Controlling Pharmacy Costs in the NC Medicaid Program

L. Allen Dobson, Jr., MD, FAAFP

Pharmacy costs account for an ever-enlarging percentage of the healthcare dollar with annual increases continuing in the double digits in recent years. Despite attempts at utilization control, the influence of new products, direct-to-consumer advertisements, and public demand for the newest medications have continued to push total pharmacy costs upward. Intuitively, better medications to treat illness should be accompanied by a decrease in other healthcare costs, such as the cost of hospitalizations. Such decreases have been modest at best and have resulted in attempts by insurers to limit access to certain expensive medications to control healthcare costs.

Physicians are all too familiar with the various management strategies utilized by insurers to keep increased pharmacy costs in check. The use of prior approval and restrictive formularies, while effective, add to administrative hassles and increase practice costs to physicians. These techniques are also rather "blunt instruments" for controlling physician behavior and prescribing practices. When coupled with the actual cost of administering prior approval, it seems that there is significant money spent overseeing the use of certain medications only to realize the small changes in behavior. These techniques must be applied generally to attain the savings, thus penalizing the majority to change the behavior of a few. For the physician dealing with multiple formularies and prior approval rules, the complexity can often be overwhelming. Use of Personal Digital Assistants (PDAs) and electronic drug lists have helped, but lasting changes in prescribing behavior have not been shown. It seems that we have yet to capture the physician's attention. Physicians are skeptical of the science or objectivity of insurers picking the most cost-effective medications for inclusion. Pairing price with available evidence of efficacy in order to pick a preferred drug requires at least some subjectivity.

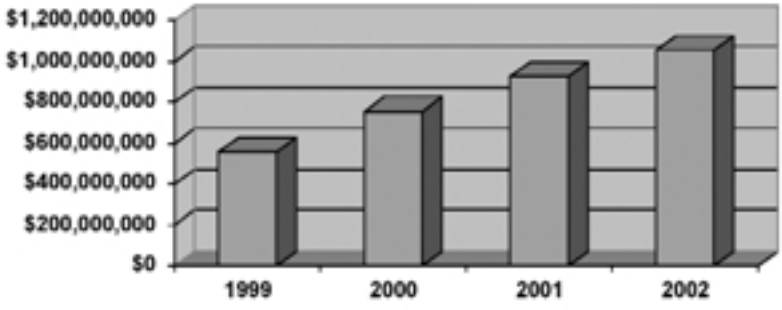
Physicians and other healthcare providers have always preferred to have a full selection of medications available for their patients. At the time of deciding what medication to use for a patient, the physician must often make an individualized decision based on patient-specific factors that often do not fit nicely into a treatment algorithm or prior approval protocol. When asked, the provider community always wants freedom from interference in patient care decisions. Yet, reality shows that prescribing habits do not always reflect best practice and certainly not the cost-effective practice.

NC Medicaid Pharmacy Program

The NC Medicaid pharmacy program is not exempt from similar cost concerns. The NC Medicaid pharmacy budget has more than doubled since 1999 to over one billion dollars per year (Figure 1) and now accounts for a greater percentage of spending than the cost of physicians or hospitals (Figure 2).

The NC General Assembly removed over $80 million from the current Medicaid pharmacy budget during the last legislative session to help balance the state budget. Meeting these budget mandates in the face of continued double digit increases is a daunting task for

Figure 1.
Medical Expenditures_Prescription Drugs



FY99
$557,772,670

FY00
$754,505,194

FY01
$927,240,693

FY02
$1,056,158,750

Allen Dobson is President of the Cabarrus Family Medicine, PA and Chair of the NC Physicians Advisory Group, Inc. He can be reached at adobson@northeastmedical.org or 315 Medical Park Dr., Suite 203, Concord NC 28205. Telephone: (704) 783-1044.

Figure 2. PAL Classes
Top 16 classes account for 60% of NC Medicaid costs

- PPIs
- H2blockers
- Cholesterol lowering
- Non-sedating antihistamines
- Cox2
- NSAID
- Calcium channel blockers
- ACE inhibitors
- Beta inhalers
- Steroid inhalers
- Stimulants
- Sedative hypnotics
- Antipsychotics
- Anticonvulsants
- SSRIs
- Narcotics

state officials. Other states facing similar budget restrictions have turned to large-scale prior approval, restrictive formularies and seeking supplemental rebates from the pharmaceutical industry resulting in lawsuits and continued bitter debate on how to best control escalating drug costs. NC has also introduced a prior approval program to help with rising drug costs. Unlike other states, NC Medicaid asked for the help of the NC Physicians Advisory Group. Through a volunteer pharmacy committee of the NC Physicians Advisory Group, a prior approval process was introduced. The committee established very selective criteria for placing medications on prior approval based on data. The minimum criteria are:

- The medication is being used as first line therapy where there are similarly efficacious, effective, and safe drugs available at substantially lower costs.
- The drug is subject to abuse or fraudulent use.
- The medication is so costly that advance assurance of indication for use is desirable rather than retrospective analysis.
- The increase in usage of the drug is far greater than would be expected based on clinical evidence of efficacy.
- Guidelines for appropriate use are complex and/or require yearly or seasonal adjustment.
- There is evidence that the medication is being used inappropriately.

The committee also established a method to remove medications from prior approval based on outcomes data. Drugs are removed from prior approval if:

- After six months of the prior approval process, there is no change in utilization and <3% denial rate. This would indicate that the use of the drug met criteria prior to PA.
- After the initial desired impact of the prior approval process, there are six continuous months of minimal change in utilization. This would indicate maximum effect and provider prescribing change achieved. If the drug is removed, utilization should be monitored for one year to assure the change is maintained.
- There are unintended negative health outcomes or negative effects on one patient group or eligibility group.
- The cost of the prior approval is greater than the cost savings or improvement in quality realized by its use.

The number of drugs that have been placed on prior approval is low and already several have been recommended for removal. The net savings to NC Medicaid using this limited approach still exceeded $12 million last year. It is clear, however, that the prior approval process alone is inadequate to control pharmacy costs.

The PAL list—NC Physician Advisory Group (PAG) and the leadership of the Community Care Program (Access II/III) have partnered with NC Medicaid to further evaluate the pharmacy program and recommend strategies to control costs while maintaining our focus on quality care for our state's poorest citizens. When taking an objective look at pharmacy expenditures, several facts stand out: (1) the top 15-16 classes of medications by costs account for almost 60% of the total pharmacy cost, (2) the issues around medication use are complex since many of these medications are used for chronic disease and among our sickest patients, (3) there are opportunities for savings involving poly-pharmacy, evaluating off-label usage, disease management programs, and focused initiatives based on data (none of which lend themselves to typical pharmacy management strategies). The single biggest impact on costs may be in educating physicians on the actual cost to Medicaid of the most expensive classes of medications and asking for voluntary help from physicians by prescribing less expensive medication when appropriate.

This approach was tested in our Access II/III networks. The Prescription Advantage List (PAL) project headed by Dr. Steve Wegner showed a 22% savings and good physician acceptance of such a volunteer approach. Feedback indicated that physicians wanted concise information about costs, a minimum number of drug classes to keep up with, and more evidenced-based information on efficacy.

Defining relative costs—Determining the actual cost of medications to Medicaid however is a complex problem. Medicaid pays pharmacists average wholesale prices (AWP) minus 10% for medications and a professional fee of $5.60 for generics and $4.00 for brand medications. The patient is asked to pay $1.00 for generic and $3.00 for brand name medications. In addition, NC participates in the federal drug rebate program in which pharmaceutical companies agree to provide a formula-based rebate on the medications purchased by the state. These rebates vary by company and greatly affect the net cost of medications to the state. In effect, the state pays the absolute lowest price available, even for brand name medications. The information, however, is protected from public disclosure.

To provide accurate information to providers, a method to show the relative cost of medications within classes including all costs and rebates was needed. The Physician Advisory Group leadership met with pharmaceutical industry representatives and state officials to develop a methodology to evaluate net cost of medications and provide physicians with accurate relative cost ranking without breaching rebate confidentiality. This information, which is reflected in the current state PAL, allows the ranking of drugs within a class from least to most expensive based on the net price to Medicaid. The list will be updated quarterly to maintain accuracy.

In developing the initial statewide list, the Physician

Advisory Group pharmacy committee was charged with defining a single unit dose for a single indication within the class to use in the relative cost ranking. The net cost methodology was then applied to provide the ranking. The list was further stratified to provide clinicians with further relative cost figures.

The PAL list can be accessed at the Division of Medical Assistance web site: http://www.dhhs.state.nc.us/dma/pal/pal.pdf.

Looking for potential savings—After the PAL list was developed, each class was evaluated for potential savings that might be achieved. The opportunity for cost savings varied widely by class. In many cases, it would not be reasonable for physicians to use the least expensive medication or prescriptions were already weighted toward generics or less expensive medications. One new opportunity was evaluated that would offer significant savings. The Physician Advisory Group pharmacy committee recommended to the Division of Medical Assistance that a state plan amendment be considered that would allow coverage for selected over the counter (OTC) medications under specific circumstances with a valid prescription. The criteria for coverage are:

- A legend drug is approved by FDA as an OTC drug and, if covered by Medicaid, the cost of the OTC version would result in significant cost savings to Medicaid.
- An efficacious drug is available only as OTC and not legend, and all other legend treatments are significantly (i.e., >20%) more expensive without a significant increase in effectiveness.
- Coverage for an OTC or a group of OTCs expands treatment options because they have been shown to decrease the total cost of care for certain conditions.

The first two medications considered and approved for coverage effective November 23rd, 2003 are Prilosec® 20 mg OTC and Claritin® 10mg OTC (also Alavert®, Loratadine®, Allergy Relief®, and Claritin® 5mg/5cc syrup). The availability of these OTC medications by prescription is an important adjunct to the clinician and provides significant cost savings to NC Medicaid.

It is estimated that the PAL list alone could help the state save up to $50 million a year without costly regulation while preserving the ability of physicians and other healthcare providers to prescribe the medicine best suited for their individual patient's needs.

Evidenced-based medicine

In addition to costs, providers have stated they would like up-to-date evidenced-based information regarding drug therapy and the difference among medications within each class of medications. NC has partnered with Oregon and nine other states to contract with Evidenced-based Practice Centers (EPCs) to do comprehensive reviews of selected classes of medication to examine current data and answer specific clinical questions formulated by representatives of the participant states. These reviews will be updated every six months with new classes added on a regular basis. The EPCs contracted to do these reviews are:

1. Oregon Evidenced-based Practice Center, Oregon Health and Science University
2. Research Triangle Institute and the University of North Carolina at Chapel Hill EPC
3. Southern California EPC-RAND in Santa Monica, CA

The full reviews will be made available to NC providers on the web and the pharmacy committee of the Physicians Advisory Group will be asked to develop key "clinical pearls" for inclusion in future PAL updates. By arming providers with relative cost and evidence-based information regarding medications, the provider will have the necessary information available to make the most cost-effective choice for their patients.

The Future: Looking at the Total Costs of Care

While the cost of medication is important, the future emphasis needs to be place on a thorough look at total cost of care for common and high-cost conditions among patients in the Medicaid program. Community Care of NC (Access II/III) has already shown significant success in quality improvement and at lower costs by taking a broader look at how care is managed in the community. By continually evaluating the data and involving those who have the knowledge to provide balanced advice to the Medicaid program, the NC Physician Advisory Group hopes to help NC establish good medical policy and a local care management system that will provide true value in the future.

The leadership of Community Care of NC, NC Physician Advisory Group, and the NC Department of Health and Human Services are committed to the philosophy of collaborative care management strategies rather than regulation as the best and most long-lasting way to control cost while improving quality of care to NC's poorest citizens.