The LEWIN GROUP®



MO HealthNet Medicaid Pharmacy Report

November 16, 2009

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Introduction

- This project's main purpose is to identify pharmacy savings opportunities in the MO HealthNet Program that can help the State address its near-term fiscal crisis and to favorably impact longer-range Rx costs
- Thus, the report does not focus extensively on the program's many strengths and achievements; Missouri has developed an innovative Medicaid prescription program with the following attributes:
  - Pharmacy program leadership staff have an exceptional level of Medicaid and prescription drug management expertise and stand out among Medicaid pharmacy staff nationwide
  - Medical related pharmacy claims are going through pharmacy benefits (to maximize the provider tax yield)
  - Smart PA program has extensive algorithm-based rules to maximize efficient use of Missouri's preferred drug list (PDL) and avoid adverse drug interactions
  - Medication Therapy Management pilot is now operational and can be expanded
  - Specialty MAC program has recently been implemented and is also being expanded
  - CyberAccess software (a product of ACS) is being extensively and increasingly used by Missouri providers to enhance their knowledge and facilitate efficient interaction with MO HealthNet

Top Priority Recommendations

1. Permit Rx benefits management to occur for all therapeutic classes on an equal basis (e.g., lift protections on access to psychotropics)
2. Reduce unenhanced portion of fill fee to $4.20, the national average Medicaid level.
3. Implement programs to "weed out" excess usage of pharmacy benefit among high-cost users and to support ongoing appropriate, cost-effective use of Rx products among this population
4. Carve-in Rx benefit to MCO when bill equalizing rebates is enacted and effective, and when Federal match returns to "normal" level
5. Reduce ingredient cost payments to national average level if this change can occur while preserving pharmacy tax program
6. Implement MAC pricing, selective contracting and care management programs for various specialty medications
7. Strive to negotiate additional supplemental rebates

Summary of Short-Term Savings Estimates

Prioritized Item #	Cost Containment Measure	Estimated Year 1 Savings	State Share of Savings at Enhanced Match (75.16%)	State Share of Savings at Regular Match (63.595%)	Legislative Statute Change Required to Implement This Item?	Estimated FY2010 Net Savings (at best four months of savings is assumed)
1	Psychotropic Medication Review and Management	$27,186,973	$6,753,244	$9,897,418	Yes	$0
2	Lower Unenhanced Fill Fee to $4.20	$5,384,818	$1,337,589	$1,960,343	No	$445,863
3	Tailored Management of 3,000+ Selected Persons	$14,900,760	$3,701,349	$5,424,622	No	$370,135
4	Managed Care Carve-In (if/when DRE is enacted)	$2,877,015	$0	$1,829,638	Yes	$0
5	Lower Brand Ingredient Payment to WAC + 6.0%	$20,547,036	$5,103,884	$7,480,148	No	$1,701,295
6	Specialty Drug MAC Pricing	$9,125,000	$2,266,650	$3,321,956	Yes	$755,550
7	Pursue Additional Supplmental Rebates	$2,888,194	$717,427	$1,051,447	No	$239,142
	Total, All Above Measures	**$55,722,824**	**$13,126,899**	**$21,068,155**		**$7,477,088**

Table Notes:

1) Above net savings are contingent on pharmacies continuing to pay tax at current percentage levels.
2) FY2010 savings values assume measure is in effect for four months (beginning March 1, 2010).

Methodology

- On-Site interviews with pharmacy director and other key leaders and staff
- Review of Pharmacy Clinical Programs
  - Smart PA
  - Care Connections
  - Missouri Pharmacy PDL
  - Step Therapy for three key conditions
    - Anemia, Hepatitis C, Multiple Sclerosis
- Review of MO HealthNet documents
- Comparisons and benchmarking with other states where data were available
- Extensive pharmacy claims data analysis
  - Data presented is based on paid "fiscal" months and does not exactly align with calendar years (e.g., 2008 is from Dec. 16, 2007 to Dec. 15, 2008)
  - CY2008 was incomplete as our data were missing gross adjustments for the claims paid in July and August 2008. We estimated annual 2008 costs by taking 1Q, 2Q, and 4Q expenditures and dividing by 0.75
  - We estimated annual 2009 costs by dividing available data by 0.74

Pharmacy Provider Tax Considerations

- The enhanced fill fee draws in substantial Federal revenue at virtually no net state cost. Thus, measures that reduce the volume of prescriptions filled will yield lower State savings – and in some cases will cause higher net State costs – than would occur in absence of P-Tax program
- Also, decreases in reimbursement for dispensing fees and/or ingredient costs can trigger statutory provisions which cause the tax to expire.
  - The dispensing fee lower limit ($4.09) is $0.75 below the unenhanced fee ($4.84), leaving room for reductions without triggering elimination of the tax.
  - Current ingredient cost reimbursement, however, is approximately equivalent to the statutory minimum.
- Our cost savings estimates assume that the overall P-Tax program will continue even if statutory language is needed to preserve it.
  - P-Tax offsets are factored into our savings estimates where applicable
- Summary of P-Tax statutory provisions is provided in Appendix D.

STATISTICAL OVERVIEW & BACKGROUND

Gross and Net Rx Costs, CY2005 - CY2009

Year	Initial Cost	Federal Rebates	Supplemental Rebates	Total Rebates	Net Cost	Rebate Percent of Initial Cost
2005	$1,181,765,498	$300,670,131	$32,027,973	$332,698,103	$849,067,395	28.2%
2006	$625,375,623	$155,957,894	$17,723,352	$173,681,245	$451,694,378	27.8%
2007	$610,742,487	$177,455,499	$16,576,826	$194,032,325	$416,710,161	31.8%
2008	$671,510,628	$205,934,060	$20,758,394	$226,692,453	$444,818,175	33.8%
2009 Annualized	$732,077,358	$236,960,646	$22,630,692	$259,591,338	$472,486,020	35.5%

- All figures based on detailed claims data tabulations.
- Creation of Medicare Part D dramatically lowered MO HealthNet pharmacy costs beginning in 2006, as dual eligibles' pharmacy costs became primary responsibility of Medicare program.
- Gross costs rose at annual rate of 9.5% from '07–'09; net costs increased at a lower annual rate (6.5%) from '07-'09 due to increased rebates.

Nationwide PMPM Cost Comparison Suggests Cost Savings Opportunities May Exist

2008 PMPM Costs Across 31 States for Disabled Persons not Eligible for Medicare

	Pharmacy PMPM	Total PMPM, All Covered Services
Missouri	$374	$1,319
Aggregate Value Across 31 States	$265	$1,404
Median, 31 States	$270	$1,596
Missouri Rank (among 31 states; #1 rank is state with highest PMPM cost)	4	21

Data source: Lewin tabulations using CMS MSIS data

- Disabled, non-Medicare subgroup shown above represents 66% of Missouri's 2008 Medicaid pharmacy spending. Missouri's PMPM cost for this group is below those of most other states (ranking 21st out of 31), but Missouri's overall pharmacy PMPM cost is 4th highest
- Figures could indicate that pharmacy services are being used cost-effectively and liberally in lieu of costlier other services, but could also indicate that pharmacy costs are much higher than necessary
- Missouri's PMPM includes medications that are typically obtained within the medical benefit, which can distort "apples-to-apples" comparisons. However, only 8% of initial (pre-rebate) CY2008 claims costs were for a single day's supply; thus the distortion to the above PMPM comparison due to this issue is likely minor. Missouri's PMPM cost for this subgroup is still 25-30 percentage points above the comparison states' averages after lowering the observed Missouri PMPM by eight percentage points.

Missouri's 2007 Generic Fill Rate Ranked In Top Third of States; Has Since Risen Considerably

Neighboring State	Generic % Of 2007 Prescriptions	Rank
KY	69.6%	6
NE	69.4%	7
IL	68.6%	8
TN	67.6%	9
MO	66.0%	16
OK	62.1%	28
IA	60.8%	32
KS	60.2%	36
AK	58.8%	41
USA Total	**63.2%**	

- Missouri's generic fill rate rose to 71.3% during the first 9 months of 2009; recent State reports show this now to be 72-73%, with generics being used 98-99% of time when a generic product is available
- 48 states reported data; only two as of 2007 -- New Mexico (71.8%) and Massachusetts (71.5%) -- had a higher generic fill rate than Missouri's 2009 YTD
- Arizona did not report data, but its program- wide generic fill rate was already higher as of 2002 (72.0%); all of Arizona's scripts occur through capitated MCOs

Generic Share of Program-Wide Prescription Volume and Costs Has Increased Each Year Since 2005

Year	Generic Percent of Scripts	Generic Percent of Initial Cost	Generic Percent of Net Cost
2005	55.5%	21.7%	28.7%
2006	60.6%	22.4%	29.5%
2007	64.0%	21.9%	29.8%
2008	67.6%	22.8%	31.7%
2009 Annualized	71.3%	24.9%	34.7%

ASSESSMENT OF PROTECTED THERAPEUTIC CLASSES

"Unprotecting" Psychotropic Drugs Will Enable State to Better Balance Access and Cost Efficiency Needs

- State statute currently protects access to psychotropic medications from being reviewed/managed in same manner as other medications.
- Synopsis of Statute (Section 208.227):
  - The medication must be prescribed to people diagnosed with mental illness or another illness for which treatment with psychotropic medication is indicated.
  - The medication must be approved by the federal Food and Drug Administration and must be a recognized treatment.
  - As the Section is written, MO HealthNet cannot impose restrictions that "preclude availability" of any "atypical antipsychotic monotherapy" for the treatment of schizophrenia, bipolar disorder, or "psychoses associated with severe depression."
- Ideal policies promote a balance between providing access to appropriate services but avoiding excessive and unnecessary services.
- Protective statutes work against achieving such a balance – they successfully promote access but deprive the State of a means of avoiding and discouraging overuse and potentially inappropriate use.

Overview of Psychotropic Dynamics

- Psychotropics are used to treat schizophrenia, bipolar disorder, mania and psychotic agitation, and depression.
- This is an expensive class of medications which is a major driver in the overall MO HealthNet drug spend.
- As new medications are approved, physicians quickly prescribe these high-cost psychotropics.
- Psychotropic cost management processes are well-documented in states that do not have statutory barriers. A listing of website links is provided in Appendix B.

22,000 Persons Received at Least Four Different Psychotropics During 2008

High Unit Cost and Potential Overuse of Many of these Drugs Amplifies State's Savings Opportunity

ALL PERSONS	Total Number of Participants	Total Amount Paid *	Total Number of Prescriptions	Average Cost Per Prescription *
1	51,245	$18,121,328	224,113	$81
2 - 3	41,072	$60,896,056	444,221	$137
4 - 5	15,220	$52,516,306	330,281	$159
6 +	6,883	$40,583,796	238,637	$170
Total	114,420	$172,117,485	1,237,252	$139

CHILDREN	Total Number of Participants	Total Amount Paid *	Total Number of Prescriptions	Average Cost Per Prescription *
1	13,051	$6,240,788	47,745	$131
2 - 3	10,754	$15,928,208	102,028	$156
4 - 5	3,606	$11,910,067	70,762	$168
6 +	1,343	$7,124,311	40,881	$174
Total	28,754	$41,203,374	261,416	$158

ADULTS	Total Number of Participants	Total Amount Paid *	Total Number of Prescriptions	Average Cost Per Prescription *
1	38,194	$11,880,540	176,368	$67
2 - 3	30,318	$44,967,848	342,193	$131
4 - 5	11,614	$40,606,240	259,519	$156
6 +	5,540	$33,459,485	197,756	$169
Total	85,666	$130,914,111	975,836	$134

* All dollar costs shown are pre-rebate.

Therapeutic classes included in above table are delineated in Appendix E

89% of 2008 costs for psychotropics were for persons receiving at least two different medications.

54% of 2008 costs were attributable to persons on four or more different psychotropic medications.

Costs shown are understated by 10% - 15% due to missing 2008 data.

MO HealthNet Has Developed a Detailed, Thoughtful Approach to Improving Management of Psychotropics

- Incorporation of Evidence Based Medicine (EBM) recommendations
- Consistent with medication management for other therapy classes
- Patient safety is key concern with avoidance of potentially dangerous drug interactions, grandfathering provisions to minimize disruption of existing therapeutic regimens, etc.
- Approach emphasizes assessing unapproved and potentially inappropriate utilization
- Supported by Missouri Department of Mental Health
- MO HealthNet staff have catalogued other states' psychotropic care and cost management approaches
- MO HealthNet staff project no savings during FY2010 due to ramp-up time needed for this initiative. Savings of $27.2 million were projected (in gross Medicaid funds) for FY2011, with higher savings projected for subsequent years.

UNIT PRICE ASSESSMENT

Missouri's Ingredient Payment to Pharmacies Are Among Highest In Nation

- Missouri's ingredient payment is WAC plus 10%
  - On an AWP equivalent (i.e., AWP minus 11%), this ranks 36th of 45 states with available data (top ranking depicts lowest payment level)
  - Missouri has highest ingredient cost among 15 selected states with large urban markets
  - Missouri has highest ingredient cost among seven of its adjacent states (Tennessee data are not available)
  - National average (unweighted mean) is estimated at WAC plus 6%
    - equivalent to AWP minus 13.2%
  - Average payment across Missouri's seven adjacent states is also estimated at WAC plus 6% (straight average)

Missouri's Dispensing Fees Are Among The Nation's Highest

- Missouri's dispensing fee of $9.66 due to tax program is nation's highest by more than $2.00. Missouri's net fill fee varies by pharmacy due to the tax program but averages below $5.00.
- National average is $4.30 (straight average across reporting states).
- Straight average across seven neighboring states is $4.20.
- Missouri's unenhanced dispensing fee ($4.84) is still 10th highest among 45 states with available data, and above all neighboring states except Arkansas.
- Most states with fill fee above $4.84 also have special federal match programs in place.

Reducing Dispensing Fees

- Each $0.10 reduction in the dispensing fee will yield annual savings of $0.84 million (all Medicaid funds).
- Reducing unenhanced dispensing fee from $4.84 to $4.20, approximately the average of the neighboring states, will yield approximately $5.4 million in gross annual savings (all Medicaid funds).
- This figure equates to $1.3 million in state fund savings during CY2010 at the enhanced FY10 federal match rate (75.16%), and $1.9 million in state savings at the “regular” match rate (64.51%).

Net Savings Based on Dispensing Fee Reductions

Estimated 2010 Savings

	# of claims	$0.10 decrease	$0.20 decrease	$0.40 decrease	$0.64 decrease
Gross Medicaid Savings	8,413,778	$841,378	$1,682,756	$3,365,511	$5,384,818
State Share using Regular FFY10 FMAP of 64.51%	8,413,778	$298,605	$597,210	$1,194,420	$1,911,072
State Share using Enhanced FFY10 FMAP of 75.16%	8,413,778	$208,998	$417,996	$835,993	$1,337,589

- These savings assume the P-tax percentage payment remains unchanged.
- Annualized 2009 costs were trended at 2.5% to estimate 2010 levels.
- Only prescriptions with either $9.66 dispensing fee on the claim were included.
- The number of scripts was multiplied by the reduction amount (e.g., $0.10) to estimate the savings.
- As the savings would reduce total pharmacy revenues, the gross savings would be offset at least 1.2% due to a decrease in P-tax revenue collected.

Reducing Ingredient Costs: Brand Drugs

- For drugs paid based on WAC, each additional percentage point reduction yields annual savings of approximately $5.1 million (in total Medicaid funds)
- Moving from WAC plus 10% to the national and regional mean of WAC plus 6% would yield annual savings of $20.5 million (in total Medicaid funds). This figure equates to $5.1 million in state fund savings during CY2010 at the enhanced FY10 federal match rate (75.16%), and $7.3 million in state savings at the "regular" match rate (64.51%)
- P-Tax program is jeopardized by any reduction in ingredient costs
  - Reductions in ingredient costs will likely trigger expiration of the tax. Statutory changes are therefore needed in order for this cost containment option to create net State savings

Net Savings Based on Reductions to WAC Reimbursement Methodology

Estimated 2010 Savings

		Gross Savings from Change in Reimbursement			
	Est. 2010 Total Ingredient Cost (WAC + 10%)	**WAC + 9%**	**WAC + 8%**	**WAC + 7%**	**WAC + 6%**
Gross Medicaid Savings	$565,043,484	$5,136,759	$10,273,518	$15,410,277	$20,547,036
State Share using Regular FFY10 FMAP of 64.51%	$200,533,932	$1,823,036	$3,646,071	$5,469,107	$7,292,143
State Share using Enhanced FFY10 FMAP of 75.16%	$140,356,801	$1,275,971	$2,551,942	$3,827,913	$5,103,884

- These savings assume the P-tax percentage payment remains unchanged.
- Annualized 2009 costs were trended at 5% to estimate 2010 levels.
- Drugs reimbursed using MAC (allowed charge source code = 2 or 3) were not included.
- Each 1% decrease from WAC plus 10% equates to approximately 0.9% savings on ingredient cost.
- As the savings would reduce total pharmacy revenues, the gross savings would be offset at least 1.2% due to a decrease in P-tax revenue collected.

Pursue Additional Supplemental Rebates, But With Some Caution

- There may be opportunities to negotiate additional supplemental rebates.
- Ohio, for example, obtains considerably larger supplemental rebates than Missouri as a percentage of overall initial claims costs (roughly 4% in 2007 in Ohio versus 2.7% in Missouri).
- However, rebates on brand drugs often come with costly "strings" regarding assured usage of relatively high-cost products. For example, Ohio has a lower generic fill rate than Missouri and a similar average net cost per prescription after adjusting for the dispensing fee differential caused by Missouri's pharmacy tax program.
- Our savings estimate assumes that an additional supplemental rebate of 0.5% off the initial paid amount can be attained on brand medications.

ASSESSMENT OF HIGH-VOLUME USERS OF PHARMACY SERVICES

Several Thousand Participants Are Using A Wide Array of Very Different Medications

- During 2008, more than 7,000 participants received medications in 21 or more therapeutic classes (using First Data Bank standard classes).
  - These participants averaged more than 140* prescriptions, 45 different drugs (counting NDC codes), over $10,000 in pharmacy expenditures (pre-rebate), nine prescribing physicians, and filled the prescriptions at an average of four pharmacies. Spending across these persons represented 15 percent of all MO HealthNet pharmacy costs.
- It is difficult to imagine that such a large number of participants is clinically better off taking this many different medications. There are grounds for some skepticism that this many participants are even taking this many different medications.

* As noted on previous slide, roughly 6% of these prescriptions are for a single day supply.

Many Beneficiaries Fill a Large Number of Prescriptions In The Same Month

- In a typical month, approximately 4,000 children and 35,000 adults received more than five prescriptions
- Approximately 15,000 persons received more than 10 prescriptions in each month assessed, including approximately 2,000 persons who received more than 20 prescriptions in each month
- Figures for adults are shown below for three recent "one month snapshots"

Adult, December 2008

# of Scripts Filled	Number of Adults	Total # of Scripts
1 - 5	102,724	221,399
6 - 10	20,590	156,046
11 - 20	10,788	150,910
20 +	2,095	56,594
TOTAL	136,197	584,949

Adult, March 2009

# of Scripts Filled	Number of Adults	Total # of Scripts
1 - 5	97,872	214,586
6 - 10	23,595	180,445
11 - 20	12,655	175,534
20 +	1,711	45,621
TOTAL	135,833	616,186

Adult, June 2009

# of Scripts Filled	Number of Adults	Total # of Scripts
1 - 5	97,275	211,972
6 - 10	23,320	178,056
11 - 20	12,047	166,748
20 +	1,597	42,851
TOTAL	134,239	599,627

Notes: Above figures include J Code items and other medications that are often not counted as "prescriptions" in other health benefits settings. However, only 6% of highest users' prescriptions were for a single day supply which suggests that this issue is not a major driver in the number of persons accessing a very large number of monthly prescriptions.

Costliest Beneficiaries Are Getting Much Costlier

Time Period	1,000 Costliest Persons	10 Costliest Persons	Costliest Individual Person
CY2005	$58,990,607	$6,579,689	$1,395,713
CY2006	$56,249,374	$6,547,913	$1,297,471
CY2007	$62,747,466	$8,052,296	$1,582,630
CY2008	$68,233,349	$11,609,120	$3,422,294
CY2009 (estimated)	$85,365,931	$14,742,535	$4,200,000
Share of Total 2009 Rx Costs	11.8%	2.0%	0.6%

Costliest 1,000 persons expected to account for 11.8% of CY2009 Rx claims costs, up from 5.0% in CY2005 and 10.3% in CY2007.

Hemophilia medications account for most of the extremely costly persons, including 63 of the 100 costliest cases thus far during 2009. Annual pre-rebate Rx costs for costliest MO HealthNet beneficiary are now exceeding $4 million.

Costliest Rx Users Tend to Have Coverage Continuity, Ongoing High Costs

- Among 1,000 costliest Rx persons in 2009, 44% were also among 1,000 costliest persons during 2008.
- Among 100 costliest persons in 2009, 51 were among the top 1,000 *each year* from 2005-2008.
- If savings are achievable for persons exhibiting extremely high Rx costs, the savings will often compound favorably into future time periods.

Many Persons Are High Volume Users On Every Criteria We Assessed

- During 2008, 3,399 persons reached all of the following six usage thresholds:
  1. $5,000 or more in Rx claims (pre-rebate)
  2. 80 or more prescriptions
  3. 25 or more different NDCs
  4. 15 or more different Standard Therapeutic Classes
  5. 8 or more prescribers
  6. 4 or more different pharmacies used
- Total pharmacy claims costs for these beneficiaries (pre-rebate) were $51.1 million, an average of more than $15,000 per person
  - These individuals accounted for 8% of total pharmacy spending.
- A net 25% reduction in these person's costs would create total Medicaid savings of $17.9 million and state fund savings of $6.4 million

Identifying Best Action Steps For These High-Cost, High-Using Persons Is Challenging

- While it seems inevitable that medication costs can be substantially lowered for a sizable number of the persons without clinical harm occurring (and in many cases with clinical improvement occurring), many of these persons have complex needs that are likely being treated responsibly with their existing mix of medications
- Imposing new requirements on physician community (e.g., requiring them to use Smart PA once their patient exhibits certain pharmacy usage characteristics) could lead some to reduce their involvement in MO HealthNet
- New requirements that evoke extensive new interaction with MO HealthNet (e.g., a monthly prescription limit with over-ride exception options) may require new hiring

Care Coordination Focused on "Whole Person" is Important to Consider for High-Volume Rx Users

- Persons who are high-cost pharmacy users due to severe and/or multiple health conditions are often also high-cost persons across entire MO HealthNet benefits package
- Cost savings initiatives for this population therefore should not be considered only in a "pharmacy silo"
- Lewin deliverables later in this engagement will consider savings (pharmacy and medical) associated with broader care coordination initiatives, such as primary care case management, comprehensive case management, disease management, and full-risk capitation
- Approaches offered on ensuing pages are limited to the pharmacy arena, which is the focus of this initial project deliverable

Immediate Suggestions To Intervene And Interact With The High-User Subgroup

- Our short-term recommendation: provide tailored outreach to selected beneficiaries (e.g., those persons meeting all six criteria shown on Slide 30 during 2008 and/or 2009 to date)
  - Outreach could be performed by an expansion of the existing MO HealthNet Clinical Management Team and its work effort, by an external contractor (possibly APS through a modification of the CCIP program), or by pharmacies under enhancements to existing Medication Therapy Management program
  - Specific scope of work needs to be defined: all targeted patients will receive a comprehensive medication review; interventions will then be tailored based on findings of that review; all intervention activities would be logged so that efficacy of each approach can be tracked; etc
  - State's technology (e.g., Smart PA) can be utilized to create several algorithm-based clinical criteria targeted at potential excess Rx users
  - Substantial share of any external contractor's revenue for this work would be contingent on level of savings achieved
  - MO HealthNet can commission independent survey of these individuals (and possibly their primary prescribers) to discern their satisfaction with the interventions that have occurred
- Based on findings from these initial efforts, adjust and/or broaden the initiative to maximize its effectiveness

Summary of Suggested Approach for High-Cost Persons

- Year 1: Intervene with high-volume users
  - Targeted patients identified by MO HealthNet for intervention by either an expanded role for the State's Clinical Management Team, expansion of the Medication Therapy Management program, or through an external contractor
  - Program will focus on improving patients' medication regimens, and on eliminating unnecessary and duplicate therapies
  - Objectives will be to achieve cost savings and improved safety for patient

- Closely evaluate the programs upon implementation, taking advantage of the "immediacy" of pharmacy claims data and the fact that the target population's monthly pharmacy costs without intervention will be highly predictable
  - While level of achievable savings is difficult to predict in advance, the level of savings actually being achieved once program is implemented should be discernible
  - Modify and/or broaden the initiative as appropriate to maximize its longer-term effectiveness

PHARMACY CARVE-IN AND CARVE-OUT OPTIONS

Pharmacy Carve-Out/Carve-In Dynamics

- All indications are that Drug Rebate Equalization (DRE) provisions will be included in any federal health reform bill that is enacted.
- Lewin has estimated that annual savings of up to 15% will occur if Drug Rebate Act is enacted, in situations where carve-out states switch to a carve-in approach.
- However, pharmacy tax program would remove several million prescriptions from the enhanced fill fee setting that is drawing down additional Federal matching funds. The lost Federal match on the enhanced fill fees will offset some, but not all of the savings.
- In Missouri, we estimate that annual net state fund savings of the carve-in will be $0.3 million to $3.4 million per year for current capitated covered lives, at regular Federal match rates (after accounting for P-Tax program-related offsets).
- Savings are created by lower usage of medications and lower-cost mix of medications when MCOs are at full risk (rather than no risk) for Rx costs, and by lower dispensing fees and initial ingredient cost payments in MCO setting.
- If DRE and/or a Missouri carve-in is not enacted, there may be ways to strengthen the savings that occur under the carve-out approach (e.g., MCO bonus/penalty clauses tied to effectiveness of medication management).

Comparison of Advantages: Carve-In and Carve-Out Options

Carve-Out Advantages	Carve-In Advantages
Access full federal and supplemental rebates	Lower volume of medications likely to occur
Single PDL for Medicaid easier for physicians who participate in multiple MCOs	Less costly mix of medications likely to occur
Carve-out substantially increases fill fees and Federal match on the enhanced fill fees.	"Private" PDLs not nearly as much of a target for lobbying and protections (as public PDL)
Rapidly available program-wide Rx data base with claims paid in single MMIS	Best supports integrated care model operationally
Carve-out does not require changing current policy	Aligns financial incentives to focus on each person's overall costs
	Considerably lower average fill fees
	Members need just one card to access all covered services

Pharmacy Carve-In: Fiscal Impact Estimate

	Carve-In (Conservative Estimate)	Carve-In (Favorable Estimate)	Carve-Out	Comments
Annual Prescriptions for MCO Enrollees	2,850,000	2,760,000	3,000,000	5%- 8% lower in carve-in
Fill Fee Per Script	$3.00	$2.50	$9.66	$2.50 - $3.00 estimated for MCOs
Ingredient Cost Per Script (pre-rebate)	$58.28	$56.44	$61.35	5% - 8% lower in carve-in
Total Cost Per Script	$61.28	$58.94	$71.01	
Total Paid to Pharmacy	$174,655,125	$162,679,920	$213,030,000	
Less Rebates	$58,136,794	$54,522,972	$68,160,000	35% - 37% rebate on ingredient cost assumed
Net Medicaid Cost for Rx	$116,518,331	$108,156,948	$144,870,000	
Net Medicaid Cost Including MCO Risk Margin	$118,848,698	$110,320,087	$144,870,000	2% MCO margin assumed; no admin difference
State Funds Cost at Regular Federal Match (63.595%)	$43,266,868	$40,162,028	$52,739,924	
State Funds Cost at Enhanced Match (75.16%)	$29,522,017	$27,403,510	$35,985,708	
Initial Total Medicaid Savings of Carve-In Model	$26,021,302	$34,549,913		
Initial State Fund Savings at Regular Match (63.595%)	$9,473,055	$12,577,896		
Initial State Fund Savings at Enhanced Match (75.16%)	$6,463,691	$8,582,198		
Federal Match and P-Tax Dynamics				
Enhanced Fill Fee Revenue	$0	$0	$14,460,000	$4.82 x 3,000,000 scripts
Federal Match on Enhanced Fill Fee Revenue (at 63.595% match)	$0	$0	$9,195,837	
Federal Match on Enhanced Fill Fee Revenue (at 75.16% match)	$0	$0	$10,868,136	
Net State Funds Savings (Loss) at 63.595% Fed Match	**$277,218**	**$3,382,059**		
Net State Funds Savings (Loss) at 75.16% Fed Match	**($4,404,445)**	**($2,285,938)**		

Note that savings will not accrue in a given year unless: 1) the DRE bill is enacted; 2) pharmacy benefits are carved in; and 3) the bill's equalized rebate provisions are in effect.

Note that carve-in savings require that MCO capitation rates reflect the net costs of the MCOs' effective benefits management efforts.

PDL CONTENT AND PRIOR AUTHORIZATION PROCESS ASSESSMENT

PDL Comparison to Other States

- Compared Missouri to 12 other states
  - AR, CO, IL, IA, KS, KY, LA, MN, OH, TN, TX, WA
- Focused on 5 high-cost, high-volume classes
  - Statins
  - PPIs
  - Asthma (Inhaled Corticosteroids)
  - Atypical antipsychotics
  - 2nd generation antidepressants (SSRI, SNRI, etc.)

Lipidtropics (Statins)

- Missouri has better than average control compared to the other states
- Missouri is one of only two states (Arkansas is the other) to have limitations on both Crestor and Lipitor
- Only one other state, Louisiana, has Altoprev as a preferred drug

Proton Pump Inhibitors

- Missouri has one of the tightest PDLs compared to the comparison group
- Missouri is only state to have only the OTCs as preferred drugs
- Tennessee has a class step therapy limitation on PPIs (Nexium and omeprazole are preferred)

Inhaled Corticosteroids

- Missouri covers more products (10) on the PDL than the average of the comparison states (8)
- Missouri has Aerobid as preferred, whereas 7 of the 12 states have it as non-preferred
- Every state in the comparison group covers at least one form of Advair and/or Flovent, the top two drugs prescribed in Missouri

Atypical Antipsychotics

- Due to statute, Missouri does not have any limitations on atypical antipsychotics
- Three of the 12 comparison states (AR, CO, KS) do not have this class of drugs on the PDL
- Five states have Invega as non-preferred and three states have Zyprexa as non-preferred

2nd Generation Antidepressants

- Due to statute, Missouri does not have any limitations on atypical antidepressants
- Two of the 12 states (CO & KS) in the comparison group do not have this class of drugs on the PDL
- The majority of states in the comparison group do not have Pristiq, Luvox CR, Pexeva, Aplenzin, or Prozac Weekly on the PDL
- Cymbalta, Missouri's highest drug spend antidepressant, is not covered on the PDL in 6 of the 10 states
- Effexor XR, the 2nd highest spend antidepressant, is covered in 8 of the 10 states

Prior Authorization Process Assessment

- MO HealthNet provides comprehensive support documentation for clinical drug edits
  - MO HealthNet web site provides a comprehensive listing of medications and therapy classes with PA edits.
  - The listing is comparable to other Medicaid programs.
  - Smart PA program is an innovative program utilizing medical and pharmacy claims.
- Evidence Based Medication Management (EBM) rules are utilized and can be expanded in ongoing PA process
  - MO HealthNet edits require specific laboratory data for continued use of:
    - Hematintics, statins
    - Measurement of serum Creatinine for those on biguanide containing medications
- 15 day limitation for beneficiaries placed on new drug could decrease drug compliance in some instances

SPECIALTY PHARMACY ASSESSMENT

Specialty Pharmacy Dynamics

- Our analyses define "specialty pharmacy" as those NDC codes with average pre-rebate costs above $500 per 30 days supply
- MO HealthNet covers a full pipeline of drugs (roughly 1,200) and new indications are expanding utilization
- Medication adherence and compliance directly affect clinical outcomes and costs
- Channel management challenges -- getting the product to the patient in a safe and timely fashion with proper dosing -- are unique for many of these medications
  - Delivery and administration of these drugs have more variability that can result in waste
- Clinical Management Programs consist of Prior Authorization and Drug Quantity Management

Specialty Pharmacy Dynamics (continued)

- Medicaid payers do not manage therapeutic classes intensely, resulting in higher costs than are necessary.
- Specialty pharmacy manufacturers have made Medicaid programs a target for sales, which provides pricing leverage to MO HealthNet.
- Managed Medicaid payers focus on care management and often contract with small specialty pharmacy management organizations and networks.

Specialty Pharmacy Products Have Sharply Rising Costs (Now Represent 30% of Net Rx Costs)

Costs for Specialty Pharmacy: NDC Codes With Average Pre-Rebate Expense Above $500 Per 30 Days Supply

Year	Amount Paid, Pre-Rebate	Percent of Total Initial Costs	Average Percent Rebate	Net Cost	Percent of Total Net Costs
2007	$156,434,415	25.6%	32.9%	$104,985,325	25.2%
2008	$185,124,559	27.6%	34.1%	$122,015,603	27.4%
2009	$218,151,593	29.8%	35.1%	$141,602,206	30.0%

- Only 1.8% of CY2009 year-to-date prescription volume (defined as days supply) had an average monthly cost above $500
- However, these prescriptions represented 30.0% of CY2009 post-rebate claims costs, versus 25.2% of costs during CY2007
- We estimate that total post-rebate pharmacy spending will increase approximately $56 million from 2007-2009
  - Two-thirds of this increase ($37 million) is due to increased spending on drugs (NDCs) with an average monthly cost above $500

MO HealthNet is Implementing an Array of Initiatives to Achieve Short-Term Cost Savings in Specialty Pharmacy Area

Project Timeline

Project	Implementation	Status	Projected Annual Savings
Specialty MAC Pricing	6/24/09	On-going	$7-10 million
Waste Management	4th Quarter '09		$1 million
Dose Optimization	November '09		$125,000
Lab Edit	Pending		$1 million

- Largest-scale short-term financial savings opportunity involves implementing specialty MAC pricing for more than 1,200 new medications
- A recent Mercer report (April 2009) estimates that a $6-7 million Year 1 savings could be achieved by implementing specific discounts for single-source brand specialty products
- MO HealthNet staff estimate that savings will increase to $10 million in Year 2

Several Additional Specialty Pharmacy Management Strategies Could Yield Substantial Longer-Range Savings

- Consider selective contracting with specialty management organization(s) in targeted areas where demonstrated expertise exists to access lower average unit costs and improve channel management
  - Different disease states may require different approaches (e.g., chemotherapy versus hemophilia)
  - Selective contracting initiatives in specialty pharmacy arena will require statutory changes to existing any willing provider provisions
  - Will likely also require a waiver of freedom of choice requirements
  - State's existing approach ensures broadest possible provider base, which maximizes access but limits cost containment options
- Identify the magnitude of waste and, if indicated, design a drug distribution strategy to decrease waste for unused drugs
  - Require patient confirmation of drug delivery and/or administration of drugs included in the prior authorization

Several Additional Specialty Pharmacy Management Strategies Could Yield Substantial Longer-Range Savings (continued)

- Member and physician education and monitoring to:
  - Review appropriate dosing schedules
  - Manage side effects and identify barriers to compliance
  - Promote proper storage and use of specialty medications
- Conduct medication adherence and persistence assessment to measure the impact of the overall costs
  - Open discussions with biopharmaceutical company to fund this study via a clinical management program discount, incremental to rebate
- Four classes of specialty drugs (Interferons, Erythropoietin, Growth Hormone, Insulin), have had key patent expirations opening the door for biogeneric savings opportunities. This is a longer term savings opportunity as new federal legislation will need to be enacted to allow the approval of biogenerics

Appendix A: Overview Cost and Usage Information

Brand Drug Spending Overview

Year	Initial Cost	Federal Rebates	Supplemental Rebates	Total Rebates	Net Cost	Rebate Percent of Initial Cost
2005	$925,043,378	$289,253,753	$30,438,514	$319,692,267	$605,351,110	34.6%
2006	$485,423,174	$151,139,057	$15,690,427	$166,829,485	$318,593,689	34.4%
2007	$477,212,501	$172,034,956	$12,529,057	$184,564,013	$292,648,488	38.7%
2008	$518,567,232	$198,987,879	$15,888,632	$214,876,511	$303,690,721	41.4%
2009 Annualized	$550,132,270	$224,701,171	$16,855,769	$241,556,940	$308,575,330	43.9%

- Net costs for brand drugs have increased modestly from 2007-2009 (average annual rate of 2.7%) due to increased rebates and greater use of generic medications.
- Brand medications as a percentage of net MO Health Net Rx costs decreased from 70.2% in 2007 to 65.3% in 2009.
- The average net cost per brand prescription increased from $89.16 in 2007 to $104.14 in 2009, an average annual increase of 8.1%.

Generic Spending Overview

Year	Initial Cost	Federal Rebates	Supplemental Rebates	Total Rebates	Net Cost	Rebate Percent of Initial Cost
2005	$256,722,120	$11,416,377	$1,589,459	$13,005,836	$243,716,284	5.1%
2006	$139,952,449	$4,818,836	$2,032,924	$6,851,761	$133,100,689	4.9%
2007	$133,529,986	$5,420,543	$4,047,769	$9,468,312	$124,061,673	7.1%
2008	$152,943,397	$6,946,181	$4,869,761	$11,815,942	$141,127,454	7.7%
2009 Annualized	$181,945,088	$12,259,475	$5,774,923	$18, 034,398	$163,910,690	9.9%

- Net costs for generic drugs have increased rapidly from 2007-2009 (average annual rate of 14.9%), reaching approx. $160 million in ‘09.
- Generic prescription volume increased at an average annual rate of 12.2% from 2007 – 2009. The average net (post-rebate) unit cost for generic medications increased 2.4% annually during this timeframe.

Unit Cost Distribution of MO Health Net Prescriptions

	% of Prescriptions			% of Gross Costs			% of Net Costs		
Initial (Pre-Rebate) Claim Cost	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**	**2007**	**2008**	**2009**
$0 - 9	10.0%	5.9%	6.0%	1.4%	0.7%	0.8%	2.0%	1.1%	1.0%
$10 - $24	47.8%	54.6%	56.4%	9.9%	10.9%	10.9%	14.2%	16.1%	14.0%
$25 - $49	11.5%	11.2%	9.7%	6.1%	5.6%	4.7%	8.1%	7.6%	5.8%
$50 - $99	10.5%	8.1%	7.3%	11.7%	8.7%	7.2%	11.2%	8.5%	7.5%
$100 - $249	15.9%	15.5%	16.1%	34.4%	33.4%	34.1%	29.9%	28.4%	31.6%
$250 - $499	3.1%	3.6%	3.3%	15.6%	17.5%	16.7%	14.4%	15.8%	15.5%
$500 - $999	0.7%	0.8%	0.9%	6.8%	8.1%	9.0%	6.4%	7.3%	8.5%
$1,000 +	0.4%	0.4%	0.4%	14.2%	15.1%	16.7%	13.9%	15.2%	16.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Subtotal, Claims above $500	1.1%	1.2%	1.3%	21.0%	23.2%	25.6%	20.3%	22.5%	24.7%
Subtotal, Claims above $100	20.1%	20.3%	20.6%	70.9%	74.1%	76.5%	64.6%	66.7%	71.7%

- Vast majority of prescriptions (roughly 80%) cost less than $100
- However, prescriptions costing above $100 account for the majority of program spending: 77% of pre-rebate costs and 72% of post-rebate costs during 2009
  - These percentages have increased sharply since 2007.

Rx Spending Level Distribution Shows More Than 10,000 Persons Generate More Than $10,000 In Pre-Rebate Pharmacy Costs

Cost Range	Number of Rx Users, 2008	Share of Rx Users, 2008	Number of Rx Users, 2009	Share of Rx Users, 2009
< $100	180,529	38.62%	182,885	40.29%
$100 - $499.99	153,318	32.80%	143,268	31.56%
$500 - $999.99	39,955	8.55%	37,461	8.25%
$1,000 - $4,999.99	63,075	13.49%	62,185	13.70%
$5,000 - $9,999.99	18,947	4.05%	17,844	3.93%
$10,000 - $49,999.99	11,303	2.42%	9,988	2.20%
$50,000 or More	369	0.08%	305	0.07%
Total Rx Users	**467,496**		**453,936**	

- All figures are pre-rebate
- Both 2008 and 2009 are incomplete data years; 2008 is approximately 87% complete; 2009 data is estimated to be 74% of full-year total based on date claims tape was submitted to Lewin

Distribution by # of Scripts Shows More Than 15,000 Beneficiaries Fill at Least 100 Prescriptions Per Year

Number of Prescriptions	Number of Rx Users, 2008	Share of Rx Users, 2008	Total Scripts, 2008	Share of Scripts, 2008
1	71,585	15.3%	71,585	0.9%
2	54,517	11.7%	109,034	1.3%
3 - 5	93,410	20.0%	358,350	4.3%
6 - 10	78,237	16.7%	608,396	7.3%
11 - 25	84,813	18.1%	1,380,800	16.7%
26 - 50	41,232	8.8%	1,477,895	17.8%
51 - 100	28,099	6.0%	1,997,041	24.1%
101+	15,604	3.3%	2,277,391	27.5%
Total Users	467,497	100.0%	8,280,492	100.0%

- Both 2008 and 2009 are incomplete data years; 2008 is approximately 87% complete; 2009 data is approximately 74% of estimated full year total
- Usage includes pharmacy-related medical claims (e.g., diagnostic test strips and many other "J-code" items) that have been moved to the pharmacy category in recent years
- Among persons with 101+ prescriptions in 2009, 6.7% of their prescriptions were for a single day's supply

Distribution by Therapeutic Classes Accessed Shows More Than 7,000 Persons Accessed Meds in at Least 21 Different Classes During 2008

Number of Therapeutic Classes	Number of Rx Users, 2008	Share of Rx Users, 2008	Number of Rx Users, 2009	Share of Rx Users, 2009
1	110,385	23.6%	110,993	24.5%
2	83,738	17.9%	82,142	18.1%
3 - 5	137,283	29.4%	133,933	29.5%
6 - 10	83,744	17.9%	80,501	17.7%
11 - 20	41,228	8.8%	41,228	9.1%
21 +	7,058	1.5%	5,028	1.1%
Total Users	**467,310**	**100.0%**	**453,825**	**100.0%**

- Standard therapeutic classes are used, of which there are 97 class categories.
- Data years 2008 and 2009 are incomplete as indicated on previous slides.

Distribution of Rx Users by Number of Physician Prescribers

Number of Different Prescribers	Number of Rx Users, 2008	Share of Rx Users, 2008	Number of Rx Users, 2009	Share of Rx Users, 2009
1	196,867	42.1%	196,211	43.2%
2	107,800	23.1%	105,851	23.3%
3 - 5	119,586	25.6%	114,142	25.2%
6 - 10	36,166	7.7%	31,989	7.0%
11 - 20	6,481	1.4%	5,279	1.2%
21 +	131	0.0%	353	0.1%
Total Users	**467,310**	**100.0%**	**453,814**	**100.0%**

- Data years 2008 and 2009 are incomplete as indicated on previous slides

Distribution of Rx Users by Number of Different Pharmacies Used

Number of Different Pharmacies	Number of Rx Users, 2008	Share of Rx Users, 2008	Number of Rx Users, 2009	Share of Rx Users, 2009
1	278,346	59.6%	276,766	61.0%
2	109,963	23.5%	106,153	23.4%
3 - 5	71,437	15.3%	64,578	14.2%
6 - 10	7,206	1.5%	6,018	1.3%
11 - 20	349	0.1%	306	0.1%
21 +	9	0.0%	4	0.0%
Total Users	**467,310**	**100.0%**	**453,825**	**100.0%**

- Data years 2008 and 2009 are incomplete as indicated on previous slides.

Therapeutic Class Overview

Rank	Standard Class	2009 Pre-Rebate	2008 Rebate Percent	2009 Estimated Net Costs	2009 Estimated Claims	2009 Generic Percent of Claims	% Increase in Claims, 2007-2009	Estimated % Increase in Net Costs, 2007-2009	Average Net Cost Per Prescription, 2007	Average Net Cost Per Prescription, 2009
1	ATARACTICS-TRANQUILIZERS	$88,534,062	31.3%	$59,305,323	839,388	73.8%	12.2%	6.0%	$74.78	$70.65
2	PSYCHOSTIMULANTS-ANTIDEPRESSANTS	$72,849,443	27.6%	$51,417,379	804,747	66.0%	12.5%	19.7%	$60.07	$63.89
3	BRONCHIAL DILATORS	$47,764,048	42.1%	$26,956,196	475,001	40.7%	9.9%	14.6%	$54.46	$56.75
4	ANTICONVULSANTS	$45,235,833	42.4%	$25,394,854	573,376	80.4%	16.5%	-11.6%	$58.36	$44.29
5	ANTIVIRALS	$37,847,373	31.3%	$25,324,870	61,385	21.1%	9.6%	33.7%	$338.08	$412.56
6	NARCOTIC ANALGESICS	$37,785,538	40.7%	$21,823,026	744,500	90.5%	23.3%	14.9%	$31.44	$29.31
7	ANTINEOPLASTICS	$23,834,455	38.7%	$14,243,031	35,046	35.1%	24.8%	38.6%	$366.03	$406.41
8	DIABETIC THERAPY	$29,326,510	54.2%	$13,090,856	305,226	49.8%	9.3%	6.9%	$43.84	$42.89
9	LIPOTROPICS	$18,636,666	46.1%	$9,783,207	234,995	37.8%	3.6%	-8.5%	$47.14	$41.63
10	ANTIARTHRITICS	$12,375,637	27.0%	$8,801,811	243,640	85.0%	8.1%	18.2%	$33.05	$36.13
11	HEMATINICS & BLOOD CELL STIMULATORS	$12,507,711	27.9%	$8,784,960	124,674	48.7%	16.6%	11.4%	$73.75	$70.46
12	OTHER HYPOTENSIVES	$12,377,989	36.8%	$7,621,472	368,892	78.0%	14.0%	6.0%	$22.24	$20.66
	Subtotal, Costliest 12 Therapeutic Classes	$426,697,277	37.9%	$264,925,515	4,441,978	66.9%	15.0%	13.0%	$60.72	$59.64
	Subtotal, All Other Therapeutic Classes	$305,380,081	32.0%	$207,560,505	5,867,938	69.4%	11.7%	13.9%	$34.69	$35.37
	Total	$732,077,358	33.8%	$472,486,020	10,309,916	68.4%	11.6%	13.4%	$45.72	$45.83

- Top 12 therapeutic classes represent 56.1% of 2009 net Rx costs and 43.1% of 2009 prescription volume
  - Standard classes (n = 97) are used throughout our analyses
- Three of the four costliest classes are in the behavioral health arena and account for 28.8% of 2009 net Rx costs and 21.5% of 2009 prescription volume
- Note that costs assigned to either no therapeutic class or "miscellaneous" collectively represented 10.7% of 2009 net costs and 3.6% of 2009 prescription volume
- The generic fill rate is strongly and inversely correlated with costs per prescription
  - For example, Antineoplastics and Antivirals had the two lowest generic fill rates among the top 12 classes and, by hundreds of dollars, the highest costs per prescription

Appendix B: Links to Websites Delineating Other States' Rules for Accessing Psychotropic Medications

Psychotropic Cost Management Processes Are Well-Documented In States That Do Not Have Statutory Barriers

- "Best practice" principles of American Academy of Child and Adolescent Psychiatry
  - http://www.medscape.com/viewarticle/709188

- Many states have guidance and programs to assure proper utilization of psychotropic medications as evidenced by the literature links below
  - http://www.ct.gov/dcf/lib/dcf/behavorial_health_medicine/pdf/guidelines_for_psychotropic_medication_use_in-children_&_adolescents.pdf
  - http://heart.bmj.com/cgi/content/abstract/hrt.2009.176040v1
  - http://www.health.state.nm.us/DDSD/Rules/QI/Policy_PsychotrpcMedUse.htm
  - http://www.azdhs.gov/bhs/guidance/psychotropic.pdf
  - http://www.dcf.state.fl.us/admin/GMWorkgroup/docs/PsychotropicMedicationManagementYouthStateCare.pdf
  - http://www.state.tn.us/youth/dcsguide/policies/chap20/PsychoMedUtilGuide.pdf
  - http://www.dshs.state.tx.us/mhprograms/psychotropicmedicationfosterchildren.shtm

Appendix C: PDL Content Summary

PDL Content Summary: Statins and Combinations

Drug Name	MO	AR	CO	IL	IA	KS	KY	LA	MN	OH	TN	TX	WA
Caduet	N	N	N	N	Y		Y	Y	N	Y	N	Y	
Lipitor	N	N	Y	Y	Y	Y	N	Y	N	Y	N	Y	N
Vytorin	N	N	N	N	N		Y	N	Y	Y	N	Y	
Lescol	Y	N	N	Y	Y	N	Y	Y	Y	Y	N	Y	N
Lescol XL	Y	N	N	Y	Y	N	Y	Y	Y	Y	N	Y	N
lovastatin	Y	N	N	Y	Y	N	Y	Y	Y	Y	Y	N	Y
Mevacor		N	N		N	N	N		N		N	N	N
Altoprev	Y	N	N	N	N	N	N	Y		N	N	N	N
Advicor	N	N	N	N	Y		N	N		Y	Y	Y	
Simcor	Y	N	N	N	Y		Y	Y	Y	Y	Y	Y	
pravastatin	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y
Pravachol	N	Y	N		N	N	N		N		N	N	N
Crestor	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
simvastatin	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Zocor	N	Y	N		N	Y	N		N		N	N	N

PDL Content Summary: Proton Pump Inhibitors

Drug Name	MO	AR	CO	IL	IA	KS	KY	LA	MN	OH	TN	TX*	WA
Kapidex		N	N	N	N	N		N	N	N	N		N
Nexium	N	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	N
Prevacid	N	N	Y	N	Y	Y	Y	Y	Y	N	N	Y	N
Prevacid Solutabs		N	Y	N	Y	Y	Y	Y	N	Y	N	Y	Y
omeprazole	N	Y	N	N	Y		N	N	Y	Y	Y	N	Y
omeprazole OTC	Y	N	N	Y	N	Y	N	N	N	N		N	Y
Prilosec					N	N	N		N		N	N	N
Prilosec OTC	Y	N	Y	Y		Y	Y			N			Y
Zegerid	N	N	N	N	N	Y	N	N	N			N	N
pantoprazole	N	N	N	N	N	N	N	N	N	N	N	N	N
Protonix	N	N	N	N	Y	N	N	N	N	N	N	N	N
Aciphex	N	N	N	Y		N	N	N	N	N	N	N	N

* TN puts entire PPI class on step therapy.

PDL Content Summary: Inhaled Corticosteroids

Drug Name	MO	AR	CO	IL	IA	KS	KY	LA	MN	OH	TN	TX	WA
QVAR	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Symbicort	Y	Y	N	Y	Y		Y	Y	Y	Y	Y	Y	Y
Aerobid	Y	N	N	Y	Y	N	N	Y	N	Y	N	N	Y
Aerobid M	Y	N			Y	N	N	Y	N	Y	N	N	Y
Flovent	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y
Flovent HFA	Y	Y	Y		Y	Y	Y	Y	N	Y	Y	Y	Y
Azmacort	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Advair Diskus	Y	N	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Advair HFA	Y	Y	N	Y	Y		Y	Y	Y	Y	Y	Y	Y
Pulmicort Flexhaler	N	N	Y	N	Y	Y	N	N	N	N	N	N	Y
Alvesco	N			N	N	N	N	N	N	N	N	N	N
Asmanex	Y	Y	N	Y	Y	N	Y	N	Y	Y	N	Y	N

PDL Content Summary: Atypical Antipsychotics

Drug Name	MO	AR	CO	IL	IA	KS	KY	LA	MN	OH	TN	TX	WA
Fazaclo	NA	NA	NA	Y	Y	NA	Y	Y	Y	N	Y	N	Y
clozapine	NA	NA	NA	Y	Y	NA	Y	N	Y	N	Y	N	Y
Clozaril	NA	NA	NA		N	NA	Y			N	N	N	N
Seroquel	NA	NA	NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
Seroquel XR	NA	NA	NA	Y	N	NA	Y	Y	Y	Y	Y	Y	Y
risperidone	NA	NA	NA	Y	Y	NA	Y	Y	Y		Y	Y	Y
Risperdal	NA	NA	NA		N	NA	N		N	Y	N	N	N
Risperdal M-Tab	NA	NA	NA		N	NA	N			N	N		Y
Reisperdal Consta	NA	NA	NA		Y	NA	Y	N			N		Y
Geodon	NA	NA	NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
Abilify	NA	NA	NA	Y	Y	NA	Y	N	Y	Y	Y	Y	Y
Abilify Discmelt	NA	NA	NA		N	NA	Y			N	Y		Y
Symbyax	NA	NA	NA		N	NA	Y	N		N	N	Y	
Zyprexa	NA	NA	NA	Y	Y	NA	Y	N	Y	N	N	Y	Y
Zyprexa Zydis	NA	NA	NA		N	NA	Y			N	N		Y
Invega	NA	NA	NA	Y	N	NA	Y	N	N	N	N	Y	

PDL Content Summary: 2nd Generation Antidepressants

Drug Name	MO	AR	CO	IL	IA	KS	KY	LA	MN	OH	TN*	TX	WA
Aplenzin	NA	N	NA	N		NA		N	N	N	N		N
bupropion HCl IR	NA		NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
bupropion HCl SR	NA		NA		Y	NA	Y	Y	Y	Y	Y		Y
bupropion HCl XL	NA	Y	NA			NA	N	N	Y	N	Y		Y
Wellbutrin XL	NA	Y	NA		Y	NA	N	N	N	Y	N		N
Celexa	NA		NA		N	NA	N		N		N	N	N
Citalopram	NA	Y	NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
Pristiq	NA	N	NA	N	N	NA	N	N	N	N	N	Y	N
Cymbalta	NA	N	NA	Y	Y	NA	N	N	N	Y	N	Y	N
Lexapro	NA	Y	NA	Y	Y	NA	N	Y	Y	Y	N	N	N
fluoxetine	NA	Y	NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
Prozac	NA		NA		N	NA	N		N		N	N	N
Sarafem	NA		NA	N	N	NA	N		N		N	N	
Prozac Weekly	NA		NA	N	N	NA	N	N	N	N	N		N
fluvoxamine	NA	Y	NA	Y	Y	NA	Y	Y	Y	Y	Y	N	N
Luvox CR	NA		NA	N	N	NA	N	N	N	N	N	Y	N

* TN puts SNRIs class (e.g., Effexor/XR, venlafaxine/XR, Cymbalta, Pristiq) on step therapy.

PDL Content Summary: 2nd Generation Antidepressants (continued)

Drug Name	MO	AR	CO	IL	IA	KS	KY	LA	MN	OH	TN*	TX	WA
mirtazapine	NA	Y	NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
nefazodone	NA		NA	N	Y	NA	Y	N	Y		N		N
paroxetine	NA	Y	NA	Y	Y	NA	Y	Y	Y	Y	Y	N	Y
Paxil	NA	Y	NA			NA	N		N		N	N	N
Paroxetine CR	NA		NA	N	N	NA	N	N		N	N		N
Paxil CR	NA		NA		Y	NA	N		N		N	N	N
Pexeva	NA	N	NA	N	N	NA	N	N	Y	N	N	Y	N
Remeron	NA	Y	NA		N	NA	N		N		N	N	N
Emsam	NA		NA	N		NA	N	N			N	N	
sertraline	NA	Y	NA	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y
Zoloft	NA	Y	NA		N	NA	N		N		N	N	N
trazodone	NA		NA	Y	Y	NA	Y	Y	Y		Y	Y	
venlafaxine	NA	Y	NA	N	Y	NA	Y	N		Y	Y	N	Y
Effexor	NA	Y	NA		N	NA	N		Y		N	N	N
venlafaxine ER	NA	N	NA	N	N	NA	N	Y	Y	Y	N		N
Effexor XR	NA	N	NA	Y	Y	NA	Y	N	Y	Y	Y	Y	Y

* TN puts SNRIs class (e.g., Effexor/XR, venlafaxine/XR, Cymbalta, Pristiq) on step therapy.

Appendix D: Statutory Highlights of Pharmacy Reimbursement Allowance Fund (P-Tax)

Statutory Highlights of Pharmacy Reimbursement Allowance Fund (P-Tax)

- 338.500 – 1. In addition to all other fees and taxes required or paid, a tax is hereby imposed upon licensed retail pharmacies for the privilege of providing outpatient prescription drugs in this state. The tax is imposed upon the Missouri gross retail prescription receipts earned from filling outpatient retail prescriptions.

- 338.535 - 1. The pharmacy tax owed or, if an offset has been made, the balance after such offset, if any, shall be remitted by the pharmacy or the pharmacy's designee to the department of social services. The remittance shall be made payable to the director of the department of revenue and shall be deposited in the state treasury to the credit of the "Pharmacy Reimbursement Allowance Fund" which is hereby created to provide payments for services related to the Medicaid pharmacy program.

- 338.550 – 1. The pharmacy tax required by sections 338.500 to 338.550 shall expire ninety days after any one or more of the following conditions are met:
  - (1) The aggregate dispensing fee as appropriated by the general assembly paid to pharmacists per prescription is less than the fiscal year 2003 dispensing fees reimbursement amount; or
  - (2) The formula used to calculate the reimbursement as appropriated by the general assembly for products dispensed by pharmacies is changed resulting in lower reimbursement to the pharmacist in the aggregate than provided in fiscal year 2003; or
  - (3) September 30, 2011.

Appendix E: List of Psychotropic Drugs Used to Create Slide 15

List of Psychotropic Drugs Used to Create Slide 15: HIC-3 Code and Description

- H2S - Selective Serotonin Reuptake Inhibitor (SSRIs)
- H2V - Treatment For Attention Deficit-Hyperactivity (ADHD)/Narcolepsy
- H4B, H4C – Anticonvulsants
- H7C - Serotonin-Norepinephrine Reuptake-Inhib (SNRIS)
- H7D - Norepinephrine And Dopamine Reuptake Inhib (NDRIS)
- H7E - Serotonin-2 Antagonist/Reuptake Inhibitors (SARIS)
- H7T - Antipsychotics, Atypical, Dopamine, and Serotonin Antagonists
- H7X - Antipsychotics, Atyp, D2 Partial Agonist/5HT Mixed

Appendix F: Monthly Drug Limit Dynamics (assessed but not recommended)

Many States Implement Limits On # of Monthly Prescriptions

States	Monthly Rx Limit/Mechanism to exceed monthly limit
Alabama	5 brand limit, Hard cap of brand at 10.
Arkansas	3 Rx limit, up to 6 per month with PA
California	6 Rx per month
Delaware	Limit of 15 Rx's per month/PA
Hawaii	PA required to exceed limit
Illinois	3 brand limit per month PA
Kansas	5 brand name drugs. RPhs allowed to override at POS
Kentucky	4 Rx limit PMPM< override provisions at POS
Louisiana	8 Rx limit PRPM. Override provisions at POS
Maine	5 brand limit
Mississippi	5 Rx per month for adults. PA for children over 5
New York	Yearly Rx limit
North Carolina	8 Rx limit. RPh can override up to 12 Rx's
Oklahoma	6 Rx's per month
Pennsylvania	6 Rx's per month
South Carolina	4 Rx's per month. Overrides unlimited
Texas	3 Rx limit
Washington	4 brand limit

Imposing Volume Limits on Prescriptions Can Be A "Blunt Instrument"

- Arbitrary volume limits are not a good means of discerning whether any given prescription is appropriate or not
  - exception processes are important to avoid blocking access to needed medications, but these processes can be burdensome for physicians and for MO HealthNet; also, those prescriptions accessed within the monthly limits may not be clinically beneficial and appropriate
- Adults' prescriptions above various monthly volume thresholds are shown below. Savings would be much lower than figures below, due to exception process and because the highest-cost prescriptions would likely continue to be accessed under the Rx benefit.

Adult, December 2008		
Prescriptions Above Monthly Threshold	# Scripts Above Limit	% Scripts Above Threshold
5 scripts	196,185	33.5%
10 scripts	78,674	13.4%
20 scripts	14,694	2.5%

Adult, March 2009		
Prescriptions Above Monthly Threshold	# Scripts Above Limit	% Scripts Above Threshold
5 scripts	211,795	34.4%
10 scripts	77,495	12.6%
20 scripts	11,401	1.9%

Adult, June 2009		
Prescriptions Above Monthly Threshold	# Scripts Above Limit	% Scripts Above Threshold
5 scripts	202,835	33.8%
10 scripts	73,159	12.2%
20 scripts	10,911	1.8%

Appendix G: 90 Day Supply Dynamics (assessed but not recommended)

Increasing Use of 90-day Supply on Generic Maintenance Medications

- The SSI population has long periods of consistent eligibility and many take several maintenance medications each month.
- Moving to 90-day prescriptions for these maintenance medications can save costs by eliminating dispensing fees and reduce the burden on the beneficiary through less trips to the pharmacy.
- The 90-day prescription would not occur until 2 months of prescriptions of the same drug (i.e., NDC) have been prescribed. A 90-day supply would then begin in the third month.
- Limiting the 90-day supply option to generics eliminates the risk of this initiative costing (rather than saving) money due to wastage or loss of eligibility. Initiative could later be expanded to brand medications for selected persons and medications.
- Using a 90-day supply for generic medications common maintenance drug classes* in the Blind and Disabled population is estimated to save $1.5 million in annual dispensing fees (in gross Medicaid dollars).

* We used a selection of generic ACE inhibitors, beta blockers, calcium channel blockers, angiotensin receptor antagonist, statins, hypoglycemics, asthma, 2nd generation antidepressants, and thyroid medications

Gross Savings from Using 90-day Supply on Generic Maintenance Medications for SSI Population

Months on Drug	# of persons	Original # of scripts per person	Revised # of scripts per person using 90-day supply	Avg. Dispensing Fee per Script	Gross Savings
1	70,950	1.03	1.03	$8.45	$0
2	32,518	2.08	2.08	$8.52	$0
3	21,493	3.13	3.13	$8.58	$0
4	15,407	4.19	3.19	$8.65	$133,214
5	11,981	5.24	3.24	$8.62	$206,555
6	9,938	6.33	4.33	$8.67	$172,270
7	9,253	7.45	4.45	$8.71	$241,654
8	9,029	8.40	4.40	$8.79	$317,426
9	8,407	9.20	5.20	$8.85	$297,620
10	2,177	10.16	5.16	$8.86	$96,414
11	30	13.50	7.50	$8.71	$1,568
12	6	12.00	6.00	$9.76	$351
Total	191,189				**$1,467,072**

Using 90-day Supply on Generic Maintenance Medications for SSI Population Would Likely Yield Net Costs (rather than savings) due to P-Tax Dynamics

90 Day Fill Fee for Generics in Selected Situations	At 63.595% Fed Match	At 75.16% Fed Match
Annual Fill Fees Avoided	150,000	150,000
Initial Fill Fee	$9.66	$9.66
Initial Gross Savings	$1,449,000	$1,449,000
Ingredient Cost On These Medications	$3,000,000	$3,000,000
Assumed Impact of 5% Wastage	$150,000	$150,000
Initial Savings Net of Wastage	$1,299,000	$1,299,000
Federal Share of Savings	$826,099	$976,328
State Share of Savings	$472,901	$322,672
Federal Match and P-Tax Dynamics	**At 63.595% Fed Match**	**At 75.16% Fed Match**
Enhanced Fill Fee Revenue	$723,000	$723,000
Federal Match on Enhanced Fill Fee Revenue	$459,792	$543,407
Reduction in Pharmacy Gross Receipts	$1,449,000	$1,449,000
Tax Revenue Reduction	$17,388	$17,388
Net State Funds Savings (Loss)	($4,279)	($238,123)

- These savings assume the P-Tax program remains unchanged.
- The average ingredient cost for these generic maintenance medications is $9.06. Where wastage or loss of eligibility occurs, there will be little adverse fiscal impact to MO HealthNet because of the low generic ingredient cost.
- MS, MT, NC, NH, VT permit or require 90-day supply on certain maintenance medications.