz Family Philanthropies agreed to undertake an analysis of the multiple prescription drug programs funded and/or operated by the State of Rhode Island, to determine whether a more efficient and cost effective design could be implemented, as well as the levels of savings that might result.

Solving the problem of affordable prescription drugs is a daunting challenge. While there is no one simple solution or any one-size-fits-all answer, we believe that our report will assist you, the state legislature, and policy makers generally, to better understand both the issues you must grapple with, as well as some different ways in which different solutions may be approached. The issues involved are complicated and do not simply involve the consolidation of existing programs or contracts. Each decision – made or not made – will have specific consequences that the State of Rhode Island must carefully weigh as it considers whether (and, if so, how) to implement the recommendations set forth in this report.

Based on our analysis, we estimate the potential savings to the State of Rhode Island that may accrue as a result of implementing the various recommendations contained herein could reach over \$34 million. We have identified a number of possible ways in which such savings could be achieved. At the same time, we realize full well that no situation is ever ideal; and we understand that legitimately competing claims and priorities have to be factored into every political equation.

We are prepared to assist you further with examining and/or analyzing any of the recommendations in this *Rhode Island Blueprint* that you may decide to pursue. Moreover, recognizing the delicate balance of these issues in Rhode Island's economy (with a major pharmaceutical manufacturer and large retail chain drug store both based in the state), each recommendation contained in the *Rhode Island Blueprint* has to be carefully weighed and evaluated. In the end, however, the *Rhode Island Blueprint* provides the state legislature and the Office of the Governor with a series of opportunities for making changes to help protect the state's fiscal position – both now and in the future.

It is important that I both thank and applaud the efforts of Speaker of the House William J. Murphy, House Majority Leader Gordon Fox, Representative Steven Costantino,

Senate President Joseph A. Montalbano, Senate Majority Leader Teresa Paiva-Weed, former Senate President William V. Irons, and former Speaker of the House John Harwood for their unselfish work with our staff and consultants in discussing, debating and evaluating the recommendations contained in this report. Their willingness to help was a great value to all of us. And, a very special thank you to Marie Ganim, Senate Health Policy Director, for her advice and counsel. Her expertise was invaluable and clearly demonstrated why the state legislature depends on her guidance and knowledge.

A number of other people deserve recognition and thanks for their contributions. Thomas Tomczyk and J. Carmelina Rivera of Mercer Human Resource Consulting, Annette Boyer from CECITY, Ynez Cross of CHC Consulting Group, LLC and Scott Ponaman of Mello and Ponaman Enterprises LLC, brought their technical expertise and thoughtful analysis to the shaping of the research, as well as the preparation and presentation of this report. Their unique insights were invaluable. So too, were Dr. Frank Gannon, Chris Black, Patrick Valasek and Bobbi Munson of the Heinz Family Philanthropies staff, for their research and editing assistance.

And very special thanks are due to Jeffrey R. Lewis, the author of this report. Jeff is my Chief of Staff and the President of the Heinz Family Philanthropies. His tireless efforts and unyielding pursuit of solutions are to be acknowledged and praised. More and more union leaders, state legislators, and governors increasingly value this level of expertise as our work expands across the United States.

Finally, I want to applaud the leadership of the Rhode Island legislature for their interest and willingness to seek out the creation of the *Rhode Island Blueprint*. Your willingness to examine the complex issues and solutions involved sets you apart from many others. Asking the tough questions and seeking the answers to which they lead, however politically difficult, is a real demonstration of true leadership. That kind of leadership needs to be embraced and praised.

Sincerely,

A handwritten signature in black ink that reads "Teresa Heinz". The signature is written in a cursive, flowing style.

Teresa Heinz
Chairman

SECTION 2

Why This Report?

Governors and state legislators are facing one of the worst crises of the past 50 years – providing quality and affordable health care. While there are a number of factors involved, the single most dominant has been the cost of health care and, in particular, prescription drug costs.

In recent years, state Medicaid program health care costs have increased significantly – and particularly the cost of the prescription drug benefit program. The State of Rhode Island has witnessed a phenomenal increase of more than 94% in state Medicaid fee-for-service prescription drug spending in a relatively short time – from \$19.4 million in FY 1997 to more than \$37.5 million in FY 2002. While these programs have unquestionably helped many people to remain healthy and/or independent, skyrocketing cost increases over the years and the unwillingness of legislators to make the tough choices needed to more effectively control these programs has impeded the ability of legislators and governors to manage such programs effectively.

For example, the trend for state spending on Medicaid prescription drug costs has far outpaced both overall inflation, and health care inflation. Although the State of Rhode Island has managed the fiscal growth of its Medicaid program, it has not escaped the financial perils that far too often shock state legislatures.

Health care costs have ravaged state budgets and become, in effect, a voracious PACman of health care dollars – relentlessly devouring resources that could be used for other state programs. As a result, various advocacy organizations (such as those representing Medicaid recipients and those looking to strengthen public education) may eventually become adversaries instead of allies.

The cost-related health care problems of today can be solved if there is a collective bipartisan willingness both to examine the root causes and to think creatively about different ways to solve these problems.

In the end, there are no silver-bullet solutions – nothing quick, nothing easy. If there were, legislators and governors would long ago have implemented them. Moreover, success will depend on the willingness and foresight of advocacy organizations, representing various constituent groups receiving prescription drug benefits in the State of Rhode Island, to recognize that, absent change, these programs may financially implode, with the end result being that the State of Rhode Island will either abandon or severely curtail such benefits and programs.

This report represents a comprehensive analysis of the following key items:

- the benefits of, and the barriers to, the coordinated purchasing of prescription drugs;
- how the State of Rhode Island could achieve increased savings through various plan design changes;
- the mechanisms whereby enhanced contracting could result in greater efficiencies and, thereby, greater savings; and finally,
- a discussion of the federal 340B program and how it could be used to lower a portion of the State of Rhode Island's fiscal responsibility for specific state programs.

The analysis focuses exclusively on six programs within the State of Rhode Island:

- The Department of Administration (DOA)
- The Department of Human Services (DHS)
- The Department of Elderly Affairs (DEA)
- The Department of Mental Health, Retardation and Hospitals (MHRH)
- The Department of Corrections (DOC)
- The Department of Children, Youth and Family (DCYF)

The Heinz Family Philanthropies undertook this study at the request of the Rhode Island legislature to determine:

- Whether and how a coordinated prescription drug purchasing plan could work in Rhode Island;
- How such an approach combined with other reforms could achieve the greatest level of savings;
- Whether the administration of multiple state prescription drug programs (in whole or part) be effectively and efficiently consolidated under one state agency;
- Alternatively, should one state director be given the sole discretion and authority to negotiate the prescription drug contracts for all or most state agencies;
- What barriers have precluded the State of Rhode Island from implementing or initiating a single procurement strategy;
- Beyond coordinating or consolidating the administration of all prescription drug programs under one agency, what specific programmatic changes should be made to enhance the efficiency and cost effectiveness of the use of taxpayer dollars;
- The consequences of inaction or minimal action by the State of Rhode Island and the short and long term fiscal implications;
- What agencies could coordinate most effectively; and
- Whether a more effective use of generated savings could be determined.

To that end, this report examines the programs that provide prescription drug benefits to different constituent groups in the State of Rhode Island. Our purpose was to examine each program, as well as the collective whole, to determine in what ways the State of Rhode Island could more effectively leverage its position both as a purchaser and provider. This report presents our findings.

In the preparation of this report the Heinz Family Philanthropies:

- Undertook an analysis of existing prescription drug information (including utilization and expenditure data) provided by the State of Rhode Island;
- Interviewed personnel from each participating agency;
- Conducted a quantitative analysis using specific assumptions to determine the financial impact of implementing a coordinated prescription drug strategy for the State of Rhode Island;
- Initiated an actuarial analysis of plan design – including analysis of existing plan design and determination of actuarial changes that could be implemented in order to yield greater savings;
- Undertook an analysis of how and to what extent the State of Rhode Island effectively utilized the federal 340B program;

While specific budget needs often determine whether decisions and actions recommended will be achieved, we firmly believe that our recommendations can help the State of Rhode Island achieve a balance between sound fiscal policy and good public policy decisions.

SECTION 3

Prescription Drug Costs Today

Prescription drugs are the fastest growing segment in health care expenses in the United States and the largest cost driver. Today, prescription drug spending has become the most volatile segment of health care in both the public and private sectors.

The major reason for the rise in the cost of prescription drug benefits is increased utilization. The number of dispensed prescriptions has risen from roughly two billion in 1992 to over three billion today. An additional 33% increase is expected over the next five years. Prescription medications are a critical component of health care and are now often used as the primary medical treatment. The cost increases have placed, and will continue to place, additional pressures on public and private employers.

Additional factors influencing or impacting the cost of prescription drug benefits include:

- The increasing numbers of Americans who use prescription drugs;
- Increased enrollment in Medicaid due to economic condition;
- The continued influx of new drugs into the market offering therapy options for previously untreated conditions;
- Medications with improved dosing schedules, delivery methods and indications;
- Increased growth in specialty populations in state Medicaid programs (e.g. catastrophic illness, HIV/AIDS, Hepatitis C, etc.);
- Increased demand for prescription drugs as front line therapies or interventions in lieu of hospitalization or surgery;
- Modified clinical treatment guidelines resulting in early diagnosis and preventative prescribing;
- Drug price inflation, which accounted for 33% of the overall increase of prescription drug costs;
- Efforts to delay generic introduction and extend patent protection;
- Active consumer influence by pharmaceutical direct-to-the-consumer advertising.

There is another set of issues for governors and state legislators to be concerned about:

- During the next few years, we will continue to see more drugs enter the market, especially around the specialty market and within some therapeutic classes.
- Although in many cases these drugs may shift the need away from lengthy hospitalizations and emergency department utilization, their cost is likely to remain high.

Over the next several years, six distinct classes of drugs are likely to represent the leading cost drivers for prescription medications. These are:

- Cholesterol-lowering medications (these could account for 10-20% of future drug trend with as many as 36 million Americans as possible candidates for this therapy);
- High blood pressure medications;
- Oral diabetes medications;
- Gastrointestinal disorder medications (medications for heartburn and stomach ulcers);
- Medications to treat asthma, pulmonary disease;
- Antidepressants.

The challenge faced by those offering prescription drug programs today is to ensure that participants receive high-quality, cost-effective care in the face of rapidly rising costs. Many solutions are being explored to manage the cost increases, such as plan re-engineering, vendor management, enhanced pharmacy benefit management, and coordinated contracting of prescription drugs. Moreover, escalating prescription drug costs have forced many states to consider legislative action to reduce the costs of state-run programs as well as to ensure accessibility of drug programs to those without coverage.

Some states have attempted to reduce prescription drug costs in varying ways, such as changing eligibility, increasing member responsibility, introducing preferred drug lists and/or limited formularies, lowering provider reimbursement rates and dispensing fees, and implementation of utilization management programs such as requiring prior authorization of specific medications.

SECTION 4

How State Agencies Administer Prescription Drug Programs in the State of Rhode Island

In Rhode Island, like most states, departments and agencies follow different approaches and utilize a variety of methods to obtain prescription drug benefits for the different constituent groups for which they are responsible. The agencies or departments utilize such methods as group purchasing, state contracts and specific agency contracts that include both in-person and mail order pharmacy services. However, there is **no one single procurement procedure or strategy** used by the State of Rhode Island to leverage its purchasing power in the marketplace today.

Department of Human Services (DHS)

The Department of Human Services (DHS) administers Rhode Island's Medicaid program. Although states are not required to provide prescription drug coverage under Medicaid, the State of Rhode Island has been doing so since 1969. Medicaid is a joint federal state partnership; in Rhode Island, the federal government participates at a 55.4 percent level. In other words, for every Medicaid dollar spent, the federal government reimburses the State of Rhode Island for slightly more than half. To further assist States in providing Medicaid benefits through this difficult economic period, the federal government expanded federal funding through the Jobs and Growth Tax Relief Reconciliation Act of FY 2003. Through this Act, the federal government has increased its reimbursement from 55.4 percent to 58.36 percent through FFY year 2004. This short-term grant is expected to reduce state expenditures for the Rhode Island pharmacy program by nearly \$11 million in calendar year 2004.

For the purposes of this report, we have focused solely on fee-for-service Medicaid recipients; that is, people who do not participate in managed care programs. In Rhode Island, fee-for-service Medicaid spending for prescription drugs has grown from \$10.7 million in FY 1990 to \$37.5 million in FY 2002 – an increase of more than 350 percent. As described above, the federal government matches this spending – meaning total pharmacy spending for Rhode Island's Medicaid program was \$79 million in FY 2002.

The Rhode Island fee-for-service program accounts for approximately 32% of the Medicaid population (54,000 eligibles). In many cases, these are individuals who have more difficult medical cases, are susceptible to severe illness, experience higher pharmacy utilization, and use more expensive medications. This is best illustrated by the fact that although blind and disabled individuals represented only 19 percent of Medicaid recipients, they accounted for nearly 52 percent of total annual Medicaid spending.

Today, the Rhode Island fee-for-service program collects rebates through the Federal Medicaid Rebate Contract. For calendar year 2004, fee-for-service rebates are expected to reduce state expenditures by nearly \$19 million. On average, this amount is 20.9% of total drug spend.

Department of Administration (DOA)

The Department of Administration (DOA) administers the health insurance program that includes a prescription drug benefit for approximately 44,000 State of Rhode Island active employees, retirees and their dependants. Total drug spend by the state was \$30.8 million after rebates in calendar year 2002. This was a 6.9% increase over 2001. Net expenditures (gross expenditures less rebates) rose 18.8% from 2000 to 2001 (\$24.2 million to \$28.8 million.) Total state spending for calendar year 2004 is expected to reach \$42 million. Both the State of Rhode Island and employees share in the cost of their health insurance.

	2000	2001	2002	Percent Increase '00 - '01	Percent Increase '01 - '02
Lives	37,760	37,756	43,321	0.0%	14.7%
Net Expenditures	\$24,224,331	\$28,786,345	\$30,766,885	18.8%	6.9%
Total Prescriptions	513,849	562,222	630,278	9.4%	12.1%
Prescriptions per person	13.6	14.9	14.5	9.4%	-2.3%

Currently the program has a three-tier copay cost share arrangement at retail.¹

The state contracts with Blue Cross Blue Shield-Rhode Island (BCBS-RI) for health benefits. BCBS-RI subcontracts pharmacy management to PharmaCare, a PBM and subsidiary of CVS Corporation. The services provided by PharmaCare include claims processing, retail pharmacy network management, rebate management, DUR activities (point-of-sale and retrospective), and some disease/health management services.

Currently, the state program does not require prior authorization for any medication. PharmaCare also maintains the retail pharmacy network. DOA offers a restricted network option, which includes the major chains of CVS and Brooks. According to BCBS-RI, the DOA receives 100 percent of pharmaceutical manufacturer rebates from PharmaCare, based on PharmaCare's rebate contracts. This amount is estimated to be \$1 to 2 million in calendar year 2004, or 4 percent of total prescription expenditures. This

¹ In 2003, members are able to obtain a 60 day supply of medication at retail for \$5/\$11/\$25. There is large union involvement; therefore, URI has had difficulty increasing the copays in the past. Scheduled copays for 2004 are \$5/\$12/\$30. Mail service is not required; usage is minimal.

rebate level is lower than other PBM commercial rebate contracts for a three-tiered co-payment benefit.

Rhode Island Department of Elderly Affairs

The Rhode Island Pharmaceutical Assistance to the Elderly Program (also known as RIPAE) is a prescription drug program offered to low and moderate income seniors 65+ and Social Security Disability Insurance (SSDI) 55-65. Eligibility for those 65 and older is based on income: A participant pays either 40%, 70% or 85% of the discounted ingredient drug cost. Only medications in certain classes of drugs are covered under this program, including:

- Anticoagulants
- Anti-diabetic agents
- Anti-infectives
- Antilipemic drugs
- Cardiac drugs
- Disposable insulin syringes vasodilators (cardiac indications only)
- Diuretics
- Drugs approved for the treatment of Alzheimer's disease
- Drugs for the treatment of Arthritis
- Drugs for the treatment of Asthma and other respiratory diseases
- Drugs for the treatment of Depression
- Drugs for the treatment of Glaucoma
- Drugs for the treatment of Osteoporosis
- Drugs for the treatment of Parkinson's disease
- Drugs for the treatment of Urinary incontinence
- Hemorrhologic agents
- Hypotensive drugs
- Insulin
- Oral antineoplastic drugs
- Prescription vitamin and mineral supplements for renal patients

Members may also receive additional discounts on prescription medications, that are not covered through the RIPAE program. Medications for cosmetic purposes are excluded from the program. RIPAE law currently prohibits mail order services. Today 24,000 people are currently enrolled in the RIPAE program.

State spending after rebates was approximately \$8.4 million in fiscal year 2002. This was an increase of 18.1% over 2001. Net expenditures rose 42.1% from 2000 to 2001 (\$5.0 million to \$7.1 million). Expenses have almost doubled in two years, and RIPAE expenditures are expected to exceed \$13 million in calendar year 2004.

DEA utilizes Scrip Solutions, a contracted PBM. The services provided by Scrip Solutions include claims processing, retrospective DUR, call center and some

disease/health management services. Scrip Solutions also invoices manufacturers each quarter for rebates and manages the retail network.

The Department of Elderly Affairs has separately contracted with pharmaceutical manufacturers for rebates commensurate with the Medicaid program less adjustments for the consumer price index (CPI). The RIPAE program retains all of the rebates, which are estimated to reach \$3.7 million in calendar year 2004, or nearly 23 percent of total prescription expenditures.

Department of Corrections (DOC)

The State Department of Corrections (DOC) provides a prescription drug program to Rhode Island adult inmates in seven correctional facilities – approximately 18,000 inmates receive benefits annually. DOC² has a direct contract with Contract Pharmacy Services (CPS) through a capitated arrangement. CPS provides medications to correctional facilities in 30-day blister packs³ (blister packs are individually sealed and labeled packets for each medication dose and patient) utilizing airmail to provide 24-hour turnaround and delivery.

CPS utilizes a common formulary across the State's correctional facilities and also provides claims processing and reporting services. This capitated arrangement includes acquisition cost of the medication, labeling/packaging into blister packs, courier/delivery service to facilities, and a per prescription management fee. CPS provides a majority of medications required at each facility in blister packs via air mail; however, emergency medications that may be required are dispensed by a local retail pharmacy Phred's on an as needed basis. The contract with Phred's is a capitated arrangement that ensures quick turnaround in emergency situations. Through this arrangement, Phred's provides a maximum three or five day supply of medication, but does not adhere to a defined formulary.

State spending in fiscal year 2002 was \$2.4 million. This was an increase of 9.6% over 2001. Spending increased 5.6% from 2000 to 2001 (\$2.1 million to \$2.2 million). HIV/AIDS care is a major cost driver for the DOC and, to date, the collaboration with the Ryan White program and DHS to maximize care coordination and cost savings has been limited.

² *URI is actively involved in program administration for DOC and provides a pharmacist (assistant professor at URI) who directly oversees the services provided by CPS and the local retail pharmacy.*

³ *Some unused medications from the 30-day blister packs are repackaged by URI for a credit.*

Department of Children, Youth and Families (DCYF)

The DCYF covers three major public areas of responsibilities including behavioral health, child welfare and juvenile corrections. For the purposes of this study, examination was of juvenile corrections, which is responsible for providing medications to an average of 1,200-1,300 detained juveniles annually.

The DCYF has a direct contract with LifeSpan, which subcontracts with CPS. In this arrangement, CPS also provides medications in 30-day blister packs and delivers via airmail to the facility while DCYF pays a capitation rate to LifeSpan for numerous services, pharmacy spending within this program is approximately \$80,000-\$100,000 annually. Medications needed on an emergency basis are obtained through a local retail pharmacy.

The majority of patient conditions treated at the facility are psychiatric in nature. DCYF representatives noted that oftentimes when juveniles are detained and counseling occurs, DCYF staff is able to eliminate the medications used in the treatment of attention deficit disorder (ADHD) or bi-polar disorder.

Department of Mental Health, Retardation and Hospitals (MHRH)

The Department of MHRH provides care and support to Rhode Island residents across the areas of mental health, developmental disability and substance abuse. The Department also provides long-term hospital care for patients through the Eleanor Slater Hospital, with facilities at the Pastore Center in Cranston and the Zambarano campus.

The Department provides pharmaceutical services to patients in the system through the Central Pharmacy Services Unit (CPSU), which consists of a warehouse distribution center (Central Pharmacy) and two institutional pharmacies. CPSU provides pharmaceutical services to both Rhode Island institutionalized patients and patients in the Community Medication Assistance Program (CMAP). The CPSU also provides non-legend medications, and surgical supplies and services to approximately 56 group homes and three skilled nursing facilities for the Division of Developmental Disabilities.

The Department of MHRH purchases medication in bulk form through the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP), delivered to the Central Pharmacy. The MMCAP program negotiates the acquisition cost of prescription drugs directly with the manufacturer – it does not negotiate any rebate contracts with pharmacy manufacturers. While the MMCAP program does allow individual states to enter into rebate contracts, however, it appears that MHRH does not hold any rebate contracts. MMCAP provides value to the State of Rhode Island by offering aggressive drug acquisition prices while allowing the state flexibility in managing its drug program.

The Central Pharmacy distributes the medications purchased through MMCAP, in bulk fashion, to community- based pharmacies for distribution to CMAP program participants. (Approximately 15 community-based pharmacies are currently contracted.)

In FY 2000, approximately \$5.3 million was spent on these medications and surgical supplies. Agency representatives note that there are about 1,900 clients in CMAP and at any given time, approximately 900 of these utilize medications and services from the program. In FY 02, medications purchased for the CMAP program totaled approximately \$3.2 million plus an additional \$200,000 for dispensing fees.

CMAP provides psychotropic medication free of charge to clients of the community mental health system that cannot afford to pay – approximately 17,300 adults in FY2002. The Central Pharmacy Services Unit dispenses approximately 350,000 units of medication per year. As of September 2003, about 380 patients are receiving total pharmacy services through the hospital system.

The CMAP program seeks to manage appropriate medication usage through a prior-authorization process where requests for certain medications are reviewed and authorized by the medical director. Approximately 19 medications are covered under this program, which includes a two-month efficacy trial funded by various pharmaceutical manufacturers. If upon review, the trial is successful, the medical director authorizes the continued supply of the medication. A number of other medical management initiatives such as retrospective Drug Utilization Review and Case Management have been implemented, but the absence of an electronic system for review and data capture has been a challenge for the Department.

SECTION 5

Key Findings and Recommendations: A Cafeteria Offering

1. Through adopting a series of recommended changes to the current design and procurement of state financed prescription drug programs, we estimate that the State of Rhode Island could achieve savings of nearly \$39 million – 32 percent of the State’s prescription drug spending. The state employee program is subject to collective bargaining – which will affect changes in cost sharing. However, the collective bargaining process will not affect all other state employee recommendations.
2. Implementing a preferred drug list (PDL) has the potential of yielding savings ranging from \$8.7 million to \$9.6 million in State of Rhode Island spending (excluding the federal share of Medicaid spending). The greatest level of savings would occur if DEA, DHS and DOA coordinate the use of the PDL, which would provide additional savings ranging from \$2.5 million to \$2.7 million. (The DOC, MHMR and DCYF are not included in these figures due to their capitated and/or alternative prescription drug arrangements.) Additional savings from coordinated use of the PDL for all agencies could result in even greater savings.

The tough choice here involves a combination of constituent concerns over any change to the status quo (and there is no question that moving from a typical open access formulary list to the more restrictive preferred drug list involves a considerable change), with the opposition of pharmaceutical manufacturers who have fought, and will continue to fight, governors and state legislators who seek such changes. Additionally, the imposition of a PDL will likely result in lobbying by advocacy groups that will voice strong opinions on what a PDL will mean for their respective constituencies. While initial opposition is probable, more than 100 million Americans have a PDL as part of their benefit plan. Within Medicaid, more than 23 states have implemented at least a handful of PDL drug classes, with more than a dozen utilizing a PDL for all but mental health and HIV/AIDS therapies.

3. The State of Rhode Island pays different reimbursement dispensing fees for the services of pharmacy providers. Today, state agencies generally pay dispensing fees that are greater than the private sector. For example, DHS pays a \$2.85 dispensing fee to long term care pharmacies and \$3.40 to retail pharmacies. The DEA pays a \$2.75 dispensing fee.

Our strategy suggests the legislature examine reducing the dispensing fee for the State of Rhode Island to \$1.50 for brands and \$2.00 for generics for the DEA programs, and \$2.50 for DHS. Reduction in dispensing fees will result in annual savings of \$0.6 million for DEA and \$0.9 million for DHS or a total of \$1.5 million. This strategy will be controversial and a tough decision for legislators as it involves reduction in reimbursement fees paid to the pharmacy providers.

Agency	Recommended Changes				Calculated Annual Savings
	Retail Branded Drug Dispensing Fee	Retail Generic Drug Dispensing Fee	Retail Branded Drug Dispensing Fee	Retail Generic Drug Dispensing Fee	
DHS	\$2.85- retail \$3.40 - NH pharmacy	\$2.85- retail \$3.40 - NH pharmacy	\$2.50	\$2.50	\$0.9 M
DEA	\$2.75	\$2.75	\$1.50	\$2.00	\$0.6 M
Total					\$1.5M

4. The State of Rhode Island pays variable pharmacy discounts for each of the three programs. DEA pays AWP less 13% and DHS pays the Wholesale Acquisition Cost (WAC) plus 5%. The State of Rhode Island will save by increasing the pharmacy discount (decreasing the reimbursement) for both DOA and DEA, which will decrease the profit margin received by the local pharmacies. The recommended reimbursement changes are noted in the following table.

Agency	Recommended Change		Calculated Annual Savings
	Retail Branded Drug Discounts	Retail Branded Drug Discounts	
DEA	AWP – 13%	AWP – 15.0%	\$0.3 M

DHS reimburses pharmacies based on WAC, which does not consistently correlate with AWP. In order to calculate the impact of changing the WAC reimbursement for DHS, the analysis should be modeled using detailed claims. Unfortunately, DHS was not able to provide this level of detail for this analysis. Moreover, due to significant variances in pricing methodologies between WAC and AWP, it is difficult to compare the aggressiveness of the state’s reimbursement to other state Medicaid programs. However, it is possible that additional savings may be yielded through a change in the reimbursement methodology for DHS. This strategy will also be controversial as it involves reduction in reimbursement fees paid to the pharmacy providers.

5. As discussed above, while the State of Rhode Island can obtain significant savings through improved "contracting of individual contracts" resulting from coordinated procurement, we are recommending the state explore the implementation of a

coordinated contracting strategy for DOA, DEA and DHS. This strategy could result in savings to the State of Rhode Island ranging from \$2.7 million to \$3.0 million.

The tough choice for elected officials will involve the ways they choose to value the benefits of such a coordinated contracting strategy. Coordinating contracts inevitably means that someone loses something – whether it is a state agency losing administrative control, a pharmaceutical corporation losing preferred drug list status for their drug(s), or pharmacy providers losing dispensing fees and profits. Likewise, such “loses” will need to be weighed with the numerous benefits.

6. State agency prescription drug programs often do not implement plans for purchasing generic drugs in the most cost-effective manner in order to take advantage of the maximum allowable cost (MAC) pricing. The implementation of an enhanced MAC program is estimated to produce savings for DOA, DEA and DHS ranging from \$1.9 million to \$2.1 million. In addition this will also result in an impact to pharmacy providers, as more competitive MAC pricing will lower reimbursement. The question here is whether pharmaceutical manufacturers will successfully convince elected officials that enhanced use of generic medications is not in the best interest of the patient and how pharmacy providers will react to the reduction in reimbursement.
7. To achieve the greatest success from using a preferred drug list formulary as well as maximizing the value of a coordinated contracting strategy, the administrative and negotiation functions should be consolidated under one agency with one state executive given the sole discretion to negotiate these contracts. The author recommends that this authority be given to the state agency director under whose jurisdiction the bulk of these coordinated programs fall.

The tough choice facing the Governor and state legislators will be their willingness to loosen the reins on these programs and give the Director both the authority and the latitude to implement a strategy that works well for the State of Rhode Island. If the Director is not given the necessary authority as well as the complete support of the Governor and legislature, then the state will fail to obtain the greatest level of savings possible.

8. Through collective bargaining between the state administration and the state employees' unions, changes to the level of cost sharing by state employees, their dependents and pre-65 retirees, may be considered. Such changes have the potential to result in savings ranging from \$1.5 million to \$7.8 million. One example would involve modifying the cost sharing program to \$7 for generics, \$15 for preferred brands and \$25 for non-preferred brands to generate savings of \$1.5 to \$1.7 million annually. Another cost sharing option is \$5 for generics, \$10 for preferred brands and 50% coinsurance for non-preferred brands, which potentially yields \$2.6 to \$2.9 million in savings per year. Another possible option for consideration might include a generic incentive plan with a \$5 generic, \$25 preferred brand and 50% coinsurance (with \$35 minimum) for non-preferred brands. This plan design could potentially

produce significant savings of \$7.0 to \$7.8 million due in large part to increased use of clinically appropriate, lower cost generic drugs.

While modifying the plan design for state employees could potentially generate material savings, the process of collective bargaining, and the more detailed analysis of the impact of these options will affect the level of savings that may be possible.

Options for review			
Agency	Current Member Retail Cost Sharing/Copay (generic/preferred brand/non-preferred brand)	Member Retail Cost Sharing/Copay (generic/preferred brand/non-preferred brand)	Potential Annual Savings
DOA	\$5/\$11/\$25	\$7/\$15/\$25	\$1.5 – \$1.7 M
DOA	\$5/\$11/\$25	\$5/\$10/50% coinsurance	\$2.6 - \$2.9 M
DOA	\$5/\$11/\$25	\$5/\$25/50% coinsurance (\$35 minimum)	\$7.0 - \$7.8 M

9. The State Employees program currently allows up to a 60-day supply of a medication for a one-month co-payment. The parties to collective bargaining for state employees might consider modifying the plan design benefit to include a maximum of 31 days supply per co-payment to reach a potential savings of 2 to 3 percent of drug spending, which would generate additional savings of \$0.8 million to \$1.3 million in CY04.
10. The greater the burden placed on state employees and dependents, the higher the savings potential. For instance, savings ranging from \$3.3 million to \$3.6 million are possible through the implementation of an individual \$100 deductible that state employees, dependents and pre-65 retirees would be required to pay (meaning that the drug benefit would not go into effect until the deductible is met).
11. Another consideration for collective bargaining on the state employee and retiree benefit plans is to have state employees, dependents and pre-65 retirees to purchase maintenance medications (those taken for 90 days or longer) through a traditional mail order facility that could yield savings of 4 to 8 percent of drug spending, which would equate to \$1.7 to \$3.3 million in CY04. This assumes 20 to 25 percent of all prescriptions are shifted to mail order. This savings is primarily due to the reduction in brand name ingredient cost and the elimination of a dispensing fee for mail order service.

To ensure appropriate drug and dose and reduce waste, mandatory mail order utilization could be designed to be in effect after the patient has received the third refill. The mail order co-payment is equal to three times the retail co-payment.

The tough choice represented by this provision involves finding a balance between the savings possible as a result of reform and the consequences of requiring state employees and others to have to begin buying their medications through the mail. Change, however necessary it may be or how carefully it is designed, is never easy or easily accepted. Despite the demonstrable benefits of the savings to be achieved, some constituents will inevitably be skeptical about the motivations behind the changes and angered by the inconveniences they entail.

12. The state could also achieve savings for state employees, dependents and pre-65 retirees who purchase maintenance medications through a retail maintenance drug program and voluntary mail order program. Participating retail pharmacies must offer greater discounts and a reduced dispensing fee to be more cost competitive with mail order. After the patient has received the third refill of a maintenance drug, the patient would be required to obtain a 90-day supply at their local pharmacy or through mail order. The co-payment for a 90-day retail supply is equal to three monthly co-payments, and two monthly co-payments for mail order. Assuming that the retail pharmacies accept a maintenance reimbursement of AWP less 18 percent for brand name drugs and a dispensing fee of \$3.00, there could be estimated savings of 0.5 to 1.0 percent of drug spend, or \$0.2 to \$0.4 million in CY04.
13. This report recommends a series of steps that the State of Rhode Island could consider in an effort to maximize possible 340B funding. We did not provide any specific savings estimates in this area because the State of Rhode Island has far too much preliminary work to undertake before this could be done. Any attempt beforehand would be misleading. The assessment of the benefit of these cost savings opportunities versus the financial and organizational impact on the participating state agencies is a key next step to prioritizing such opportunities.
14. One of the most difficult aspects of this report was addressing the true needs of the state long-term care hospital system. While the leadership of the long-term care hospitals was difficult to work with, it became clear that what the long-term care hospital system needs more than anything else is the expertise and leadership of the School of Pharmacy at the University of Rhode Island. URI needs to immediately undertake a pharmacological review, both retroactive and prospective, of the state long-term care hospitals to determine the changes needed to guarantee to taxpayers and the legislature that public dollars are being spent both wisely and effectively. Moreover, harnessing the resources and expertise of the pharmacy experts at URI will also ensure that both qualitatively and quantitatively the citizens of Rhode Island are being properly served.

15. While there is an earlier recommendation for the legislature to examine why dispensing fees paid to pharmacists vary among state agencies and to evaluate creating a single state rate, there is a real need to recognize and financially value the work done by pharmacists who provide cognitive therapy to patients. This is when a pharmacist assists the patient in evaluating a generic vs. brand name drug; when they counsel the patient on the kinds of prescription medications and over the counter medicines they are taking to ensure against conflict; when they take the time to explain how specific prescriptions can and should work, etc. This is typically a service that has long been provided by neighborhood or community pharmacies because they, not doctors, serve as the medical personnel who actually spend time talking to patients and counseling them on both quality and cost issues as they pertain to the prescriptions they fill and the medicines they purchase over the counter. To effectively value this work, we are recommending that the State of Rhode Island initiate a demonstration plan that provides financial compensation for these services.
16. A PDL, as addressed in previous findings, will decrease ingredient cost and also increase rebate revenue. Supplemental rebates within the Medicaid program will generate 6 to 8 percent savings – and require the state to contract directly with pharmaceutical manufacturers. The state may achieve material savings for other programs, such as DOA and MHRH, if it contracts directly with pharmaceutical manufacturers for rebates for all state programs. Direct contracting will affect the current arrangement between DOA and BCBS-RI/PharmaCare; however, since 100 percent of these rebates are passed back to the DOA, it should not have any financial impact on the existing financial arrangements.
17. The DOA currently pays BCBS-RI for managing pharmacy services. Based on experience in other state employee programs, the DOA may achieve between 5 and 10 percent savings through direct contracting with a pharmacy benefit administrator (PBA) or pharmacy benefit manager (PBM) through a competitive bidding process. This process will allow the incumbent PBM – PharmaCare – to continue to serve this population if it is successful through a state procurement process.

SECTION 6

What is Coordinated Contracting of Prescription Drugs?

The challenge facing Governors and state legislators is to ensure that program participants receive high-quality, cost-effective healthcare in the face of rapidly rising costs. Many solutions are being explored to manage prescription drug cost increases, including, but not limited to, health care re-engineering, employee health insurance plans, more effective management of all vendors, and enhanced pharmacy benefit management.

Coordinated Contracting allows an employer, or an entity like the State of Rhode Island, to consolidate the administration of various state programs providing prescription services under the auspices of one or several state agencies.

The consolidation of prescription drug contracts into a single administrative purchasing unit under, or within, a state agency, ensures that the state is maximizing its purchasing clout and valuing the use of taxpayer dollars. Thus, a consolidated approach brings all eligible individuals into a pool or state agency where volume is used to leverage more favorable financial and service arrangements. Currently, federal agencies and large private sector purchasers operate in this manner.

By combining the various purchasers into one contractual arrangement, the combined state agencies could conceivably receive more competitive ingredient cost discounts and dispensing fees, administrative fees, and rebates, in addition to securing greater economies of scale, than they would receive individually.

Coordinated purchasing of pharmaceuticals is often likened to the purchasing of other commodities. It is important to note, however, that there are some important differences. Coordinated purchasing of pharmaceuticals encompasses not only the purchasing of a commodity (such as medications), but also involves the need for coordination of services (such as utilization management, claims administration, network management, rebate management, etc.) associated with administering the pharmacy benefit.

For this report, aggregate or coordinated purchasing is not simply the act of taking the prescription drug programs from many state agencies and combining their purchasing power through one state agency. It also involves the barriers a state like Rhode Island might face in achieving the greatest level of savings possible. The challenge to the Governor and the legislature is whether they are prepared to accept and implement all the changes that would be necessary to allow aggregate or coordinated purchasing to work to its fullest potential, and to achieve the greatest possible savings and administrative efficiencies. It also assumes that the legislature is, and will remain, fully committed to the concept of aggregate or coordinated purchasing and to the program itself.

Combining Collective Purchasing and Program Management

Drug expenditure trends for the commercial, public sector employee and retiree program and other public programs' populations are rising at an alarming rate. Current prescription drug trends have risen to over 18% in the commercial market with public programs seeing increases up to, and in some cases exceeding, 20–30%. The fragile economy has magnified this concern with local tax revenues falling and state budget deficits ranging from millions to billions of dollars. In order to reduce the impact of these deficits, state governors are now looking to the private sector and private sector programs to find innovative strategies to significantly reduce drugs expenditures. As a result, leaders of state agencies across the country have identified two key pharmaceutical areas that they believe will provide the greatest cost-savings and return on investment (ROI):

- Management of the commodity itself through economies of collective purchasing and contracting; and
- Program management of the consumption, or utilization, and effectiveness of pharmaceuticals.

In **Collective Purchasing**, entities unite in order to leverage their combined purchasing power to negotiate and contract for discounted pharmaceutical delivery system services. Several states have either banded together internally, or with other states' programs with similar populations, to form collective purchasing alliances, coalitions or pools (collective purchasing includes bulk purchasing strategies).

Bulk purchasing is another strategy employed to manage the economies of purchasing and contracting. Bulk purchasing can be defined as strategic volume purchasing that takes advantage of economies of scale resulting in volume discounting of products. States are now developing drug-purchasing strategies in response to these two key objectives.

Program Management of pharmaceutical consumption in a state agency context requires the alignment of strategies around:

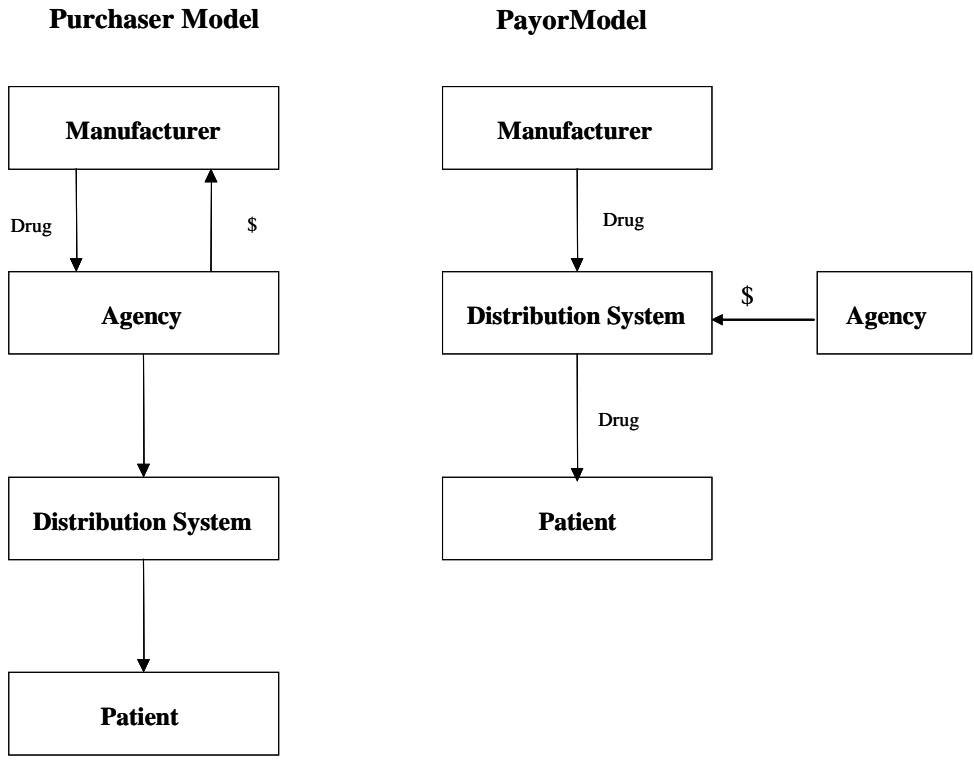
- Management of utilization through benefit design and clinical management strategies;
- Health care provider and patient behavior modification;
- Health care provider and patient education;
- Maximizing and managing the use of new management and treatment technologies;
- Aggregate data reporting and analysis in order to identify population-based health care management opportunities; and
- Coordination of enrollment and funding streams to ensure movement of the appropriate population to either federally subsidized or externally funded programs, and to maximize federal matching for state programs.

Integration of collective pharmaceutical purchasing and program management strategies under a collaborative model can be thought of as a Coordinated Prescription Drug Purchasing Strategy.

A coordinated strategy must be defined and developed uniquely for each state and its agencies. In order to develop this collaborative model the leadership and/or change agents need to:

- Understand how each agency delivers and manages their prescription drug benefit;
- Identify who are the third-party payors and who are the direct purchasers of prescription drugs;
- Understand the relationships (similarities and differences) between agencies in terms of the:
 - population(s) served;
 - existing delivery systems and vendor relationships;
 - services provided; and
 - funding source(s)/mechanisms.

Each agency can deliver the prescription drug benefit through either a Third-party Payor (Payor) model or a Direct Purchaser (Purchaser) model. The Payor model is a state pharmacy procurement model, where a state agency contracts for access to a delivery and/or distribution system for medications such as community-based retail networks or a mail service provider. A Purchaser model owns or provides medications directly to a distribution system and purchases drugs directly from the manufacturer or through a “prime vendor” relationship. Prime vendors are often contracted by purchasing alliances to negotiate and purchase directly from the manufacturers on behalf of the entire pool of purchasers. These vendors typically manage a central distribution facility and service for the participating agencies. The following flow charts illustrate these purchasing arrangements:



Collective purchasing strategies have enabled payors to obtain significant volume discounts on the purchase of prescription drugs through the following mechanisms:

- negotiate for greater discounts in insurance premiums;
- lower dispensing fees;
- reduce administrative costs;
- obtain larger rebates.

Understanding the relationships among the various agencies regarding populations served and existing vendor relationships has allowed states to develop strategies focused on program management. Such strategies have helped states meet their cost savings objectives while improving access and clinical outcomes, while meeting the needs of the individual and collective population(s). These efforts are focusing on:

- prescription drug utilization management;
- health and case management;
- maximizing and coordinating funding and program enrollment;
- reducing the administrative burden through identification of efficiencies (unified claims processing and eligibility verification).

The following are recent examples of the key models that have been utilized by federal and state agencies to explore **Coordinated Prescription Drug Purchasing**.

Purchaser Strategies

Interagency Purchaser Model: The US Department of Defense (DOD) and Veterans Affairs (VA) have experimented with pooled drug purchasing. The DOD and VA are two of the largest drug purchasers in the country and therefore already receive significant discounts on drug purchases. In 1999, a congressional commission mandated that they develop a joint procurement process and a single clinically based formulary. The commission estimated that this effort would lead to approximately \$1.9 billion savings over 5 years or about \$383 million per year. As a result of a coordinated drug purchasing and management strategy, to date the combined agency savings have been significantly greater than their prior experience as individual purchasers. In 2002, the DOD and VA saved over \$26 million in outlays through these efforts. It is estimated that the cost savings for the two agencies will grow to approximately \$1.4 billion by 2011.

Multi-State Prescription Drug Purchasing Model: Since 1985, the Minnesota Department of Administration, Materials Management Division, has administered the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP). MMCAP is a purchasing pool for multiple state agencies and nonfederal governmental entities across more than 38 states. Participants are able to obtain pharmaceuticals through MMCAP using contracts established with drug manufacturers and other vendors. As more states and entities join MMCAP, their ability to leverage direct purchasing from the pharmaceutical companies increases. Currently, more than 2,600 facilities receive services from MMCAP. MMCAP is funded through administrative fees from contracted drug manufacturers, and these funds are used exclusively to support the program. Minnesota currently has contracts with over 130 pharmaceutical manufacturers for more than 6,039 products.

Payor Strategies

Multi-state Agency Model: In October 2000, the State of Georgia implemented a multi-state agency-purchasing model. The state agencies selected to participate in this strategy included the State Employees and Medicaid programs. The Board of Regents elected to participate through the Department of Community Health (Medicaid). In January 2000, a joint RFP was released for a PBM contract. As a result, the state agencies are now coordinating their pharmaceutical purchasing and management through Express Scripts, Incorporated. As part of this effort, program management strategies included benefit changes (e.g., a pharmacy card program was implemented with 3-tier copay structures), an enhanced Maximum Allowable Cost (MAC) pricing was implemented, and a single Preferred Drug List was implemented across the participating state agencies and their populations. The key goal of these management changes was to incentivize appropriate utilization. Primarily as a result of the implementation of these program management strategies, and to a lesser extent resulting from the collective contracting synergies, Georgia has realized a reduction in pharmacy cost trends for the Medicaid program of 18% to 25%.

SECTION 7

Fiscal and Policy Implications of the Current Programs

When designing a coordinated prescription drug contracting strategy, the State of Rhode Island should look for ways to leverage effectively similarly designed programs and/or population groups. In doing so, the goal is both to maximize the level of savings possible while ensuring a level of quality that the State of Rhode Island supports. This is best achieved by providing appropriate access to medications, services, and appropriate pharmacy management strategies, for all participants. The most significant areas that must be addressed are the prescription drug formulary and clinical management programs.

Prescription Drug Preferred Drug List (PDL)

A PDL (also recognized as a formulary), is a listing of medications covered by the third party payor that are chosen by clinical experts on the basis of efficacy, quality and cost. The current state employee health insurance plan (DOA) has adopted an open access formulary approach – which allows benefit coverage of all medications within therapeutic classes. The fee-for-service Medicaid program uses the formulary defined by the manufacturers that participate and offer rebate contracts within the Federal Rebate Program. Due to high manufacturer participation in the Federal Rebate Program, the vast majority of medications on the market are included on this formulary; thereby, resulting in an open access formulary.

The Department of Elderly Affairs (DEA) offers a prescription benefit in which only medications within certain therapy classes are covered; thereby utilizing a closed formulary approach. The greatest efficiency resulting from a coordinated contracting strategy would be the development of a common preferred drug list (PDL) that would be utilized by Medicaid, state employees (dependents and pre-65 retirees) and the DEA program.

The implementation of a PDL requires determination of the medications that will be represented on the PDL. In order to minimize the administrative burden associated with developing and maintaining a customized PDL, consideration should be given to using Rhode Island's specific drug adoption by all agencies that will utilize the PDL. This drug utilization information should be compared to determine the common drugs used and physicians' prescribing patterns within the State of Rhode Island and could serve as the base listing of medications represented on the PDL. Other approaches include the use of a base formulary as a starting point, such as the basic formulary offered by PBM contracted administrators; or the purchase of evidence-based therapeutic class reviews from a third party entity, such as Oregon Health Resources Commission. Either approach will require that final decisions and modifications to the PDL be made by the state's Pharmacy and Therapeutics and/or DUR Committees.

One example of a state utilizing a coordinated contracting strategy is the State of Georgia working with Express Scripts, a nationally recognized PBM, that administers the contracts for a preferred drug list for Medicaid, state employees and a higher education entity. Careful consideration must be given as the State of Rhode Island builds a state-specific PDL. Some of the PBM administrators within the marketplace have a great deal of experience in this arena; which will also means that when the state issues an RFP for these services, the level of interest and the extent of competition should be such that increasingly favorable rates, enhanced rebates, and savings result.

Clinical Management Programs

The ability to incorporate commercial (private sector) management tools, such as a PDL, network management, plan design, and utilization management strategies where appropriate, will help a coordinated contracting strategy achieve great efficiency and maximize the level of achievable savings.

Allowing the contracted PBM administrator to "do what it can do best" and manage program performance through management tools enhances the ability of an employer and/or state entity to balance quality and cost savings. Additionally, it allows access to revenue streams such as network contracts and rebate contracts.

Ability to implement and administer utilization management programs

In addition to a more competitive financial arrangement, additional savings could be achieved through the administration of utilization management programs. Aggregating the individuals from multiple programs allows a state, for example, to implement consistent benefit design and utilization management strategies among a critical mass of participants.

In Rhode Island, aggregate purchasing strategies will likely result in increased market concentration. 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. Such efficiencies are maximized by aligning strategies for PDL management, coverage policy, and clinical management tools, as well as enabling groups to educate providers and participants collectively, and more effectively, on program policy. The result should be improved outcomes that translate into program savings.

Clinical management programs would need to be designed to address the diverse clinical needs of the populations coordinating their contracting policies. Because Medicaid is an entitlement program, it is subject to myriad influences from lobbying groups and other entities. The influence of such groups can deter a legislative body from its focus on the balance of cost and quality.

Finally, many aspects of pharmacy program management for Medicaid are guided by legislative language. Federal regulations specify requirements relative to the design, implementation and reporting of many clinical management programs.

As the State of Rhode Island evaluates the impact of any coordinated purchasing strategy, it is important to understand the various similarities and differences among the program contracts to be coordinated. It is only through an understanding of the influence these factors have on each program, that a relevant and successful strategy can be developed and adopted. Such a strategy must not only capitalize on the efficiencies that can be gained by combining similar programs; it must also address the unique issues and needs faced by each individual program.

Financial Analysis

Coordinated Contracting Savings for the State of Rhode Island

The primary goal of our analysis was to determine what level of savings, if any, could be achieved through coordinating contracting for any of the six programs. Each of the programs included in this study currently use a different procurement approach. As a result, they do not achieve individual or collective competitive financial and service arrangements. At best, they receive what is perceived to be the best deal possible in each individual circumstance.

Since Medicaid discounts and dispensing fees are legislated under Rhode Island law, and rebates are legislated under federal law, the negotiating power between Medicaid and an administrator, on its own, is almost entirely eliminated. Absent a change in legislation, the financial arrangements under the Medicaid program will generally remain the same. It is important to note that several states have recently chosen to address similar issues through changes in legislation.

DHS does, however, play an important role in a coordinated purchasing strategy. With the largest share of lives and drug spend in Medicaid fee-for-service, DHS in conjunction with DOA (state employees), and DEA combined, could have greater clout in the marketplace. Given the desire of some plan administrators such as PBMs to gain Medicaid market share, this will leverage the purchasing power of the combination of the three entities. Additionally, the opportunity to benefit from pharmacy benefit management strategies used in the commercial market could significantly benefit all three programs, and in particular, the Medicaid program, resulting in significant savings.

The remainder of this section, which discusses the financial impact of coordinated purchasing, is divided into two sections:

- Coordinated Contracting: The Consolidation of Existing Contracts under Current Rhode Island Law; and
- Additional Cost Savings – which can be obtained with or without coordinated purchasing.

The Consolidation of Existing Contracts under Current Rhode Island Law

Summary

The coordination of the existing DHS (Medicaid), DOA (state employees) and DEA under a coordinated contracting strategy will produce both direct and indirect savings. This aggregation, and thus accrual of savings, can only occur after the contractual obligations with current plan administrators are met. In total, it is estimated that, in the first year, between \$19.7 million to \$21.7 million in savings to the State of Rhode Island is possible, as shown in the following table.

The State of Rhode Island Coordinated Contracting Strategy			
State Agency	Projected Rx Spending (CY04)*	Direct Cost Savings	Revised Spending
DOA	\$41.3 million	\$4.6 – \$5.0 million	\$36.3 – \$36.7 million
DEA	\$13.3 million	\$3.9 – \$4.3 million	\$8.9 – \$9.4 million
DHS	\$68.3 million	\$11.2 – \$12.4 million	\$55.9 – \$57.1 million
Total	\$122.9 million	\$19.7 – \$21.7 million	\$101.1 – \$103.2 million

** State of Rhode Island spending, net of member cost share and excluding the federal match on Medicaid spending.*

Direct Savings

As a result of our review of the current financial and administrative arrangements for DOA, DHS and DEA, we conservatively estimate that the combined purchasing power of these three entities could produce direct cost savings of \$19.7- \$21.7 million in CY 04. These savings, which represent approximately 16.0%-17.7% of projected prescription drug program costs for these three entities, do not reflect any changes to the current cost sharing and other plan design features. The estimated direct cost savings result from savings in the following four areas:

- More competitive ingredient cost discount arrangements – including an enhanced maximum allowable cost (MAC) program;
- Decreased dispensing fees paid to the pharmacies;
- Lower claim processing fees; and
- Preferred Drug List (PDL) with enhanced pharmaceutical rebates.

The direct cost saving analysis includes financial arrangement assumptions based on the competitiveness of the current marketplace. It is important to realize that changes in the competitiveness of the current marketplace would impact the cost saving potential. Additionally, we have shown each component of the financial arrangement separately for illustrative purposes only. Typically when evaluating multiple financial arrangements, it is important to assess the combined effect of the components, and not focus on each item separately. For example, a lower dispensing fee is not necessarily the best deal if the ingredient cost discount associated with that dispensing fee is less competitive than the discount associated with the higher dispensing fee.

More Competitive Ingredient Cost Discount Arrangements

Although the DOA currently has competitive discount arrangements, the purchasing power created through coordinated contracting of DOA, DEA and DHS (fee-for-service) would lead to enhanced ingredient cost discounts for the combined programs due to the greater volume of lives. This would be inclusive of a maximum allowable cost (MAC) program discussed in a later section.

Lower Dispensing Fees

Since the dispensing fees under the Medicaid program are legislated for Medicaid providers, administrators do not have the ability to offer more competitive dispensing fees to Medicaid absent state and federal approval. However, through a coordinated contracting strategy, the combined purchasing power could lead to lower dispensing fees. However, it must be underscored that lower dispensing fees directly impact both chain and independent pharmacies, resulting in lower overall profits. Setting aside the politics and potential political headaches, a logical question should be: Why does Medicaid pay a different dispensing fee than RIPAE to dispense the same brand drug?

Lower Claim Processing Fees

The combined purchasing power created by coordinated purchasing could also lead to lower claim processing fees. Based on information provided for the administrative expenses associated with the processing of electronic claims and other administrative activities, savings of approximately 2%-4% could be obtained through a coordinated contracting strategy.

PDL with Enhanced Pharmaceutical Rebates

The combined purchasing power created by coordinated contracting, augmented by plan design and pharmacy management tactics, potentially leads to enhanced pharmaceutical rebates. As a result, while our conservative analysis includes cost savings attributed to enhanced rebates, it is possible that even more aggressive rebates could be negotiated generating additional cost savings. This is particularly true if the State of Rhode Island also enacts a preferred drug list and/or formulary where negotiations with manufacturers should yield either enhanced rebates and/or substantially lowers costs.

Indirect Savings

As a result of more efficient administration and improved pharmacy management, indirect savings are also possible under the coordination of the three programs. It is estimated that significant savings could be achieved. However, the actual dollar savings cannot be calculated until the legislature determines whether and to what extent it is willing to implement a coordinated contracting strategy.

Moreover, under a coordinated contracting strategy, the opportunity exists for the state to align the management strategies across the various programs. For example, the state could choose to align pharmacy management strategies – such as development of a common formulary or preferred drug list, managed pre-authorization, quantity and duration limitations and concurrent and retrospective drug utilization management – across all programs. The level of additional savings that could be achieved for each program would depend on the competitiveness of the strategies currently implemented for each group. By aligning management strategies, the State of Rhode Island could anticipate not only the direct savings typically associated with each program, but also the indirect benefit of creating the critical mass of participants required to influence prescribing behaviors.

Other Savings Opportunities Outside of Coordinated Purchasing

While coordinated contracting represents savings ranging from \$19.7 million to \$21.7 million, there are a number of other recommendations the individual agencies can implement that will result in savings. These include:

- Implementing a more competitive MAC pricing list for Medicaid;
- Changing current legislation to allow for lower dispensing fees under the Medicaid program;
- Revising the benefit designs for state employees;
- Implementing a preferred drug list and contracting for supplemental rebates;
- Improved individual agency contracting.

Implement a more competitive MAC pricing list for Medicaid

A Maximum Allowable Cost (MAC) program establishes the maximum cost that will be paid for a generic product. This program encourages a pharmacy to purchase generic drugs in a cost-effective manner. When setting up a MAC program, the availability and pricing of FDA approved generics is reviewed. Then, a price is set that allows the pharmacy to make an adequate profit while saving the State of Rhode Island a great deal of money. This program more accurately addresses what pharmacies are paying for generic medications as opposed to using the AWP price, which remains a fairly inaccurate measure of pharmacy acquisition cost.

Although the provider reimbursement for prescription drugs under Medicaid is legislated under Rhode Island law, it is possible that the current discount arrangement for generic prescription drugs could be altered to provide additional savings. As legislated by the State of Rhode Island, generic drugs that appear on the Federal Upper Limit pricing (FUL or CMS MAC) are reimbursed as such. However, comparison of the FUL with a plan administrator's basic MAC listing shows that the FUL listing lacks both depth and breadth (the number of generic products represented and the aggressiveness of the reimbursement price).

Therefore, the state can obtain savings for each program individually, or for all programs combined, by creating the opportunity to have a more expansive list of generic drugs priced at the MAC level. It is estimated that a savings of \$1.9 million to \$2.1 million could be possible for State of Rhode Island spending for the DOA, DEA and DHS programs combined.

We estimate that the State of Rhode Island is paying AWP-45% for generic drugs in the HCFA MAC list. A commercial or enhanced state MAC list usually equals AWP-50% or greater for generic drugs. Therefore, the State of Rhode Island could expect to save an additional 5% on the cost of generics in addition to expanding the list to include more generics. These savings will be even greater as generic versions of high volume drugs (such as Prilosec[®]) continue to enter the market.

For the Medicaid population, the savings from an enhanced MAC list could reach approximately 10-15% annually for generic drug spend, which can equate to 2-3% of total drug spend. In order to quantify this more accurately, specific drug utilization for this population would need to be reviewed.

Preferred Drug List Formulary (PDL)

Preferred Drug List with Supplemental Rebate Strategy Recommendation

A preferred drug list is similar to a formulary in nature, selected on the basis of quality and cost, to encourage physicians to prescribe, and members to use, appropriate cost-effective medications. The preferred drug list is developed through a balance of clinical and financial decisions. The list should be subject to scheduled, periodic reviews and modification by the plan and used by physicians when making decisions on what medication to prescribe to a plan member.

Supplemental rebates represent a rebate amount that is negotiated with a manufacturer in excess of the rebate provided to Medicaid agencies through the federal rebate program and CMS rebate contracts. The additional rebate is negotiated for medications deemed appropriate for preferred status. Rebate amounts can vary significantly depending on the methodology and processes the state adopts in the selection of preferred medications for the PDL as well as the PDL management techniques.

Moreover, supplemental rebates are often driven by management initiatives, such as pharmacy point-of-sale messages, education of patients and physicians, and prior

authorization and interchange programs that actively provide information to physicians or patients to encourage a change from a non-preferred drug to a preferred drug.

The last component is to coordinate the opportunity to have a common preferred drug list based on the combined agencies' ability to influence the market share of particular drug products. The ability to coordinate with additional agencies to provide a consistent multi-agency PDL will provide additional leverage to maximize savings to the State of Rhode Island. The plan design approach adopted by each agency may provide additional leverage.

For example, a closed formulary can significantly influence the use of particular drugs, thereby increasing the pharmacy benefits provider's ability to negotiate higher rebates with certain manufacturers to include their drugs. In comparison, the least restrictive type of preferred drug list provides little or no financial incentives for patients to use particular drugs. In this case, a provider has a reduced ability to negotiate rebate payments from manufacturers in exchange for the inclusion of their drug.

There are a few options the State of Rhode Island can consider for the PDL. With each option, and the inclusion of additional agencies, the level of savings increases. Supplemental rebates are contracted for in each option.

Option 1: DHS develops and implements its own PDL.

Option 2: DHS and DEA develop and implement a combined PDL.

Option 3: PDL is expanded to the other agencies.

Option	Agencies	Projected Drug Spend CY04 (millions)	Savings (millions)
1	DHS	\$68.3	\$7.3-\$8.1
2	DHS and DEA	\$81.5	\$8.7-\$9.7
3	DHS, DEA and DOA	\$122.9	\$11.1-\$12.4

Assumptions:

- Applied trend factor of 17- 20% to FY02 spend data.
- DHS drug spend and projected savings are expressed in State of Rhode Island dollars.
- DHS savings and expenditures must be doubled to reflect total agency spending including the federal match.
- DOA drug spend includes Medicare retirees, unlike figures in the plan design discussion.
- No change in financial arrangements and/or provider reimbursement (i.e., improved contracting).
- No coverage for drugs not on the PDL unless authorized and a moderate to aggressive supplemental rebates strategy.

- No additional administrative staff.

Option 1 assumes that DHS develops and implements its own PDL. As shown, the savings are significant at \$7.3 to \$8.1 million.

Option 2 illustrates the potential significant level of savings, \$8.7-\$9.7 million, possible if DHS and DEA implement a “coordinated” PDL. The significance here is not only the aggregated number of lives, but also the increased level of supplemental rebates available.

Option 3 illustrates the increased potential savings, \$11.1-\$12.4 million available with the creation of a single PDL that would be used by three state agencies: DHS, DEA and DOA.

Improved Individual Agency Contracting

The pharmaceutical distribution system in place for the State of Rhode Island is through various contracts administered primarily by BCBS-RI, PharmaCare, Scrip Solutions and EDS. Each of these contracts has different provider reimbursement arrangements.

One of the opportunities for consideration is to improve upon the reimbursement policy and leverage better discounts and lower dispensing fees for each individual contract or in a coordinated fashion. The coordinated strategy leverages a larger population of lives for enhanced savings opportunities.

State of Rhode Island: Improved Contracting for Individual Contracts			
	Projected Rx Spending (CY03)	Direct Cost Savings	Revised Spending
DOA	\$41.3 million	\$0.5 – \$0.6 million	\$40.7 – \$40.8 million
DEA	\$13.3 million	\$0.8 – \$0.9 million	\$12.4 – \$12.5 million
DHS	\$68.3 million	\$0.9 – \$1.0 million	\$67.3 – \$67.4 million
Total	\$122.9 million	\$2.2 – \$2.5 million	\$120.4 – \$120.7 million

This option illustrates the level of savings to the State of Rhode Island (excluding federal match) that is possible if individual state agencies are able to improve upon their individual prescription drug contracting. However, as shown previously, the level of savings is greater under a coordinated contracting strategy.

Revise the benefit designs of each program

As stated earlier, this section illustrates the level of savings that could be achieved through benefit plan design changes. The benefit designs that are illustrated are based on increased member/participant cost sharing.

The benefit design changes are shown here for illustrative purposes only. The current plan design for state employees (and dependents) for CY04 is:

State of Rhode Island Department of Administration (DOA) CY04		
	Actives	Pre-65 Retirees
Mandatory Generic	No	No
Retail (up to 60 day supply)		
Generic	\$5	\$5
Preferred Brands	\$12	\$12
Non-Preferred Brands	\$30	\$30
Mail Order (brand and generic) 90 day supply	Same as retail	Same as retail

Under the current plan design, there is a minimal incentive for people to use more cost effective medications. An incentive-based PDL/formulary economically encourages participants to want to use more cost-effective drugs. However, in order to promote greater use of generics, a wider financial difference should be imposed between preferred and non-preferred drugs.

In general, the utilization trend is slowed when the participant's cost-share increases between 2-10 percentage points from the previous plan year's cost share. Furthermore, when a patient's cost share increases more than 10% from the previous year, a negative utilization trend results.⁴ This positive impact needs to be balanced with the fact that some of this decreased utilization may result from patients no longer taking medications that are essential and member perception that their benefits have been reduced.

Through collective bargaining between the state employee unions and the state department of administration, consideration should be given to the potential to achieve savings of 14.6% - 55% by adjusting their three-tier formulary, implementing a \$100 deductible, reducing supply from 60 to 31 days, and balancing the retail and mail order co-payments from the current design.

There are always advantages and barriers anytime plan design changes are considered or implemented.

⁴ *The Merck-Medco Drug Trend Report 2001*

Plan Design Recommendations	
<i>Advantages</i>	<i>Barriers</i>
<ul style="list-style-type: none"> ▪ Increased member contribution 	<ul style="list-style-type: none"> ▪ Member/union resistance
<ul style="list-style-type: none"> ▪ Increased rebate potential 	<ul style="list-style-type: none"> ▪ Pharmaceutical industry resistance
<ul style="list-style-type: none"> ▪ Promotes appropriate utilization 	<ul style="list-style-type: none"> ▪ May require legislative support for changes
<ul style="list-style-type: none"> ▪ Retains access to all medications albeit at tiered co-pays (not a closed formulary) 	<ul style="list-style-type: none"> ▪ Communications needs (patient, physician)
<ul style="list-style-type: none"> ▪ Promotes consumerism - members become more aware of drug costs 	<ul style="list-style-type: none"> ▪ Perception that State of Rhode Island is trying to exclude expensive drugs from coverage

In order to create a more economically incentivized prescription drug program for state employees, dependents and pre-65 retirees, we are recommending two options for the Governor and legislature to consider. The savings for these options range from \$6.0 million to \$13.0 million.

Plan Design Feature	Option 1	Option 2	Option 3
Member Cost Share	\$7 generic \$15 preferred brand \$25 non-preferred brand	\$5 generic \$10 preferred brand 50% coinsurance, non-preferred brand	\$5 generic \$25 preferred brand, 50% coinsurance (\$35 minimum), non-preferred brand
Mandatory Generic Dispensing	Yes	Yes	Yes
Maximum Day Supply per Member Cost Share	31	31	31
Mail Order Co-payment (90 day supply)	\$14 generic \$30 preferred brand \$50 non-preferred brand	\$10 generic \$20 preferred brand 50% coinsurance, non-preferred brand	\$10 generic \$50 preferred brand, 50% coinsurance (\$70 minimum) non-preferred brand
Deductible	\$100	\$100	\$100
Annual Savings	\$6.0 - \$7.0 million	\$7.2 - \$8.2 million	\$11.6 - \$13.0 million

The state employee benefits are negotiated through the collective bargaining process, which may affect the state's ability to achieve the cost sharing provisions identified above.

Section 8

340B Prescription Drug Pricing: Opportunities Are Available

In 1992, Congress enacted Section 340B of the Public Health Service Act (PHSA). The Pharmacy Affairs Branch (PAB) in conjunction with the US Department of Health and Human Services (HHS) through the Health Resources and Services Administrations (HRSA) and Bureau of Primary Health Care (BPHC) administers the 340B discount program. This legislation was enacted to provide indigent populations greater access to medication by offering steep discounts for pharmaceuticals to the “covered entities” that serve these populations. If a grantee or hospital meets the qualifications specified for a covered entity, a form is filed with the PAB for 340B purchasing eligibility. Discounted drugs can then be purchased through a prime vendor who serves as the liaison with the wholesalers and/or manufacturers and is responsible for distribution to the 340B participating entities.

Participation Requirements

Under Section 340B, a covered entity includes facilities that participate in designated federal grant programs that serve people with specified illnesses and those belonging to designated populations. These entities include federally qualified health centers (FQHCs) as defined in section 1905(1)(2)(B) of the Social Security Act (SSA). FQHCs, city and county health departments, and other small facilities that do not have in-house pharmacy capability are allowed to utilize contract pharmacies. Section 340B identifies those entities that are eligible for 340B pricing and specific requirements for participation in the program. Covered entities include:

- FQHCs;
- health centers for residents of public housing;
- family planning service centers;
- early intervention services for HIV;
- other certified HIV health care service programs;
- state-operated AIDS drug assistance programs (ADAP);
- black lung clinics;
- hemophilia diagnostic treatment centers (HTC);
- certified state or local entities for the treatment of sexually transmitted diseases (STD) or tuberculosis;
- native Hawaiian health centers;
- urban Indian organizations;
- certain subsection hospitals that are: owned or operated by a unit of state or local government, are a public or private non-profit corporation that are formally granted governmental powers by a unit of state or local government, or is a private non-profit

hospital that has a contract with a state or local government to provide health care services to low income individuals who are not entitled to benefits under title XVIII of the SSA or eligible for assistance under the state plan under this title; has a disproportionate share (DSH) adjustment percentage, as determined under section 1886(d)(5)(F) of the SSA, greater than 11.75 percent for the most recent cost reporting period that ended before the calendar quarter involved; and does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

The PAB has published final notice of guidelines on the definition of a patient to allow a clearer understanding of which individuals may receive prescribed medications purchased by 340B programs. “In summary, an individual is a ‘patient’ of a covered entity (with the exception of State-operated or funded AIDS drug purchasing assistance programs) only if:

- the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual’s health care; and
- the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity; and
- the individual receives a health care service or range of services from the covered entity, which is consistent with the service, or range of services for which grant funding or federally-qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals (DSH) are exempt from this requirement.

The 340B legislation also mandates the following five additional requirements:

- A covered entity may not request payment under title XIX of the SSA for medical assistance with respect to a drug that is subject to an agreement under this section if the drug is subject to the payment of a rebate to the state under section 1927(a)(5)(C);
- The Secretary is responsible for ensuring compliance with this first additional requirement;
- A covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity;
- A covered entity shall permit the Secretary and the manufacturer of a covered outpatient drug that is subject to a 340B purchasing agreement with the entity to audit at the Secretary’s expense the records of the entity that directly pertain to the entity’s compliance with the requirements stated above;
- In the case of a covered entity within a distinct part of a hospital, the hospital shall not be considered a covered entity under this paragraph unless the hospital is otherwise a covered entity as defined above.

Cost Savings Opportunities

Section 340B also ensures that drug manufacturers who sell covered drugs to eligible entities that serve Medicaid populations must sign a pharmaceutical pricing agreement with the Secretary of HHS. In this agreement, the manufacturer agrees to charge a price for covered outpatient drugs that will not exceed the statutory ceiling price. The ceiling price is the average manufacturers' price (AMP) reduced by a drug-specific discount.

For the outpatient drugs that are available through the covered entity, the discounted pricing methodology is dependent on the type of entity (e.g., DSH or HTC) and the scope of each entity's grant funding. Therefore, the formulary for each covered entity is dependent on the population that is being served and/or the clinical focus of the program. Section 340B also mandates that in billing Medicaid for drugs, "a Section 340B entity can bill no more than its actual acquisition cost (AAC), plus a reasonable dispensing fee established by the state Medicaid agency."

The 340B discount is calculated using the Medicaid rebate formula and is deducted from the manufacturer's selling price rather than paid as a rebate. The covered entities are also authorized to negotiate sub-ceiling prices and save by not paying drug mark-ups and dispensing fees to retail pharmacies.

The 340B program also provides for an alternative model for entities that do not have the resources to support an independent pharmacy distribution system for the covered patients. These programs can submit for rebates for the covered patients' medication through the prime vendor retrospectively. States have explored this option for unique populations like the HIV patients within the Corrections environment.

For state Medicaid agencies, access to 340B pricing discounts is cost-effective, as studies have calculated that 340B discounts equate to approximately average wholesale price (AWP) minus 51 percent, whereas, the Medicaid best-price discounts equate to AWP minus 32.1 - 39.5 percent. National studies have demonstrated a 25 to 30 percent cost savings for 340B-purchased drugs when compared to Medicaid net rebate pricing.

Several states have expanded their 340B strategies to additional populations that have provided for significant immediate cost savings. These states have utilized the patient definition to expand the covered population through coordination with the providers of the covered entities under the 340B regulations. The following are specific successful state experiences that are also key opportunities for Rhode Island:

340B for Medicaid Fee-for-service Patients

Minnesota Medicaid has entered into an agreement with the 340B covered entities in that state under which the covered entities provide drugs to Medicaid fee-for-service patients that are purchased at 340B prices. Claims generated thereby may not be and are not submitted for OBRA 90 rebates (Medicaid rebates). The covered entities receive a fee

premium for this effort, making it an economically viable process. The state saves in several ways:

- The direct drug cost savings occurs immediately; there is no need to accrue data, submit the data to CMS, then wait for the rebates to be paid many months later by the drug manufacturers.
- No follow up or audit is needed to assure that the payments occur or that they are correct.
- The covered entities typically are much more aggressive in managing formularies and controlling utilization.
- Federal rules governing the covered entities require that any revenue they receive be used exclusively for their designated care missions. Accordingly, the extra revenue they receive through this program translates into better care for their indigent (sliding fee) patients. Often this means that the indigent population get drugs that would otherwise be unavailable to them. All of this translates into improved health care outcomes, less likelihood of hospitalization, etc. All of which means lower health care costs to the state.

340B Savings for the Department of Corrections Population

The State of Texas has developed an innovative program under which medicines for the Corrections population are purchased at 340B prices. The program includes the following steps:

1. All prisoners become members of one or more designated HMOs.
2. The HMO, in turn, makes that member a patient of an entity that qualifies for 340B pricing (e.g., DSH).
3. It is most likely that this will be a disproportionate share hospital [DSH].
4. The drugs are subsequently provided to the prisoners by the covered entity's pharmacy. The pharmacy may be operated directly by the covered entity, or outsourced through rules well defined by HRSA through its Office of Pharmacy Affairs [OPA]
5. This process has the added benefit of providing extra revenue for the covered entity, which can be used to further its health care mission.

It should be pointed out that health care for the prisoners can be well managed through this process, by drawing upon the HMO's or DSH infrastructure.

SCHIP Population

Drugs prescribed for CHIP recipients are not eligible for OBRA 90 rebates (Medicaid). Accordingly, the state must try to reduce drug costs through formulary and rebate programs in the same manner as is done for drugs for state employees. At best, these rebates are much less than those available through OBRA 90. Accordingly, we

recommend that the state consider ways in which these CHIP patients can become patients of 340B-covered entities. Doing so would lower drug costs dramatically.

- States have achieved this goal by using the same technique as described above for the corrections population. Primarily the key focus is to:
- Enroll CHIP recipients in one or more HMOs.
- These HMOs, in turn, makes the CHIP recipient a patient of a covered entity.
- The covered entity's pharmacy provides the drugs at 340B prices.

Options

Options for a state to maximize 340B-pricing discounts include:

- collaboration between the appropriate state agencies to expand the population for which expensive drugs are purchased under the 340B programs;
- exploring sole source options with a single 340B entity (e.g., existing hemophilia center provider) to provide targeted drugs at 340B pricing for targeted high cost/high risk populations (e.g., hemophilia) (with or without the inclusion of case management (CM) - this option most likely will require submission of a CMS 1915 waiver);
- investigating opportunities with several 340B entities to provide targeted drugs (i.e. high cost injectables) at 340B pricing (with or without the inclusion of CM);
- collaborating with community health centers (CHCs)/FQHCs and other "qualified" entities to obtain 340B status; determining the appropriate "management fee" to overcome requirement of actual acquisition cost, plus the Medicaid dispensing fee. The state will most likely need to hold a series of meetings to determine an equitable dispensing rate. It may work out that there are different dispensing rates for different drugs. The fees would be determined by factors ranging from carrying fees to the return policies of the pharmaceutical companies (some companies do not allow returns on some of these drugs so the pharmacy would not receive credit for expired medications); and focusing on the use of the 340B entity to maximize the purchasing and distribution of certain medications (e.g., HIV/AIDS) for which 340B programs may already exist.

Barriers/Considerations

While there appear to be some opportunities for significant savings with 340B pricing, there are some barriers to consider before the State of Rhode Island aggressively pursues these options. These barriers include:

- Administrative burden on the state - this will vary depending on the selected approach but all will require a significant commitment to implement. Encouraging and assisting community clinics and other FQHCs in obtaining 340B status may be the most labor intensive, but also the most palatable politically.

- Political resistance – if it is determined that channeling participants to 340B entities is allowable under current law and/or code, the state should expect to receive opposition from patient advocacy and other provider groups. Advocacy groups can view this as a hindrance to quality of care, and they may perceive the state’s actions as resulting in a loss of local care or the severing of a relationship with a trusted health care professional (prescriber, home health agency, or pharmacist). Additionally, state pharmacists, pharmacy associations, and home health agencies/associations will not want to lose the business that these drugs generate. Subsequently, they will solicit political support to defeat these initiatives.
- Financial incentive of Medicaid providers – as mentioned earlier, the PAB acknowledges that there is a conflict of interest on behalf of the covered entities to treat and prescribe drugs to Medicaid patients. Too often the entity has no financial incentive to purchase drugs at the 340B discount only to be required to bill the state for the AAC plus a “reasonable” dispensing fee.
- Preventing dual-discounts – the 340B law stipulates that a drug cannot be dispensed and paid under two discount programs (i.e., 340B and Medicaid) from the manufacturer. Thus the PAB would require the state to have a separate reporting and review mechanism in place to audit the applied discount under each program.
- Hospitals and group purchasing – 340B-eligible hospitals are prohibited from engaging in group-purchasing arrangements. Thus, any state-operated or contracted hospital that currently participates in a group-purchasing contract may be disqualified from gaining 340B status.
- Universal access and coordination of care with covered entities – the 340B law expressly prohibits a covered entity from dispensing discounted drugs to anyone other than their own patients. The result is that participant access to the 340B discounts is significantly limited, and would, in effect, require the state to coordinate a select network of providers. Participants would then need to receive all or part of their health care within this network; while indigent patients may already have a relationship with a 340B covered entity, other participants may be reluctant to change providers.

Conclusion – Recommendations for Next Steps for the State of Rhode Island

If the 340B model appears an attractive and cost effective solution for a state Medicaid agency, incentives will need to be developed to encourage enrollees to shift their care to covered entities. This can be accomplished through charging higher co-pays for drugs dispensed by non-340B pharmacies, or building seniors or disease management programs around the 340B providers. 340B providers can also minimize the access limitations with mail order programs or by contracting with retail pharmacies pursuant to the 340B contract pharmacy guidelines.

The President and Health and Human Services Secretary Tommy Thompson have declared their commitment to providing indigent populations with improved access to prescription drugs. Through HRSA, they offer grants, alternative method demonstration project opportunities and funded professional technical assistance to covered entities that assists them in developing a pharmaceutical dispensing strategy with or without the inclusion of clinical care. New initiatives include PBA's assistance in decreasing administrative costs through closer monitoring of the inventory and dispensing practices of 340B providers. HRSA is also offering additional grants to eligible health centers that wish to participate in the 340B program through an in-house pharmacy and/or through the use of contracted pharmacies.

For Rhode Island the regulations provide an opportunity that will lead to immediate significant cost savings and long-term cost effective program management, if structured appropriately. The guidelines that define the 340B-eligible patient include the following criteria:

- the covered entity has established a relationship with the individual, such that the covered entity maintains records of the individual's health care; and
- the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity; and
- the individual receives a health care service or range of services from the covered entity that is consistent with the service or range of services for which grant funding or federally-qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals (DSH) are exempt from this requirement.

Currently, there are several 340B either participating entities and/or eligible entities within the State of Rhode Island. The DSH and HIV exemptions and patient definition guidelines allow for expansion of the targeted populations to additional groups regardless of their living setting (e.g., Indigent, HIV, Corrections, Medical Assistance). Discussions with the PAB technical support staff have supported expanding the provider relationships under the patient definition and utilizing the incentive provided by the current administration to expand the program through demonstration projects, to increase the 340B opportunities for these vulnerable population programs in states like Rhode Island. DHS has identified the current DSH hospital population(s), Community Medical Assistance Program, Department of Corrections, and Department of Elderly Affairs populations as potential targeted groups to explore for this opportunity. We would also recommend that Rhode Island consider expanding these initial populations to include the Medicaid fee-for-service and SCHIP populations.

Based on this information, a preliminary assessment of the potential cost savings has been performed to quantify the potential impact of expanding the current 340B services utilized within the State of Rhode Island. National studies have demonstrated an average cost savings of 25 to 30 percent for drugs purchased under 340B pricing when compared

to over 200 drugs purchased under the Medicaid rebate strategy. These savings estimates are based on the Medicaid net pricing (after application of the rebates). These savings can be greatly enhanced by integrating the 340B program into the drug and medical utilization management and quality outcome measurement strategies within vulnerable population public sector programs. This analysis demonstrates that a potential exists for a minimum retained cost savings by the state of \$928,834 (after program development and implementation phases and costs – assuming 3 months of operation) in the remainder of SFY 2004, and \$6,592,175 (net savings after all costs – internal and external) in SFY 2005. The following table illustrates the potential targeted populations and estimated costs and savings.

Entity/Population	SFY 2003 Drug Costs	SFY 2004 Estimated Annualized 340B Cost Savings (25%)	SFY 2005 Estimated Drug Costs (15% Trend)	SFY 2005 Estimated 340B Cost Savings (25%)
Slater DSH	\$13,000,000	\$3,250,000	\$14,950,000	\$3,737,500
Dept. of Elderly Affairs	\$8,400,000	\$2,100,000	\$9,660,000	\$2,415,000
Community Medical Assistance Program	\$3,200,000	\$800,000	\$3,680,000	\$920,000
Dept. of Corrections	\$2,421,341	\$605,335	\$2,784,542	\$696,136
Total	\$27,021,341	\$6,755,335 - annualized \$1,688,834 – 3 months	\$31,074,542	\$7,768,636
Estimated External Consulting & Support Fees		(\$700,000)		\$1,865,295
Estimated State Cost to Implement & Support		(\$60,000)		(\$240,000)
State Retained Savings		\$928,834		\$6,592,175

Based on this analysis, we would recommend that Rhode Island perform a complete assessment of the regulations, eligible populations, eligible entities and current 340B participating providers. Based on a preliminary assessment we have identified the following key phases that could be implemented to assess, develop, implement and provide ongoing support for the program:

Phase I: 340B Assessment

The Heinz Family Philanthropies will continue to support the development of the 340B strategy for the state by providing technical support to Rhode Island's state agencies to accomplish the following key steps in preparing for program implementation:

- Literature and regulatory review to confirm all of the potential program areas and/or populations that may benefit from a 340B program in the state;
- Interviews with key stakeholders (state agency staff, providers) to develop a gap analysis of the current infrastructure and available resources versus the needed program elements and/or resources;
- Interviews with key staff from the Health Resources and Services Administration (HRSA), Pharmacy Affairs Branch (PAB) to confirm the areas and/or populations for 340B strategy identified during this phase: and
- Submission of the 340B application to HRSA.

This Heinz Family Philanthropies-funded effort has been identified as Phase I and will include a complete assessment of the 340B opportunity for the State of Rhode Island with a focus on the DSH hospital(s) and their infrastructure, Community Medication Assistance Program (CMAP), Behavioral Health programs, Department of Elderly Affairs and Correction populations.

Phase II: Program Development and Implementation

Phase II will include the following key activities:

- Negotiation with HRSA to obtain final approval of Rhode Island's 340B application;
- The collaborative development of an implementation work plan with key stakeholders;
- Technical support during the implementation of the program;
- Development and implementation of strategies to either integrate or enhance the existing prescription drug and medical utilization management processes that can be impacted by the 340B program;
- Collaborative development of strategies with the provider community to maximize the utilization of clinically equivalent drug strategies that maximize the most cost-effective 340B opportunities;
- Development and implementation of provider and client communication strategies;
- Development of monitoring and reporting strategies to ensure the state receives the maximal benefit (e.g., immediate cost savings) from the program;

- Development and implementation of strategies to ensure long-term cost effectiveness of the program.

Phase III: Program Support and Oversight

Once implemented the success of the 340B program will be heavily weighted on the distribution system and oversight of the procurement process between the state agency staff and the 340B prime contractor. A state 340B support team should provide oversight and ongoing support for this effort through close collaboration with state staff and the providers. The state should identify strategic partners who can support the transactional needs of this program and implement monitoring and reporting strategies to ensure that the program meets the cost-savings expectations of the state. We would propose that this phase be at least partially funded through the cost savings generated by this program through a sharing of the savings realized by the state. In addition, the state should explore working with partners who can identify enhanced federal matching opportunities for many of these activities that can be accessed through a vendor who is a PRO-like entity certified by CMS.

Section 9

The President's Recommendations

Are There Prescriptive Solutions for the State of Rhode Island?

The Rhode Island Blueprint was prepared at the request of the state legislature to provide a road map – a strategy setting forth various options by which the State could more effectively reduce and control overall state spending on all of its state-funded and administered prescription drug programs.

Most importantly, the blueprint explains how \$40 million in savings could be achieved. These savings, both individually and collectively, reflect the options the state legislature and the Office of the Governor might choose ---or might choose from--- to reduce state spending on its prescription drug programs.

While the findings section above addresses the various ways that the State of Rhode Island could save up to \$40 million, this section, of the report makes very specific recommendations that we believe the state should pursue. I recognize, of course, that the Office of the Governor and/or the legislature may not agree with any or all of these recommendations; but I hope that they will, at least, initiate an lively and fruitful discussion. As the author of the report, it is my responsibility to assess the tough choices involved and at least to provide a road map.

In the end, just as these are tax dollars that are being spent, we are dealing with tax dollars that might be saved (or at least be used more wisely and/or effectively). With taxes constantly on the rise, and deficits growing, the appeal (as well as the palatability) of the options below may become greater.

It has been an honor to assist the State of Rhode Island, and to work with members of the state legislature, all of whom have been willing to listen, consider, and candidly express their reaction to specific ideas. The leadership in the House and Senate are clearly a group of men and women who care deeply about the future of Rhode Island, the needs of its citizens, and solvency of all of the prescription drug programs and social programs generally.

Recommendation One – Challenge the Status Quo

The state has six different programs providing prescription drug coverage to different populations; each of the six use different PBMs, PBAs or consultants. As a result, they are not able to effectively leverage their collective purchasing power to achieve the maximum value of each public dollar spent. It is recommended that the state empower one state official with the authority to negotiate collectively all state contracts, and to use

one PBA/PBM to manage the overall program. The determination of who this individual should be jointly decided by the Governor and the state legislature.

The consolidation of these responsibilities will greatly enhance the state's purchasing power, and create an atmosphere where individual pharmaceutical manufacturers, as well as other health care entities, will not be able to negotiate their way onto one formulary when another state agency has determined that a less expensive brand or generic drug is equally effective.

Recommendation Two – Audit Existing State Prescription Drug Contracts

The legislature and the Office of the Governor should agree to collaborate on an initiative that implements true “fiscal fitness.” The state has a number of direct contracts with vendors and PBMs, as well as health insurers, etc. all of which provide assistance with, and/or the administration of, prescription drug programs. However, absent a fiscal audit of such direct and indirect contracts, the state does not know whether and to what extent it is receiving all that these specific contracts have promised or guaranteed.

For example, the state has contracts with a variety of vendors assisting state agencies in managing their pharmacy benefit programs, but they do not know whether (and if so how) these contracts are delivering value. Moreover, the state has a contract with Blue Cross of Rhode Island. Blue Cross provides state employees (and their dependents) and retired state employees with prescription drug coverage through a contract with PharmaCare, a subsidiary of CVS. However, it is not known whether the state receives all of the rebate dollars (or what portion of such rebate dollars) and the best value from this contract. An audit of all of these contracts would provide the Governor and state legislature with the information they need to evaluate the PharmaCare contract, and whether PharmaCare is required to share a portion of the rebate dollars with Blue Cross.

An audit performed by an outside entity jointly selected by the State legislature and the Office of the Governor would demonstrate bipartisan support for such a measure, and would ensure that both branches of government are working together, and not in opposition to each other. Moreover, the firm conducting the audit could report to a joint nine member committee composed of a group of six legislators (two each appointed by the Speaker of the House and the Senate President, and one each appointed by the minority leaders from the House and Senate), and three members appointed by the Governor.

This is not to suggest that either Blue Cross or PharmaCare are doing anything wrong. Rather, it is to propose a tool that the state can and should use to ensure that it is receiving the best value for each taxpayer dollar being spent. This is, in fact, what might be called “preventive fiscal medicine.”

Recommendation Three – Direct Contracting with Pharmaceutical Manufacturers for All Large State Prescription Drug Programs to Ensure for the Best Value

Each state agency ----such as DOA, DHS, DEA and MHRH---- could enter into direct rebate contracts with pharmaceutical manufacturers. This will allow the state to enhance its rebate revenue to near the best price level. This will provide material savings for programs such as DOA ---- potentially increasing its rebate revenue to as much as 10 percent of drug cost. Some states have entered into supplemental rebate contracts with drug companies for the Medicaid program, which increases rebates from the federal level of approximately 19 percent of drug cost to 24 to 27 percent of drug cost - in addition to approximately 3 percent in ingredient cost savings from lower cost prescription drugs. States have contracted with companies specializing in Medicaid PDLs and supplemental rebate contracting, such as First Health and Provider Synergies. The Center for Medicare and Medicaid Services (CMS) requires a state to procure these services competitively, which can add six to nine months to the implementation process. The state may alternatively garner expertise for this process through URI and/or consultants that are experts in rebate contracting.

Many state programs, particularly state employees, have long utilized Prescription Benefit Managers (PBMs) for their pharmacy programs. On average, a PBM is able to provide rebates equal to 4 to 6 percent of total drug costs to the state. While these companies are able to offer cost effective management services, there is increasing concern about how much money the PBM receives from drug companies and how much of that money is passed back to the state through rebates and other program funding. This issue – often referred to as “transparency”, continues to be a concern for future state contracting.

While PBMs provide a vast number of pharmacy management services, the PBM is only eligible for “behind the line” funding when it manages a client’s drug formulary – controlling which drugs are prescribed and negotiating and holding rebate contracts. If a PBM does not directly control the formulary or hold the rebate contract, it will not receive any “behind the line” money from the drug companies. Therefore, for a state to ensure transparency from drug companies it could eliminate formulary control and rebate contracting from the PBM; it may continue to utilize other PBM management services such as claims processing.

Although the aggregation of services often provides economies of scale, where rebate contracting is concerned, it may work against the state. The Federal Medicaid Rebate Contract set parameters for rebates and established minimum rebate levels in addition to best price criteria – both of which are highly confidential. Drug companies attempt to minimize rebates in order to increase profit margins. Therefore, they may offer a larger rebate directly to a small state program---such as state employees--- up to the minimum rebate level or best price. In contrast, they are less likely to maximize the rebate level for a large PBM as they will reduce their profit margin for a very large population base. So in addition to the concern over transparency – how much the PBM passes back to the state – the state may also receive lower rebates than it could through direct contracting.

For example, if a state employee program were able to contract to the minimum rebate level or best price, it could easily achieve an additional 10% in drug cost savings.

Recommendation Four – Change the Level of Copays for Active and Retired State Employees to Create an Incentivized Formulary

Today, active and retired state employees receive a valued and important prescription drug benefit. The co-pay levels they pay are low, compared to the actual cost paid by uninsured and elderly citizens who do not have such coverage. However, these benefits, which are the result of collective bargaining, are also often the result of state employees giving up something else in order to hold down how much they pay out-of-pocket for medical care generally, and for prescription drug coverage in particular.

Nevertheless, if active and retired state employees do not become more active in helping the state control and ultimately reduce its costs, such prescription drug benefits will face a much larger looming fiscal crisis. This situation is further compounded by annual cost growth of 20%. To avoid this, the Rhode Island Blueprint recommends creating an incentive-formulary where generic medications are far less expensive than all other drugs (those on tier two and three of the formulary). Under the recommended change, participants would pay substantially less (\$5) for generic drugs and more (at least \$25) for brand name medications, and even more for non-preferred or tier three drugs (in a three-tiered formulary). The level of savings possible from making this change ranges from \$ 7.0 to \$ 7.8 million.

While savings alone do not necessarily make such a change palatable, the reality in today's changing prescription drug world is that more and more brand name drugs are available in a generic equivalent. With the increasing cost of all employee benefits, employers are looking for ways to achieve greater levels of savings. Changes, such as this, offer employees an opportunity to assist states as they battle rising deficits and declining revenues. And, as discussed earlier, the decision here is not whether to implement such a change; rather, it is the necessity of having to deal with the consequences of some action versus the certain consequences of no action at all.

Recommendation Five – Encourage the State Medicaid Program To Implement a Preferred Drug List Immediately

The state Medicaid program is forgoing millions of dollars in savings by not implementing a comprehensive preferred drug list (PDL). A PDL would allow the state to pursue and achieve greater savings from pharmaceutical manufacturers as well as additional savings from supplemental rebates. Many states have implemented a PDL, pursued supplemental rebates, and achieved valued savings.

Below, is a table illustrating the number of states that have implemented PDLs as well as those pursuing supplemental rebates. Many states have postponed implementation of supplemental rebates due to political pressure from drug companies and “grant” money paid to the state by drug companies in lieu of supplemental rebates. For these states,

there is continued pressure to demonstrate the value of the PDL without the supplemental rebates. Furthermore, the Center for Medicare and Medicaid Services (CMS) issued a letter to all State Medicaid Directors in September 2002 urging them to pursue supplemental rebates.

State	Pharmacy Included in Managed Care (Carve-In)	Use of PDL	Supplemental Rebates
Alabama	No	Yes	No
Alaska	No	No	No
Arizona	Yes	No	No
Arkansas	No	No	No
California	Yes	Yes	Yes
Colorado	Yes	No	No
Connecticut	Yes	No	No
District of Columbia	Yes	No	No
Delaware	No	No	No
Florida	Yes	Yes	Yes
Georgia	No	Yes	No
Hawaii	Yes	No	No
Idaho	No	Implement in 2004	Implement in 2004
Illinois	Yes	Yes	Yes
Indiana	Yes	Yes	In process
Iowa	No	Implement in 2004	Implement in 2004
Kansas	No	Yes	No
Kentucky	No	Yes	Yes
Louisiana	No	Yes	Yes
Maine	No	Yes	No
Maryland	Yes	Yes	Yes
Massachusetts	Yes	Yes	No
Michigan	Yes	Yes	Yes
Minnesota	Yes	Yes	No
Mississippi	No	Implement in 2004	No
Missouri	Yes	Implement in 2004	Implement in 2004
Montana	No	No	No
Nebraska	No	No	No
Nevada	No	Implement in 2004	Implement in 2004
New Hampshire	No	No	No
New Jersey	Yes	No	No
New Mexico	Yes	No	No
New York	No	Implement in 2004	Implement in 2004
North Carolina	Yes	No	No
North Dakota	No	No	No

State	Pharmacy Included in Managed Care (Carve-In)	Use of PDL	Supplemental Rebates
Ohio	Yes	Yes	Yes
Oklahoma	Yes	Yes	No
Oregon	Yes	Yes	No
Pennsylvania	Yes	No	No
Rhode Island	Yes	No	No
South Carolina	No	No	No
South Dakota	No	No	No
Tennessee	No	Implement in 2004	Implement in 2004
Texas	No	Implement in 2004	Implement in 2004
Utah	No	Implement in 2004	No
Vermont	No	Yes	Yes
Virginia	Yes	Implement in 2004	Implement in 2004
Washington	Yes	Implement in 2004	No
West Virginia	No	Yes	Yes
Wisconsin	Yes	No	No
Wyoming	No	Implement in 2004	Implement in 2004

California has maintained the Medi-Cal PDL and supplemental rebate program for more than a decade. It receives federal rebates of nearly 19 percent, and supplemental rebates amounting to nearly 7.4 percent. In federal fiscal year 2001, that meant California taxpayers saved an additional \$106 million. Florida, another state utilizing a PDL with supplemental rebates, has reported significant savings⁵ of nearly \$62 million from their program within this fiscal year. At this writing, we are seeking similar numbers from other states. However, due to the recent implementation of many programs, data is limited and most savings figures remain projections.

In Rhode Island, the state Medicaid program has chosen to approach the creation of a PDL on a drug-by-drug basis. This stretched out approach both deprives taxpayers of achieving greater savings and prohibits state legislators from using those savings to help with other state needs such as public school education (infrastructure, salaries, books, supplies, etc.), rebuilding roads and bridges, possible tax relief, etc.

Typically, states are slow to pursue the implementation of a PDL because of a reluctance to confront and be challenged by the pharmaceutical industry that dislikes PDLs because

⁵ Savings resulting from the Preferred Drug List (PDL) and Prior Authorization (PA) processes were in excess of \$127 million for the first fiscal year of the program. The total savings (adjusted for inflation) for the year ending June 30, 2003 was over \$170.1 million. For the six month period 4Q02-1Q03, savings were \$81.3 million or 16.6% of the client's total drug expenditure. Of this, \$46.5 million resulted from shifts in market share to less costly agents while the remaining \$34.8 million was in the form of Supplemental Rebates.

they force them to compete for placement on a PDL formulary by demonstrating the value of their specific drug as compared to one of a different manufacturer or a generic.

Recommendation Six – Create An Enhanced Dispensing Fee For Pharmacists Offering Counseling

For years, community pharmacists have been America's front line soldiers offering patients help in understanding the drugs prescribed by their physicians, educating them about the ways such medications may or may not interact with their existing prescriptions, and informing them whether a generic drug could bring them the same relief at less cost.

If states are ever going to stop Medicaid patients from using emergency rooms as acute care facilities, offering pharmacists a financial incentive to assist in doing this is the most likely and perhaps cost effective way. Currently, pharmacists receive the same dispensing fee regardless of how much work or how little they undertake with the patient. It is recommended that Rhode Island follow the Iowa model and create a demonstration program.

The Iowa Pharmacy Association has implemented a demonstrated program in this area that the state Medicaid program may want to review.

Recommendation Seven – Carve Out the Medicaid Managed Care Prescription Drug Benefit

The state should explore the value of carving out the prescription drug benefit for all Medicaid recipients participating in its managed care plan. While opponents of this approach will argue that the state would lose more than it would save, unless and until this is actually effectively analyzed, this real answer will remain unknown. Recent studies have indicated savings opportunities through a carve-out of prescription benefits if the state has a well-managed fee-for-service pharmacy program and utilizes a PDL with supplemental rebates.

Recommendation Eight – Create One Formulary That All State Programs Would Use

Today, Rhode Island, like many other states, has a prescription drug formulary for each of its prescription drug programs. As a result, savings are lost by not leveraging one formulary against drug manufacturers who want to compete to have their drugs included. The lack of competition translates into lost savings. It also causes confusion among physicians, pharmacies and patients.

The challenge is to move to one formulary for all state programs – forcing state agencies to work cooperatively and also requiring manufacturers to focus on delivering greater value for the state and taxpayers generally.

Recommendation Nine – Expand Use of the 340B Program

The 340B Program provides savings opportunities to many state programs, including DHS, DOC, MHRH and DCYF. HRSA has established a formal process for considering the testing of alternative methods of participating in the 340B drug discount program through demonstration projects that focus on expanding the distribution of drugs into the indigent and Medicaid populations. (Please note: further research on such demonstration opportunities has revealed that there is no time limit on applying, and that they provide flexibility to states to expand to broader distribution of these services.

Recommendation Ten – Coordination of Reporting/Data Management

Development of a coordinated or common reporting and monitoring strategy can present significant cost savings opportunities and improved program efficiencies and clinical management. Programs like Kaiser have coordinated their clinical and pharmaceutical reporting strategies as an opportunity to identify common trends and opportunities for improved clinical and pharmaceutical management – which has also led to the ability to speak with a consistent voice to the provider community when trying to create behavior change in such areas as pharmaceutical management. This would also allow for the development of a common P&T/Technology assessment committee that could assess expensive drug and other medical technologies coming to the marketplace and make consistent coordinated decisions on whether or not to support the coverage of these technologies. This could save the State of Rhode Island significant amounts of money.

This group could also identify common opportunities for drug utilization management that, when implemented across all state programs, would generate large cost savings for the State of Rhode Island. This strategy would also allow for the assessment of the utilization/encounter data across state programs to allow for a coordinated disease/health management approach. The key is a targeted approach that is going to deliver the greatest ROI for Rhode Island's population. This coordination would allow for an opportunity to review the actual utilization across state programs to assess whether or not the disease management and/or pharmaceutical cost savings strategies are appropriate for this population; if they aren't, they won't deliver the ROI expected.

Care/disease management programs are most successful if they are fully integrated into the pharmaceutical management and delivery strategy and clinical delivery system. Significant pharmaceutical cost savings can occur if patients are well managed on the maintenance drugs that help to minimize emergency room and inpatient utilization. We would recommend that a strategy is developed to integrate the disease management provider programs with the State of Rhode Island and state-contracted pharmacy providers to ensure a collaborative approach that saves the State of Rhode Island money through appropriate utilization.

Conclusion:

Coordinated contracting of prescription drug programs and the administration and operation of these programs is a valuable tool to assist in ensuring that tax dollars are being used as effectively as possible. Additional plan and program changes can offer material savings to the state in the absence of coordinated contracting – or maximized savings when implemented as part of the coordinated contracting process. The level of savings will be determined by the ability and willingness of the Governor and the legislature to tackle the tough choices set forth in this report. We hope that this blueprint may serve as a first step in an effort to re-design state prescription drug programs. Decisions, large and small, will require a balance of obtaining significant cost savings with the assurance of maintaining quality. This cannot be done quickly, but it can be accomplished effectively.

Jeffrey R. Lewis, President
Heinz Family Philanthropies

Glossary of Terms/Acronyms	
340B	Enacted in 1992, section 340B of the Public Health Service Act requires drug manufacturers to provide pharmaceuticals to eligible health care centers, clinics and hospitals at a reduced price. Typically, this discount is applied during the sale and the state does not have to submit for rebates after payment.
ABD	Aged/Blind/Disabled
Annual Benefit Limit	A clause in the certificate of coverage or pharmacy benefit description that specifies a dollar limit for the total reimbursement of drug costs during a benefit period.
Average Wholesale Price (AWP)	The published, suggested wholesale price of a drug. It is often used as a cost basis for pricing prescriptions in the private sector by statute for the drugs covered by Medicare and by many states for pharmacy payment in Medicaid.
Adjudication	The process of completing all validity, process, and file edits necessary to prepare a claim for final payment or denial.
Administrative Costs	The costs assumed by a vendor for administrative services such as claims processing, billing, and overhead costs.
Administrator	A vendor that performs the operational functions associated with a pharmacy benefit. Administrators may include Pharmacy Benefit Managers, health plan insurers, government agencies, or other Third Party Administrators.
Ambulatory Care	Health services delivered on an outpatient basis. If the patient makes the trip to the doctor's office or surgical center without an overnight stay, it is considered ambulatory care, but if he or she is treated at home, it is not.
Appeal	A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, or benefit payment.

Glossary of Terms/Acronyms	
AWP Discount	The special ingredient cost reimbursement allowed by the plan sponsor. For example, AWP minus 10% percent is 90% of the published AWP price.
AWPLs (Any Willing Provider Laws)	Requires enrollment to any provider who is willing to join, as long as they meet the provisions outlined in the contract.
Beneficiary (insured)	The primary person receiving the benefit coverage. This information is maintained on the eligibility file.
Brand Drug	Pharmaceutical product, which is trademarked by its originator or a licensee. If the product is on patent it is usually the only source for that particular medication.
Capitated Payment	A negotiated per capita rate to be paid periodically, usually monthly, to a healthcare provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Case Management	The process whereby a health care professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic disorder or who is receiving mental health services. Case managers are thought to reduce the costs associated with the care of such patients, while providing high-quality medical services.
Catastrophic Limit	Once a member exceeds a set dollar threshold of expenditures out of his or her pocket, specific drugs are covered at some level by the plan. Catastrophic coverage may require a specified level of member cost sharing.
Claim	Information submitted by a provider or covered person to establish that pharmacy services were provided to a covered person.
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)

Glossary of Terms/Acronyms	
Coinsurance	Cost sharing that requires a member to pay a specific percentage of the charge for each prescription drug. (for example, 20 percent of the prescription cost).
Concurrent Drug Utilization Management	Prescriptions are reviewed at the time of dispensing as a safeguard to catch inappropriate dosages, combinations of drugs, therapy duplication, etc.
Coordination of Benefits (COB)	Coordination of benefits applies when a member is covered under more than one pharmacy plan. It requires that payments of benefits be coordinated to eliminate benefit duplication or prevent double payment for services. The coordination of benefits agreement states that the primary plan pays first and the secondary plan pays last.
Co-payment	Cost sharing that requires a member to pay a fixed dollar amount for each prescription drug (for example, \$15 per prescription).
Cosmetic Drug	A drug used to improve complexion, or to enhance beauty.
Covered Lives	Refers to the number of persons who are enrolled within a particular plan.
DAW (dispense as written)	A notation used by a physician, pharmacy, or cardholder that will determine whether or not generic substitution occurs.
Deductibles	The amount that a member pays under the plan each benefit year, in addition to the applicable premium, before prescription drug coverage begins.
DESI (Drug Efficacy Study Implementation)	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.

Glossary of Terms/Acronyms	
Disease Management (DM)	A philosophy toward the treatment of the patient with an illness (usually chronic) that seeks to prevent recurrence of symptoms, maintain high quality of life, and prevent future need for medical resources by using an integrated approach to health care. Pharmaceutical care, continuous quality improvement, practice guidelines, and case management all play key roles in this effort, which should result in decreased health care costs as well.
Dispensing Fees	Negotiated professional fee paid to the dispensing pharmacy for processing/filling of a prescription claim. The dispensing fee is added to the negotiated formula for reimbursing ingredient cost.
Drug Trend	The rate of change in drug spending over time. Drug trend is influenced by factors such as price/inflation, specific utilization and the medications (drug mix) used by a patient population.
Drug Utilization Management Programs	Examples of such programs include drug utilization review, prior authorization, formulary management, and generic substitution.
Drug Utilization Review (DUR)	A program management strategy that involves a review of the medication being prescribed, applies guidelines and rules and checks against the patient's medication history to ensure that medications are used appropriately, safely and effectively.
Effective Discount Pricing	The impact of negotiated provider discounts, usual and customary pricing, and generic dispensing rates, on the overall discount.
Exclusions	Drugs not covered under the pharmacy benefit of the health plan.
Federal Poverty Level (FPL)	The federal government's official statistical definition of poverty.
FFS	Fee-for-service

Glossary of Terms/Acronyms	
Formulary	<p>A continually updated list of medications, related products and information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health. This list of drugs is selected on the basis of quality and. The list is used by physicians when making decisions on what medications to prescribe. Several formulary options exist:</p> <p>Open formulary – all medications are covered with little or no cost-sharing implication to the member for selecting a non-formulary medication.</p> <p>Closed formulary – medications deemed as non-formulary are not included as a covered benefit.</p> <p>Incentive formulary – all medications are covered, however there is a higher co-payment amount applied for medications not on the formulary.</p>
Formulary Management	<p>A program management strategy focused on managing the placement and utilization of specific medications within a formulary. For example, review of covered/excluded medication or preferred/non-preferred status determination.</p>
Formulary Rebates	<p>Payments made by pharmaceutical manufacturers to plan administrators based on utilization or market share of their products.</p>
Generic Drug	<p>A drug the FDA has determined is a chemically equivalent version of a brand-name drug. A generic drug is generally less expensive than the brand-name drug.</p>
Generic Substitution	<p>The practice of substituting a generic for a brand drug when authorized by patient and physician.</p>

Glossary of Terms/Acronyms	
Health Management	A program management strategy where individuals receive customized education and support to help control, alleviate, or prevent illness. The communication efforts – targeted to specific illnesses or conditions, provide quality assurance programs that educate patients and providers on high-cost diseases, such as diabetes or heart disease, to encourage better compliance and lifestyle changes.
HRSA	Health Resources and Services Administration – Government agency that administers the 340B pharmacy discount program through their Office of Pharmacy Affairs (OPA).
Incentive or tiered formulary	A pharmacy benefit plan design with different co-payments based on the type or classification of a drug. As an example, one tier for generic drugs, one tier for preferred drugs, and one tier for nonpreferred drugs.
Incurred Basis	There is a period of time between the point when a liability arises and when payment is made to satisfy that liability. When prescription drug modeling is done on an incurred basis, there are no adjustments to reflect the period of time between the incurral and the payment of claims, premiums and rebates.
Mail Service	A program that offers maintenance prescriptions mailed directly to members from a mail order pharmacy.
Maintenance Drug	A drug that is taken daily for a chronic condition, and for a period of time generally longer than three to six months.
Mandatory Generic	A program management strategy that requires an individual to receive a generic medication if a generic equivalent is available. In the Medicaid environment, medical necessity must be demonstrated to receive the brand name equivalent. In the commercial environment, if a member opts to receive the brand name medication, they are responsible for payment of any medication cost exceeding what the plan sponsor would have paid for the generic equivalent. If an individual opts to receive the brand name medication, they may be responsible for payment of any medication cost exceeding what the plan sponsor would have paid for the generic equivalent.

Glossary of Terms/Acronyms	
Maximum Allowable Cost (MAC)	A maximum reimbursement price for generic and/or multi-source brand drugs.
Maximum Dispensing Limits	A pharmacy benefit management strategy to ensure the duration of therapy or the quantity supplied in each prescription remains consistent with manufacturer and/or industry accepted dosing guidelines.
Maximum and Minimum Charge per Prescription	In coinsurance plan design programs, often a maximum and/or minimum charge is indicated on a per prescription basis. For example, if the coinsurance is 20% with a minimum of \$5 and a maximum of \$100, the member would pay \$20 on a drug costing \$100. If the drug cost is \$600 and the member cost is 20%, the member would pay \$100 (20% or the maximum of \$100).
Member Cost Share	Based on plan design, the amount of financial contribution a member is required to make toward the purchase of prescription medications.
MMIS	Medicaid Management Information System
Multi-source Brand-Name Drug	A brand-name drug available from more than one manufacturer because of approved generic substitutes.
Net Program Cost	Total cost of proposed program after discounts, rebates and member cost share are considered.
Non-Formulary	Drugs not included in the formulary. Health plans that use formularies have policies in place to give physicians and patients access to non-formulary drugs where medically appropriate or medically necessary.
Nonpreferred Drug	A prescription drug that is determined, by criteria typically established by a P&T Committee, to be disfavored over other products within the same drug class, by being subject to a higher co-payment or to nonpreferred brand co-payment.

Glossary of Terms/Acronyms	
OTC	Over the counter drug; a pharmaceutical that may be sold without federal or state prescription requirements, and may be purchased without a doctor's order.
Out-of-Pocket Limits	The total dollar amount, a combination of co-payment and deductible that a member pays of their own money. Unless otherwise specified, once the limit is reached, specific drugs are covered at 100 percent for the remainder of the benefit year.
P&T Committee	Pharmacy and Therapeutics Committee. An advisory committee that is responsible for developing, managing, updating, and administering the drug formulary system. P&T Committees are comprised of primary care and specialty physicians, pharmacists, and other health care professionals.
PDL	Preferred Drug List
Pharmacy Benefit Design	Contractually specifies the level of coverage and types of pharmaceutical services available to health plan members.
Pharmacy Benefit Manager (PBM)	An organization that specializes in providing administrative and management services to reduce the cost of pharmacy benefits.
Pharmacy Management Savings	Cost savings that can be achieved by implementing various drug utilization management strategies aimed at promoting appropriate utilization of prescription drugs.
Pharmacy Network	A network of retail pharmacies (typically including chain and independent pharmacies) that contract with a pharmacy benefit manager to provide services to plan members.
Plan Sponsor	An entity such as an employer or state agency that is fiscally responsible for funding a benefit program.
Preferred Drug	A prescription drug that is determined, by criteria typically established by a P&T Committee, to be favored over other products within the same drug class, by being subject to a lower co-payment or to preferred brand co-payment.

Glossary of Terms/Acronyms	
Premium	Fees, usually paid monthly by beneficiaries, for insurance coverage.
Prescription Drug Carve-Out	Prescription drug benefit administration by a stand-alone pharmacy benefit administrator rather than being integrated with the medical carrier and/or health plan.
Prior Authorization	A process under which members must receive approval before prescriptions can be dispensed. Usually reserved for high cost drugs with the potential for abuse or misuse.
Pro-Like	Certification provided to organizations that perform medical and quality reviews with state and federal government agencies. These entities allow states to receive enhanced federal match for the services performed by these entities.
QMP	Qualified Medical Professional (e.g., pharmacists, nurses, physicians)
Rebate	A monetary amount that is returned to a payor from a prescription drug manufacturer based on use by a covered person or purchases by a provider.
Retrospective Drug Utilization Management (Retro DUR)	Past prescription drug utilization patterns are reviewed to identify any apparent overuse or non-compliance with the pharmacy management strategies.
S-CHIP	State Children’s Health Insurance Program
SSI	Supplementary Security Income
Subsidy	Financial assistance provided to a member to help lower out-of-pocket program expenditures.
TANF	Temporary Assistance for Needy Families

Glossary of Terms/Acronyms	
Therapeutic Substitution	Dispensing by a pharmacist of a product different from that which was prescribed, but which is deemed to be therapeutically equivalent. In most states such a practice requires the prescribing physician’s authorization before the substitution may occur. A pharmacy and therapeutics (P&T) committee most often approves the rationale for therapeutic equivalency prior to such practice.
UCR	The usual and customary retail amount charged by a pharmacy for a particular medication when no third party payors are involved. UCR can be referred to as the “retail” or “cash price”.
Usual and Customary (U&C)	The amount of money usually charged for drugs. Also referred to as “cash price.”