



Coordinated Contracting of Prescription Drugs:
A Fiscal and Policy Strategy for the
Commonwealth of Virginia

A project of the Heinz Family Philanthropies

Teresa Heinz, Chairman

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The Honorable Mark Warner, Governor
Commonwealth of Virginia
State House
Richmond, Virginia

Dear Governor Warner:

At your request, the Heinz Family Philanthropies agreed to undertake an analysis of the multiple prescription drug programs funded and/or operated by the Commonwealth of Virginia, to determine whether a more efficient and cost effective design could be implemented and determine the level of savings that may result.

Solving the problem or question 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. Rather, each decision made (or not made) will have specific ramifications that the Commonwealth must carefully weigh as it considers whether (and if so, how) to implement the recommendations we will present in this report.

We estimate the potential savings to the Commonwealth of Virginia that might accrue as a result of implementing the various recommendations contained herein could reach over \$165 million. We have identified a number of possible ways in which savings can be achieved. At the same time, we realize full well that no human situation is ever ideal; and we understand that legitimately competing claims and priorities always have to be factored into every political equation.

We are prepared to assist you further with examining and/or analyzing any of the recommendations you may decide to pursue.

Many people deserve recognition and thanks for their contributions to this report. Annette Boyer, Lisa Coe and Scott Ponaman from Mercer Human Resource Consulting, 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. He continues to lead the effort to keep the vision of my late husband, Senator John Heinz, alive and flourishing.

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?

Today, many governors and state legislators are facing a severe fiscal crisis – perhaps the worst in the last 50 years. While there are many factors involved, two in particular have dominated the erosion of state revenues: the significant downturn in the economy in general and the significant – and unprecedented – rise of health care costs.

In recent years health care costs related to state Medicaid programs have significantly contributed to these increases – and, in particular, the cost of the prescription drug benefit program they provide. The Commonwealth of Virginia has witnessed a phenomenal increase of more than 480% in state Medicaid prescription drug spending in a relatively short time, from \$76.4 million in FY 1990 to more than \$445 million in FY 2002. While these programs have unquestionably helped many people to remain healthy and/or independent, skyrocketing cost increases over the years have impeded the ability of legislators and governors to effectively manage such programs.

For example, the trend for state spending on Medicaid prescription drug costs has far outpaced both overall inflation, and health care inflation as well. Although the Commonwealth of Virginia has managed the fiscal growth of its Medicaid program, it has not escaped the financial catastrophe that far too often shocks state legislators.

This has had a direct impact on the Commonwealth's ability to allocate funds to address or attack other specific needs such as education in K-12 programs; the infrastructure requirements of public schools, and other infrastructure needs, such as building or rebuilding roads, bridges, and sewers, etc.

Health care costs have ravaged state budgets and become, in effect, like the voracious PACman of health care dollars – 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 even become adversaries instead of allies.

Today's health care cost problems can be solved if there is collective bipartisan willingness both to examine the root causes of these problems and to think creatively about different ways to solve them.

In the end, there is no silver-bullet or overnight solution. If there was, legislators and governors would have long ago implemented such design changes. However, equally challenging will be the willingness and foresight of advocacy organizations representing various constituent groups receiving prescription drug benefits in the Commonwealth to recognize that absent change and increased fiscal responsibility, these programs will financially implode and cause the Commonwealth to either abandon or severely curtail such programs.

This report represents a comprehensive analysis regarding the benefits of, and the barriers to, the coordinated purchasing of prescription drugs; how the Commonwealth of Virginia 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 Commonwealth's fiscal responsibility for specific state programs.

The analysis focused exclusively on six programs within the Commonwealth of Virginia:

- The Department of Medical Assistance Services (Medicaid – (DMAS)
- The Department of Human Resource Management (state employees)
- The Department of Health
- The Department of Mental Health, Mental Retardation and Substance Abuse Services
- The Department of Corrections
- The Department of Juvenile Justice

The Heinz Family Philanthropies undertook this study at the request of Governor Mark Warner to determine:

- Whether and how a coordinated prescription drug purchasing plan could work in Virginia;
- How such an approach combined with other reforms could achieve the greatest level of possible savings;
- 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 Commonwealth 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 six specific programs that provide prescription drug benefits to different constituent groups in the Commonwealth. Our purpose was to examine each program, as well as the collective whole and to determine in what ways the Commonwealth 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 provided by the Commonwealth;
- 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 Commonwealth of Virginia;
- Initiated an actuarial analysis of plan design that included analyzing the existing plan design and determining what actuarial changes could be implemented that would yield greater savings;
- Undertook an analysis of how and to what extent the Commonwealth of Virginia effectively utilized the federal 340B program;
- Provided the Secretary for Health and Human Resources with a draft copy of the report, and requested comments to ensure that the facts and data presented were accurate.

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

SECTION 3

The State of Play: Prescription Drug Costs and Usage in the United States Today

Prescription drugs are the fastest growing segment in health care expenses in the United States and the key 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 now a critical component of health care and are 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:

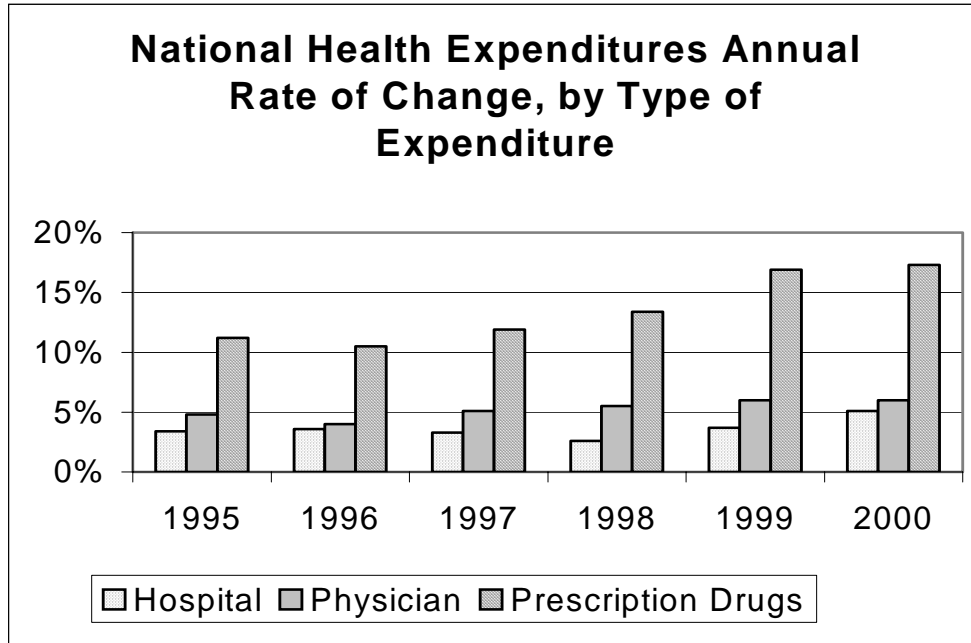
- The increasing numbers of Americans who use prescription drugs.
- The continued influx of new drugs into the market.
- Increased growth in specialty populations in state Medicaid programs (e.g. catastrophic illness, HIV/AIDS, Hepatitis C, etc.).
- Increased demand for prescription drugs as front line therapies or interventions in lieu of hospitalization or surgery.
- Drug price inflation, which represented or accounted for 33% of the overall increase of prescription drugs. Drug price inflation is likely to remain at or near 6% for the next few years.
- 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 drugs 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.

In the future, as illustrated in Figure 1 below, spending on prescription drugs will continue to be significant – and is, indeed, likely to continue to grow as a key cost driver.

Figure 1



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 formularies, lowering provider reimbursement rates and dispensing fees, and requiring prior authorization of specific medications, etc.

SECTION 4

How State Agencies Administer Prescription Drug Programs in the Commonwealth of Virginia

State agencies follow different approaches and utilize a variety of methods to obtain prescription drug benefits for the different constituent groups for which their respective departments or agencies are responsible. The agencies or departments utilize such methods as group purchasing, state contracts, federal assistance, 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 Commonwealth to leverage its purchasing power in the marketplace today.

Department of Medical Assistance Services (DMAS)

The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid program. Medicaid is a joint federal state partnership. In Virginia, the federal government participates at a 50 percent level. In other words, for every Medicaid dollar spent, the federal government reimburses the Commonwealth for half. Although states are not required to provide prescription drug coverage under Medicaid, the Commonwealth has been doing so since 1969.

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 Virginia, Medicaid spending for prescription drugs (fee for service only) has grown from \$38.2 million in FY 1990 to \$223 million in FY 2002 – an increase of more than 480 percent. As described above, the federal government matches this spending, meaning total spending for Virginia's Medicaid program was \$445 million in FY 2002.

The Virginia fee for service program accounts for approximately 46% of the Medicaid population (292,000 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 a recent JLARC report that found that although blind and disabled individuals represented only 19 percent of Medicaid recipients, they accounted for 45 percent of total annual Medicaid spending.

If Virginia does nothing to mitigate and/or manage this trend, Commonwealth spending for the DMAS program may reach \$691 million by 2005.

Department of Human Resource Management (DHRM)

The Department of Human Resource Management administers the health insurance program that includes a prescription drug benefit for 206,000 active Commonwealth employees and retirees and their dependants. Both the Commonwealth and employees share in the cost of their health insurance. Of particular note, the Commonwealth of Virginia has seen an increase of 109% - from \$44.7 to \$93.3 million since FY 1996 on its expenditures for prescription drug benefits for active employees, dependents and retirees (including both early retirees and retirees over age 65).

Virginia Department of Health (VDH)

The Virginia Department of Health (VDH) provides public health, environmental health, and medical services through 119 local health departments. Medical services, including prescription drugs provided to VDH clients, are funded through a combination of State general funds, local match funds, agency-generated revenues (typically from patient co-payments determined on a sliding scale), and any additional local funding. Based on the *Code of Virginia*, pharmaceuticals and biologics are provided at no charge for certain sexually transmitted diseases and for immunizations required for school entry.

In FY 2002, VDH spent approximately \$27 million on prescription drugs. About \$18 million of the total is spent through the federal AIDS Drug Assistance Program (ADAP). In addition, VDH spent approximately \$8.8 million for medical and laboratory supplies. VDH estimates that more than 95 percent of medical supply purchases are obtained through State contracts.

VDH operates a central pharmacy that serves most of the public health departments. They procure pharmaceuticals through contractual relationships with the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP) and the federal 340B discount program (a specific discussion of the 340B program occurs later in this report), a program of the Public Health Service of the federal government. VDH also has been very effective at using a variety of pharmaceutical manufacturer funded patient drug assistance programs that provide about \$4 - \$5 million in free drugs per year.

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)

DMHMRSAS operates mental health facilities and mental retardation training centers that provide treatment for individuals suffering from mental illness, mental retardation, and alcohol or other substance abuse problems. The Commonwealth operates an Aftercare pharmacy facility that services the 40 locally based community service boards that provide outpatient medications. The highest volume of medications is supplied through the Aftercare facility for this program.

The recent JLARC report on prescription drugs provides a valuable explanation of how DMHMRSAS recipients access prescription drug benefits.¹ In FY 2002, DMHMRSAS spent \$20 million in total expenditures for which \$16 million was accounted for as atypical anti-psychotics. It is important to note that the largest percentage population served by this program are not eligible for Medicaid and are, therefore, funded with taxpayer revenues.

Currently, they primarily procure pharmaceuticals through contractual relationships with the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP) and have been actively pursuing opportunities to access the 340B pricing structure.

Department of Corrections (DOC)

The Department of Corrections (DOC) houses more than 24,000 Virginia inmates and 3,000 inmates from other states in its 58 facilities. It is estimated that state general funds – taxpayer dollars – account for more than 86 percent of expenditures.

¹ *Clients access the State-operated facilities through Community Service Boards (CSBs). CSBs are responsible for delivering mental health, mental retardation, and substance abuse services to citizens in their localities, and refer those individuals with severe conditions to State-run in-patient facilities.*

While all of the in-patient facilities operate their own pharmacies, most CSBs provide prescription drugs to outpatient clients through the mail-order aftercare pharmacy located on the campus of Hiram W. Davis Medical Center. The aftercare pharmacy employs a number of effective cost containment methods including maintaining a strict formulary, encouraging the use of generics, package merging, and dose manipulation (for example, two 50 mg caplets in the place of one 100 mg caplet). In addition, the aftercare pharmacy implemented a unique program, called Medsaver, designed to conserve unclaimed medication by collecting undispensed prescription drugs from the CSBs and then by repackaging and redistributing the medication. In FY 2002, the Medsaver program saved \$2.6 million. Savings in FY 2003 through September were approximately \$1.4 million.

DOC contracts with a mail order pharmacy and pays a per capita rate that includes all formulary medications dispensed to inmates based upon a closed formulary that includes most pharmaceuticals. However, several high cost classes of medications such as anti-retrovirals and hepatitis C drugs are not included in this capitated arrangement. These medications and other non-formulary medications are purchased separately through negotiated rates with an outside medical contractor.

DOC stated that mental health drugs and antiretroviral, HIV, and hepatitis drugs constituted the bulk of prescription expenditures. For example, In FY 2002, DOC paid approximately \$2 million dollars under the capitated arrangement and \$11.35 million dollars for all non-formulary medications including antiretroviral, HIV, and hepatitis drugs and several behavioral health medications such as the atypical anti-psychotic.

Department of Juvenile Justice (DJJ)

The Commonwealth's juvenile correctional centers are operated by the Department of Juvenile Justice. They are responsible for purchasing prescription drugs for the approximately 1200 juvenile offenders in their custody. The Department spent \$968,991 on prescription drugs in 2002 – an increase of 282.4 percent since 1998 when it spent \$253,419. Pharmacy services are provided through a mail order vendor with a local retail distribution network for emergency dispensing.

The challenges confronting the Department of Juvenile Justice are as follows:

- Approximately 50 percent of the youth housed at DJJ receive medication and about 25 percent are receiving psychotropic (anti-anxiety, anti-depressant, and anti-psychotic) medication.
- Approximately 34.5 percent of offenders have a history of psychotropic usage prior to entering a facility or are on psychotropics upon admission.

According to officials at DJJ, when possible, physicians try to use generic medications. For most medical situations, the use of generics does not pose a problem. However, the process of substituting medications becomes more challenging when dealing with psychotropic or atypical medications. As a result of the relatively short length of stay (average stay is 9 months) for most offenders, DJJ maintains an open formulary and reports that facilities generally prescribe the same drug for the juvenile that he or she used prior to detention and that will be provided post-detention in the community.

SECTION 5

Key Findings

1. Through adopting a series of recommended changes to the current procedures regarding prescription drug programs, we estimate that the Commonwealth of Virginia could achieve savings of over \$165 million. The toughest choice facing the Governor and legislators within the Commonwealth will involve their willingness and ability to work together on a bipartisan basis, to implement these changes and to begin reforming a state health care system desperately in need of overhaul.
2. Implementing a preferred drug list (PDL) has the potential of yielding savings ranging from \$23 million to \$78 million in Commonwealth spending (excluding the Federal share of Medicaid spending). The greatest level of savings would occur if all state agencies (DMAS, DHRM and DMHM RSA) coordinate the use of the PDL. 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 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. Also, changing pharmaceutical access may incur the wrath of advocacy organizations that will be told of the problems a PDL will mean for their respective constituencies.
3. The Commonwealth of Virginia pays different rates for the services of pharmacy providers. These services are reimbursed through dispensing fees. Today, state agencies pay dispensing fees that differ dramatically from the private sector. Our strategy recommends creating a dispensing fee for the Commonwealth of \$1.50 to \$3.50. This will be controversial because it will involve reducing fees to pharmacists.
4. Through improvements in individual state agency provider contracts for prescription drugs, it is estimated that DMAS, DHRM, DOC and DJJ could achieve savings ranging from \$11.4 - \$15.5 million in Commonwealth spending. As discussed in this report, the tough choice here for the Governor and state legislators would be whether to strengthen individual agencies and their purchasing of prescription drugs, or to move to a

coordinated contracting strategy that will produce greater savings, but also limit the autonomy of state agency personnel handling these programs.

5. As discussed above, while the Commonwealth can obtain significant savings through improved "contracting of individual contracts" through coordinated procurement, we are recommending exploring the implementation of a coordinated contracting strategy for DMAS, DHRM, DOC and DJJ. This strategy could result in savings to the Commonwealth ranging from \$36.2 million to \$49.7 million. The tough choice for the Governor and state legislators 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.

6. State agency prescription drug programs often do not implement plans for purchasing generic drugs in the most cost-effective manner in order to obtain the maximum allowable cost (MAC). The implementation of an enhanced MAC program is estimated to produce savings for DMAS, DHRM, DOC and DJJ ranging from \$6 million to \$8.3 million. The tough choice here is whether pharmaceutical manufacturers will successfully convince the Governor and state legislators that enhanced use of generic medications is not in the best interest of the patient. In addition this will also result in an impact to pharmacy providers, as more competitive MAC pricing will impact 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 administration and negotiation functions should be consolidated under one or two state agencies with one state executive given the sole discretion to negotiate. The author recommends that this authority be given to the Secretary of Health and Human Resources 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 Secretary both the authority and the latitude to implement a strategy that works well for the Commonwealth. If the Secretary is not given the necessary authority as well as the complete support of the governor and legislature, then the Commonwealth will fail to obtain the greatest level of savings possible.

8. Changes to the level of cost sharing by state employees, their dependents and pre-65 retirees can result in savings ranging from \$10 million to \$27 million. The tough choice here will be to implement a true three-tiered incentivized formulary – one that is vastly different from the current design.²

9. Savings ranging from \$4 million to \$8 million are possible through the implementation of an individual deductible that state employees, dependents and pre-65 retirees would be required to pay (meaning that the drug benefit would not go into effect unless and until this deductible was met). The tough choice here for state legislators will be their willingness to require state employees, dependents and pre-65 retirees to pay a deductible for benefits they are now receiving for a minimal share.

10. Requiring state employees, dependents and pre-65 retirees to purchase maintenance medications (those taken for 90 days or longer) through a traditional mail order facility could yield savings of \$2.4-\$4.5 million, assuming a 5-8% increase in mail order utilization. Current utilization is only 6% for Commonwealth employees, dependents and pre-65 retirees. To minimize the impact of such a mandatory mail program on local pharmacies, participants would still be allowed to purchase their medications at the retail counter as long as the pharmacy agrees to be paid at the mail order price. 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.

11. This report recommends a series of steps that the Commonwealth should consider in an effort to maximize possible 340B funding. We did not provide any specific savings estimates in this area because the Commonwealth has far too much preliminary work to undertake before this could be done. Any attempt beforehand would be misleading. The

² Although we did not model the Medicare retiree population -- 65+ -- we believe that increasing their level of cost sharing would also increase the level of savings to the Commonwealth.

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 these opportunities.

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, such as health care re-engineering, employee health insurance plans, more effective management of vendors such as insurers, enhanced pharmacy benefit management, etc.

Coordinated Contracting allows an employer or entity like the Commonwealth of Virginia to aggregate, or consolidate the administration of various state programs providing prescription services under the auspices of one state agency.

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

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

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, etc.) associated with administering the pharmacy benefit.

For this report, 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 Virginia 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 coordinated purchasing to work to its fullest, 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 coordinated purchasing and to the program itself. If not, the Commonwealth must carefully weigh the benefits of this approach.

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 public sector and public programs to find innovative strategies to significantly cut drug expenditures to reduce the impact of these deficits. As a result, leaders of state agencies 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 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 product. 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 resource utilization through benefit design and clinical management;
- Health care provider and patient behavior modification;
- Maximizing and managing the use of new management and treatment technologies;
- Aggregate data 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.

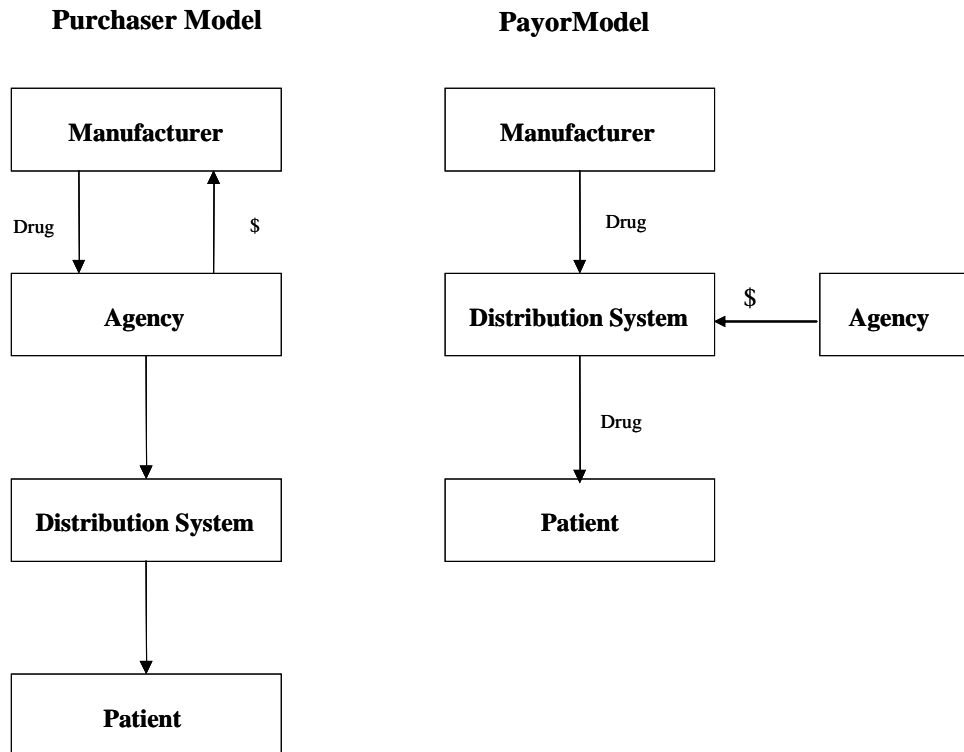
Integration of collective pharmaceutical purchasing and program management strategies under a collaborative model can be thought of as a Coordinated Prescription Drug Purchasing Strategy.

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 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.

The Third-party Payor (payor) model is a state pharmacy procurement model usually 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. Direct Purchasers (purchasers) in this model own or provide medications directly to a distribution system and purchase 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:



In order to develop a strategy that will provide the greatest return on investment for the Commonwealth, it is important to understand where the synergies are between the payor versus purchaser strategies.

Collective purchasing strategies have enabled payors to:

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

Bulk purchasing has enabled purchasers to obtain significant volume discounts on the purchase of prescription drugs.

Program management has allowed states to develop strategies that meet their cost savings objectives while improving access and clinical outcomes, and are targeted at meeting the needs of their population(s). These efforts are focusing on:

- prescription drug utilization management
- health management
- maximizing and coordinating funding and enrollment
- reducing administrative burden through identification of efficiencies

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 Commonwealth should look for ways to effectively leverage 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 Commonwealth 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 and/or Formulary

A PDL and/or formulary is a listing of medications, chosen on the basis of quality and cost, that are covered by a plan. The current public employee health insurance plan and Medicaid (fee for service) has adopted an open access approach that allows coverage of all medications within a given therapeutic class. Currently, the public employee plan and Medicaid (fee for service) offer an open formulary.

The Medicaid program uses the formulary defined by federal rebate contracts. Because of high manufacturer participation in the Federal Rebate Program, the vast majority of medications are included on the formulary. The greatest efficiency resulting through a coordinated contracting strategy would be the development of a common preferred drug list (PDL) for Medicaid, public employees (dependents and pre-65 retirees) and the MHMR programs.

In order to minimize the administrative burden associated with developing and maintaining a customized PDL, consideration should be given to using Virginia's specific drug utilization for all programs considered. The drug utilization information should be compared to determine the common drugs used and physicians' prescribing patterns within the Commonwealth, or another approach is to use the administrator's base formulary as a basis, or starting point, for a preferred drug list. For example, Virginia uses First Health, a Pharmacy Benefits Administrator (PBA) with national credentials that may be able to assist with the development of a coordinated contracting strategy.

More recently, Georgia has been working with Express Scripts (a nationally recognized Pharmacy Benefits Manager – PBM) which administers the contracts for a preferred drug list for Medicaid, public employees and higher education entity. While careful consideration must be given as the Commonwealth builds a customized PDL, among some of the PBMs there is a great deal of experience in doing this. This also means that when the Commonwealth 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 and/or formulary, network management, plan design, and utilization management strategies where appropriate, will help a coordinated contracting strategy achieve its greatest efficiency and maximize the level of savings it can achieve.

Allowing the administrator to "do what it can do best" and manage program performance enhances the ability of an employer and/or state entity to balance quality and cost savings. In addition, it allows access to additional 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. Additionally, aggregate purchasing may 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 and/or formulary management, coverage policy, clinical management, and enabling the groups to educate providers and participants collectively, and more effectively, on program policy. The result should be better 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 a myriad of 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 Medicaid are guided by legislative language. Federal regulations specify requirements relative to the design and implementation of many clinical management programs, and define many of the reporting requirements associated with them.

As the Commonwealth evaluates the impact of coordinated purchasing strategy, it is important to understand the various similarities and differences among the program contracts to be coordinated. It is only through 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 Commonwealth of Virginia

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 under each individual circumstance.

Because Medicaid discounts and dispensing fees are legislated under Virginia 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 legislation.

DMAS does, however, play an important role in a coordinated purchasing strategy. With the majority of the lives in Medicaid fee-for-service, DMAS in conjunction with DHRM (public employees), and DMHMRSAS combined, would 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 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 Virginia Law; and
- Additional Cost Savings – which can be obtained with or without coordinated purchasing.

The Consolidation of Existing Contracts under Current Virginia Law

Summary

The coordination of the existing DMAS (Medicaid), DHRM (public employees), DOC (incarcerated adults) and DJJ (incarcerated juveniles) 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 \$36.2-\$49.7 million in savings to the Commonwealth is possible, as shown in the following table.

The Commonwealth of Virginia Coordinated Contracting Strategy			
	Projected Rx Spending (CY03)*	Potential Savings	Revised Spending
DMAS	\$287.0 million	\$30.0 – \$40.0 million	\$247.0 – \$257.0 million
DHR	\$84.1 million	\$5.6 – \$8.0 million	\$76.1 – \$78.5 million
DOC	\$14.5 million	\$0.5 – \$1.5 million	\$13.0 – \$14.0 million
DOJJ	\$1.3 million	\$0.1 – \$0.2 million	\$1.1 – \$1.2 million
Total	\$386.9 million	\$36.2 – \$49.7 million	\$337.2 – \$350.7 million

** Commonwealth 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 DMAS, DHRM, DOC and DJJ, we conservatively estimate that the combined purchasing power of these four entities could produce direct cost savings of \$36.2- \$49.7 million in calendar year 2003. These savings, which represent approximately 9.4%-12.9% of projected prescription drug program costs for these four 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;
- Lower dispensing fees;
- Lower claim processing fees; and
- 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 DHRM currently has competitive discount arrangements, the purchasing power created through coordinated contracting of DMAS (fee for service), DHRM, DOC and DJJ 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

While 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 \$4.25 to dispense a brand drug and DHRM, \$2.00?

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 2%-4% could be obtained through a coordinated contracting strategy.

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 Commonwealth also enacts a preferred drug list and/or formulary where negotiations with manufacturers should yield either enhanced rebates and/or substantially lower 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 Commonwealth to align the management strategies across the various programs. For example, the Commonwealth 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 Commonwealth 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 \$36.2 million to \$49.7 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 Commonwealth of Virginia 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.

Since the provider reimbursement for prescription drugs under Medicaid is legislated under Virginia law, plan administrators do not have the same opportunity to provide deeper discounts for single source brand and multi-source medications that are not subject to MAC pricing. It is, however, possible that the current discount arrangement for generic prescription drugs could be altered to provide additional savings. As legislated by the Commonwealth, most generic drugs are

currently priced at either the Federal Upper Limit pricing (FUL or HCFA MAC), or the specified Virginia MAC level.

The Commonwealth can obtain savings for each program individually or combined by creating the opportunity to have a more expansive list of generic drugs priced at the MAC level. Since the MAC lists used by most commercial administrators incorporate pricing for a greater number of generic drug products than the HCFA MAC list or typical state MAC lists include, it is estimated that a savings of \$6 million to \$8.3 million could be possible for Commonwealth spending for the DMAS, DHR, DOC AND DJJ programs combined.

We estimate that the Commonwealth 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 Commonwealth could expect to save 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 blockbuster drugs (such as Prilosec®) continue to enter the market.

In general, 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 is subject to periodic review and modification by the plan and is 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 CMS rebate contracts. The additional rebate is negotiated for medications deemed appropriate for preferred status. Rebate amounts can vary significantly depending on how the Commonwealth elects to select medications for preferred status and the PDL management technique adopted by the State.

Moreover, supplemental rebates are often driven by the management initiatives, such as pharmacy point-of-sale messages, education to patients and physicians, 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 Commonwealth. 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. As a result, due to increased volume and a concentration in a given region, there is a greater opportunity to influence market share, resulting in increased rebates.

There are a few options the Commonwealth can consider for the PDL. With each option the level of savings increases. In each option supplemental rebates are contracted for.

Option 1: DMAS develops and implements its own PDL.

Option 2: DMAS and DHR develop and implement a combined PDL.

Option 3: PDL is expanded to the other agencies.

Option	Agencies	Projected Drug Spend CY 03 (millions)	Savings (millions)
1	DMAS	\$287	\$23-\$40
2	DMAS and DHR	\$406	\$49-\$73
3	DMAS, DHR and DMH	\$432	\$52-\$78

Assumptions:

Applied trend factor of 17- 20% to FY02 spend data.

DMAS Drug spend and projected savings are expressed in Commonwealth dollars. DMAS savings and expenditures must be doubled to reflect total agency spending including the federal match.

DHR 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 DMAS develops and implements its own PDL. As shown, the savings are significant at \$23 to \$40 million. **Option 2** illustrates the potential significant level of savings, \$49-\$73 million, possible if DMAS and DHRM 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, \$52-\$78 million available with the creation of a single PDL that would be used by three state agencies; DMAS, DHRM, and DMHMRSAS. The savings, while larger than Option 2, are only slightly higher because of the limited classes of pharmaceuticals used by people served by DMHMRSAS that are not purchased through a 340B program.

Improved Individual Agency Contracting

The pharmaceutical distribution system in place for the Commonwealth of Virginia is through various contracts administered primarily by First Health, Trigon, Blue Cross/Blue Shield, and Diamond Pharmacy. 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.

For illustrative purposes, for individual or coordinated contracts, an arrangement of Average Wholesale Price (AWP) minus 12-13% is barely competitive for large clients. Due to the competitive nature of the market, marketplace benchmarking yields AWP-14%-15%. A similar issue involves dispensing fees where the current arrangements are set at \$2.00-\$4.25 and the competitive marketplace is at \$1.50-\$3.00.

Commonwealth of Virginia: Improved Contracting for Individual Contracts			
	Projected Rx Spending (CY03)	Potential Savings	Revised Spending
DMAS	\$287.0 million	\$8.1 – \$10.9 million	\$276.1 – \$278.9 million
DHR	\$84.1 million	\$2.8 – \$4.0 million	\$80.1 – \$81.3 million
DOC	\$14.5 million	\$0.4 – \$0.5 million	\$14.0 – \$14.1 million
DOJJ	\$1.3 million	\$90,000 – \$130,000	\$1.1 – \$1.2 million
Total	\$386.9 million	\$11.4 – \$15.5 million	\$371.3 – \$375.5 million

This option illustrates the level of savings to the Commonwealth (excluding Federal match) that is possible if individual state agencies were able to improve upon their individual prescription drug contracting. However, as shown previously, the level of savings is almost three times as great 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 cost sharing.

The benefit design changes are shown here for illustrative purposes only and affected the DHRM program (public employees). The current plan design for public employees (and dependents) is:

Commonwealth of Virginia Department of Human Resource Management Program		
	Actives	Pre-65 Retirees
Mandatory Generic	Yes	Yes
Retail (brand and generic)		
Up to 34 days	\$17	\$27
34 to 90 days	\$34	\$54
Mail Order (brand and generic)		
90 day supply	\$25	\$32

Under the current plan design, there is no incentive for people to use more cost effective medications. Although generic drugs are mandatory, the copay for generic and brand name drugs are the same. The lack of a “true” three-tiered, or incentive PDL/formulary economically incentivizing people to want to use more cost-effective drugs is vitally important. Moreover, because the current plan design allows employees to obtain expensive or less clinically effective drugs at the same price, people have no incentives to “value” their purchase.

For the Commonwealth of Virginia, the recommendations on member cost share focus on a strategy that encourages consumerism.

In general, the utilization trend is slowed when the patient’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%, a negative utilization trend results.³ This positive impact needs

³ *The Merck-Medco Drug Trend Report 2001*

to be balanced with the fact that some of this decreased utilization may result from patients no longer taking medications that are essential.

In a tiered design, a patient's copay is lowest for generics (tier one), somewhat higher for preferred brands (tier two) and highest for non-preferred brand products (tier three).⁴ In general, a plan can expect to save between 3-15% of total drug expenditures by implementing a three-tier formulary design.

The Commonwealth of Virginia Department of Human Resource Management (DHRM) has the ability to achieve savings of 12-32% by implementing a three-tier formulary and balancing the retail and mail order copayments from the current design.

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

Plan Design Recommendations	
<i>Advantages</i>	<i>Barriers</i>
<ul style="list-style-type: none"> ▪ Increased member contribution 	<ul style="list-style-type: none"> ▪ Pharmaceutical industry resistance
<ul style="list-style-type: none"> ▪ Increased rebate potential 	<ul style="list-style-type: none"> ▪ Requires legislative support for changes
<ul style="list-style-type: none"> ▪ Promotes appropriate utilization 	<ul style="list-style-type: none"> ▪ Communications needs (patient, MD)
<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"> ▪ Perception that Commonwealth is trying to exclude expensive drugs from coverage
<ul style="list-style-type: none"> ▪ Promotes consumerism - members become more aware of drug costs 	

In order to create a more economically incentivized prescription drug program for public 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 \$10 million to \$33 million.⁵

Coinsurance in lieu of flat dollar copays

Coinsurance is the percentage of prescription drug cost you are responsible for. Where a deductible is required, your coinsurance begins after your deductible is met. One of the reasons

⁴ *Express Scripts 2000 Drug Trends Report, June 2001*

⁵ *Includes the effect of changes to cost sharing for employees, dependents, and pre-65 retirees. Although we did not model the Medicare retiree population -- 65+ -- we believe that increasing their level of cost sharing would also increase the level of savings to the Commonwealth.*

coinsurance is recommended is to avoid the need for a requirement to raise prescription drug dollar copays as costs increase. Coinsurance, on the other hand, automatically adjusts to price changes in the marketplace. The scenarios and corresponding savings modeled for active employees and pre-65 retirees are illustrated below.

Coinsurance Model								
		Retail			Mail			Projected Savings
	Deductible	Generic	Brand	Non-Preferred	Generic	Brand	Non-Preferred	
Active Employee	None	30%	30%	80%	\$24	\$45	\$70	\$10-12 million
Pre-65 Retiree		30%	30%	80%	\$36	\$60	\$80	
Active Employee	\$100 Individual	30%	30%	80%	\$24	\$45	\$70	\$16-18 million
Pre-65 Retiree	\$150 Family	30%	30%	80%	\$36	\$60	\$80	
Active Employee	None	30%	50%	80%	\$24	\$45	\$70	\$24-27 million
Pre-65 Retiree		30%	50%	80%	\$36	\$60	\$80	
Active Employee	\$100 Individual	30%	50%	80%	\$24	\$45	\$70	\$30-33 million
Pre-65 Retiree	\$150 Family	30%	50%	80%	\$36	\$60	\$80	

Copay Model								
		Retail			Mail			Projected Savings
	Deductible	Generic	Brand	Non-Preferred	Generic	Brand	Non-Preferred	
Active Employee	None	\$12	\$22	\$35	\$24	\$45	\$70	\$12-14 million
Pre-65 Retiree		\$18	\$30	\$40	\$36	\$60	\$80	
Active Employee	\$100 Individual	\$12	\$22	\$35	\$24	\$45	\$70	\$18-20 million
Pre-65 Retiree	\$150 Family	\$18	\$30	\$40	\$36	\$60	\$80	
Active Employee	None	\$15	\$25	\$45	\$30	\$50	\$90	\$18-20 million
Pre-65 Retiree		\$15	\$25	\$45	\$30	\$50	\$90	

Section 8

340B Prescription Drug Pricing: Opportunities Are Available

In 1992, Congress enacted Section 340B of the Public Health Service Act (PHSA). The 340B discount program is administered by the Office of Pharmacy Affairs (OPA) 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). 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 OPA for 340B purchasing eligibility. Discounted drugs can then be purchased through a wholesaler and/or manufacturer.

Participation Requirements

Under Section 340B, a covered entity includes facilities who 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, or
- certain subsection hospitals that are: owned or operated by a unit of state or local government, is a public or private non-profit corporation that is 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 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;
- Prohibition of resale of drugs – a covered entity shall not resell or otherwise transfer the drug to a person who is not a patient of the entity;
- Auditing – 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; and
- Treatment of distinct units of a hospital – 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.

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 39.5 - 32.1 percent.

Despite very low pricing, very few Medicaid agencies have accessed 340B discount pricing. Another important stipulation of the PHSA states that in order for an entity to provide pharmaceuticals at 340B discounts, patient care and treatment must be provided by the approved entity.

Options

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

- collaboration between the Department of Health and other appropriate state agencies (e.g., DOC) to expand the population for which expensive drugs are purchased under the 340B programs. For example, the DOC is currently purchasing their non-capitated, expensive drugs (e.g., anti-retrovirals) through a negotiated contract with minimal cost savings. This population would qualify for 340B purchasing and the state already has a distribution system in place through the Department of Health that could be utilized within the qualified entity regulations. Another option would be for the DOC to provide the manufacturers with documentation of the administered medication and doses to receive 340B level rebates.
- 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 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 appropriate “management fee” to overcome requirement of Actual Acquisition cost, plus the Medicaid dispensing fee. The Commonwealth 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 Commonwealth aggressively pursues these options. These barriers include:

- Administrative burden on the Commonwealth - 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 Commonwealth 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 OPA 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 Commonwealth 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 OPA would require the Commonwealth 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 Commonwealth to coordinate a select network of providers. Participants would then need to receive all or part of their health care within this network, and while indigent patients may already have a relationship with a 340B covered entity, other participants may be reluctant to change providers.
- Restrictive formulary - when contracting with 340B providers, Medicaid agencies will need to examine the breadth of the providers’ formularies to confirm that patients have access to all necessary medications.

Conclusion

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 OPA'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 Virginia, however, the 340B program represents a lot of hard work yet to come. The recent JLARC study provided the Governor and the legislature a thoughtful review of the various aspects of the 340B law, it's possible application to Virginia and a sense of what the possible savings could be if the Commonwealth utilized the 340B program. While this approach is informative and useful for purposes of understanding the program, the author does not support the financial finds that JLARC projects. The reason is simple: before savings can reasonably be projected, the Commonwealth has a great deal of preliminary analysis and research that needs to be completed first. Once that is done, the Commonwealth will have a much greater understanding of what is and is not practical and possible in its quest to achieve maximum use of 340B funds.

In the Appendix of this report, a detailed work plan is provided recommending specific steps and actions that need to be taken to help prepare the state agencies and the legislature if it is going to pursue ways to maximize the level of 340B participation.

Section 9

What Does This Mean for the Commonwealth of Virginia?

Coordinated contracting of prescription drugs presents an opportunity for the Commonwealth to reduce the costs of the prescription drug programs paid for with state funds, and more effectively leverage the use of federal funds. By coordinating the purchasing power of multiple state prescription drug programs under one state executive, greater efficiencies and savings can be achieved. However, the level of programmatic efficiencies and cost savings will be greatly influenced by the willingness of the legislature and the Governor to agree on a bipartisan basis to undertake the following:

- The creation of a single state preferred drug list and/or formulary to influence market share;
- Where appropriate, implementation of uniform pharmacy benefit management strategies for all Commonwealth-sponsored prescription drug programs;
- Empowering one state executive with the authority to negotiate prescription drug contracts and the ability to modify the drugs covered on the preferred drug list. The author recommends that the authority rest with the Secretary of Health and Human Resources;
- Provide the state executive with the ability to determine with the administrator and a selected P&T committee the composition of included and excluded medications for the state preferred drug list or, alternatively, individual state program preferred drug lists;
- Implement the improved contracting recommendations set forth in this report;
- Shift more and more people using prescription drugs into a mandatory generic drug program to achieve increased savings in both the short and long term;
- Improve procedures for individual contracts should the Commonwealth not implement a coordinated state contracting strategy in whole or part;
- Consider implementing an individual and family deductible for state employees;

- Implement a tiered based program that allows individuals to make decisions to use generic and brand name drugs based both on clinical and economic reasons;
- Aggressively pursue a federal/state 340B strategy that allows the Commonwealth to more effectively and efficiently utilize federal 340B cost savings to assist with the funding of specific programs in lieu of state funds; and
- Consider providing the Secretary of Health and Human Resources the authority to negotiate directly with pharmaceutical manufacturers on the development of a preferred drug list and/or formulary to minimize and ultimately eliminate the need for negotiation of rebates and supplemental rebates.

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. 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. This should, however, be viewed 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
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Commonwealth of Virginia: Prioritized Recommendations

RECOMMENDATION:

340B Purchasing Opportunities

- Alternative Method Demonstration Project
- DMH/DMAS – Billing coordination maximization

DESCRIPTION:

Alternative Method Demonstration Project

Goal: Assess opportunity to develop alternative delivery system for 340B program that can potentially lead to expanded covered population for Medicaid, VDH, DHR, and DOC.

HRSA has established a formal process of 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 past the covered entities which in the past were treatment centers. The Commonwealth of Virginia already has a drug warehouse dispensing program in place within the Department of Public Health. This warehouse could serve as a foundation for the Commonwealth to significantly expand the population served by this program through the development of an alternative distribution process supported by these demonstration initiative opportunities. These efforts can focus initially on a small but high prescription drug cost population (e.g., hemophilia) for the purposes of piloting this demonstration initiative before broad implementation.

(Please note: further research on these 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. However, although HRSA is not able to offer a grant specifically for these demonstration projects, they do offer funded technical assistance and other grants to expand these services).

DMH/DMAS – Billing Coordination Maximization

Goal: *Ensure that DMH and DMAS are coordinating billing to make sure that Medicaid has passed on cost savings from all 340B providers under VDH.*

DMH and DMAS have Medicaid populations who are already receiving their prescription medications through current 340B programs in the Commonwealth. Periodic auditing of the prescription drug claims for these enrollees needs to ensure that DMAS and DMH are having these cost savings passed onto the Commonwealth.

NEXT STEPS:

Alternative Method Demonstration Project

1. Identify a cross-agency 340B team (including representatives from DMAS, DMH, VDH, DOC, DOJJ and key stakeholders) who can assess and prioritize all of the 340B opportunities including but not limited to the Alternative Method Demonstration Project. This assessment would include an analysis of the cost savings benefits versus the financial and resource impact on each of the participating agencies and for the Commonwealth in the aggregate.
2. Ensure adequate consulting support for the development of a strategic workplan and negotiation with HRSA's Office of Pharmacy Affairs (OPA) to obtain approval for a demonstration project.
3. Identify all 340B providers not under VDH and assess:
 - Opportunities for moving a larger eligible population under these programs
 - Coordinating with disease management vendors to increase utilization of these programs.
 - Develop partnerships with programs to increase utilization of both the 340B opportunity and improved care management for special populations.
 - Assess which state providers or contracted providers can qualify as 340B providers and support implementation of program (e.g., state hospitals, FQHCs).
4. Identify all potential 340B entities and assess and prioritize supporting these programs becoming 340B entities to maximize state population receiving their medications through this funding program.
5. Utilize the workplan to develop a pilot project focusing on one population or agency.
6. Implement the pilot and measure the success by financial, access and clinical outcome indicators.
7. Move toward broad implementation across state agencies.

DMH/DMAS – Billing Coordination Maximization

1. Develop coordinated workplan with DMH and DMAS MMIS, SUR and Finance staff to identify appropriate 340B drugs to audit for 340B pricing versus claims pricing.
2. Identify appropriate audit edits to identify these claims prospectively.
3. Retrospectively seek reimbursement for any overcharges identified.

RECOMMENDATION:

Coordination of Reporting/Data Management

- Monitoring of drug utilization
- Identify economies of scale
- P&T/Technology Assessment Committee
- DM/Health Management Coordination
- Review of appropriateness of programs

Coordination of DUR/Care Management Initiatives

DESCRIPTION:

Goal: Development of a prospective coordinated reporting and data management strategy in partnership with all state agencies and contracted managed care organizations, disease management and pharmacy distribution/management vendors.

- Development of a coordinated or common reporting and monitoring strategy can have 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. This 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 market place and make coordinated consistent decisions on whether to support or not support the coverage of these technologies. This could save the Commonwealth 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 Commonwealth and improvement of health status.

- 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 for Virginia's population that is going to deliver the greatest ROI.
- 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.
- We would recommend an immediate assessment of the Commonwealth's data to see if all the programs under way with Heritage are appropriate for Virginia's population, and to see if other state programs would benefit from these contracts. In addition, Heritage is currently providing over 5 disease management programs to each agency. However, the populations served within each program are too small for statistically significant outcome findings to be reported. This may indicate that these programs are not truly targeted toward the population needs of Virginia.

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 their maintenance drugs that help to minimize emergency department and inpatient utilization. We would recommend that a strategy is developed to integrate the disease management provider programs with the Commonwealth and state contracted pharmacy providers to ensure a collaborative approach that saves the Commonwealth money through appropriate utilization.

NEXT STEPS:

1. Identify a team of representatives from each state agency, the MCOs, disease management vendors, and pharmacy vendors who will serve as the leadership to drive this initiative.
2. Other team members should include state employed providers (e.g., medical directors, pharmacists, quality directors) and stakeholders from the community.
3. This team will identify and prioritize activities based on the opportunities identified under this recommendation.
4. The team should identify key indicators to monitor the success of its initiatives and activities.

RECOMMENDATION:

Maximizing Federal Match

DESCRIPTION:

Goal: Maximize the Commonwealth's federal (enhanced) matching funds for qualified medical personnel (QMP) and other eligible activities (e.g., utilization review).

- State employed qualified medical personnel (QMP – e.g., pharmacists, nurses, physicians) salaries are matched at an enhanced 75% level by CMS
- Regulations support enhanced matching for QMP related activities including DUR, pharmacy management and clinically focused studies for vendors who are either Medicare PROs, PRO-Like entities or External Quality Review entities.

NEXT STEPS:

1. Vendors (e.g., those performing DUR) can be encouraged to become PRO-Like entities that can then be paid at an enhanced matching level.
2. Identify all opportunities within the Commonwealth and its contracts (e.g., DUR, Disease Management vendors) for this level of matching funds. This can lead to at least a 25% reduction in these related costs.
3. Identify the percent of time dedicated to the Medicaid population by all state agency QMPs. Work with the finance staff to ensure that the percent of salary is claimed at an enhanced matching level.
4. Need to assess if federal matching is being maximized across state programs where improved coordination can occur (e.g., Medicaid and VDH-Ryan White Care Act).
5. Develop strategy to maximize enrollment in the programs where maximal federal match is available (e.g., Childrens' Health Insurance Programs – CHIP, Ryan White, and Medicaid).

Glossary of Terms/Acronyms

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.
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.
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.
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.
CMS	Centers for Medicare and Medicaid Services (formerly HCFA)
Coinsurance	Cost sharing that requires a member to pay a specific <u>percentage</u> of the charge for each prescription drug. (for example, 20% 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, duplication, etc.

Glossary of Terms/Acronyms	
Coordination of Benefits	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. For example, a husband might have coverage from the state and his wife's coverage might be through an employer-sponsored program. The coordination of benefits agreement states that the primary plan pays first and the secondary plan pays last.
Copayment	Cost sharing that requires a member to pay a <u>fixed</u> dollar amount for each prescription drug (for example, \$15 per prescription).
Deductibles	The amount that a member pays under the plan each benefit year, in addition to the applicable premium, before prescription drug coverage begins.
Dispensing Fees	Negotiated professional fee paid to the dispensing pharmacy.
DM	Disease Management
Drug Trend	The rate of change in drug spending over time. Drug trend is influenced by factors such as price, specific utilization and the medications (drug mix) used by a patient population.
Drug Utilization Management	Applies guidelines and rules to identify and intervene, when appropriate, during or after the medication dispensing process, on opportunities for quality improvement and savings.
Drug Utilization Review (DUR)	A program management strategy that involves a review of the medication being prescribed 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.
Federal Poverty Level (FPL)	The federal government's official statistical definition of poverty.
FFS	Fee for Service
Formulary	<p>A list of drugs, selected on the basis of quality and cost, developed to encourage members to use appropriate, cost effective medications. The list is used by physicians when making decisions on what medications to prescribe. The list is subject to periodic review and modification by the plan. Several formulary options exist:</p> <p><u>Open formulary</u> – all medications are covered with little or no cost-sharing implication to the member for selecting a non-formulary medication.</p> <p><u>Closed formulary</u> – medications deemed as non-formulary are not included as a covered benefit.</p> <p><u>Incentive formulary</u> – all medications are covered, however there is a higher copayment amount applied for medications not on the formulary.</p>

Glossary of Terms/Acronyms	
Formulary Management	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.
Formulary Rebates	Payments made by pharmaceutical manufacturers to plan administrators based on utilization or market share of their products.
Generic Drug	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.
Generic Substitution	The practice of substituting a generic for a brand drug when authorized by patient and physician.
HCBS	Home and Community Based Services
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.
Incentive or tiered formulary	A pharmacy benefit plan design with different copayments 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.
Insurance Loss Ratio	The ratio of the annual claims paid by an insurance company to the premiums received. Insurers will establish premium rates based upon an anticipated loss ratio that supports claim payments, administrative costs, profit requirements and an appropriate risk margin for adverse experience.
LTC	Long Term Care
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.

Glossary of Terms/Acronyms	
Mandatory Generic	A program management strategy that requires an individual to receive a generic medication if a generic equivalent is available. If an individual 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.
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).
MCO	Managed Care Organization
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
MRDD	Mentally Retarded and Developmentally Disabled
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.
Network	A network of retail pharmacies typically (including chain and independent pharmacies) that contract with a pharmacy benefit administrator to provide services to plan members.
Nonpreferred Drug	A prescription drug that is determined, by criteria typically established by a Pharmacy and Therapeutics (P&T) Committee, to be disfavored over other products within the same drug class, by being subject to a higher copayment or to nonpreferred brand copayment.
Out-of-Pocket Limits	The total dollar amount, a combination of copayment and deductible, that a member pays of their own money. Unless otherwise specified, once the limit is reached, specific drugs are covered at 100% for the remainder of the benefit year.
P&T Committee	Pharmacy and Therapeutics Committee
PDL	Preferred Drug List

Glossary of Terms/Acronyms	
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 pharmacy management strategies aimed at promoting appropriate utilization of prescription drugs. Examples of such programs include drug utilization review, physician education, formulary management, prior authorization, patient education, mandatory mail service and generic substitution programs.
Pharmacy Network	A network of retail pharmacies that generally includes about 90% to 95% of available pharmacies in the required areas of coverage, consisting of most chains and some independents.
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 copayment or to preferred brand copayment.
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 who perform medical and quality reviews with state and federal government agencies. These entities allow states to receive enhanced matching for the services performed by these entities
QMP	Qualified Medical Professional (e.g., pharmacists, nurses, physicians)
Retrospective Drug Utilization Management	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

Glossary of Terms/Acronyms	
Subsidy	Financial assistance provided to a member to help lower out-of-pocket program expenditures.
TANF	Temporary Assistance for Needy Families
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 committee (P&T) most often approves the rationale for therapeutic equivalency prior to such practice.
TPA	Third Party Administrator
UCR	The usual and customary 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."