

March 12, 2008

# Supplement on the Department's Management of the Medicaid Pharmacy Benefit Commonwealth of Pennsylvania

Final

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## Executive summary

The Commonwealth of Pennsylvania (Commonwealth) continues to operate under the fiscal reality that the Medical Assistance Program consumes 20 percent of the Commonwealth's general fund and continues to grow. The management staff tasked with operating this important program need to continually look for and implement innovative solutions that maximize the limited resources available to serve those who depend most on the services and support provided by the Commonwealth. One such solution is to transition responsibility for payment/management of the Medicaid drug benefit from the contracted managed care organizations (MCOs) to the Department of Public Welfare (Department).

***The Medical Assistance Program has unique purchasing power including access to federally-required pharmacy rebates***

***The transition will achieve savings without reducing Medicaid eligibility or benefits***

Within this supplement, cornerstones (e.g., key elements) associated with this transition, achievements made by the Department in modernizing and managing the Medicaid drug benefit and the related benefits to providers, tax payers and consumers will be presented and discussed. Key figures and actual Department experience data with pharmacy rebate collections, policy initiatives and program enhancements are included to give perspective and context to this report.

## Cornerstones of this transition

Consistent with other policy goals and objectives, the cornerstones of this transition include:

- Taking further advantage of the Department's purchasing power
- Simplifying the administration of the Medicaid drug benefit
- Maximizing savings by leveraging tens of millions of dollars in federally-mandated drug rebates on the larger volume of drug spend
- Gaining additional savings and leverage for millions more in supplemental state rebates on the larger volume of drug spend
- Ensuring continuity of care for the consumer

***The Department's total pharmacy rebates are nearly 7x those of the PH-MCOs on a per claim basis***

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- Sharing electronic pharmacy information with the PH-MCOs to facilitate uninterrupted care management and coordination

## Department achievements

As part of the Department's overall management strategy for the Medical Assistance Program, the Department has made significant strides to modernize its pharmacy policies, procedures and payment methodologies, along with implementation of proven pharmacy management tools and techniques that have resulted in the following achievements:

- Created, staffed and expanded a new Pharmacy Division
- Negotiated and collected millions of dollars in state-supplemental rebates, in addition to the already substantial federally-mandated rebates
- Implemented changes to payment methodologies to optimize savings while retaining a high dispensing fee for pharmacies in the Commonwealth
- Implemented a preferred drug list (PDL) with related quality controls
- Developed a specialty pharmacy drug program to optimize clinical quality, dispensing efficiencies and savings
- Increased the prescription drug generic dispensing rate to over 60 percent
- Initiated data transfer processes to ensure that pharmacy claims information is readily available to the BH-MCOs and ACCESS Plus vendor for care management
- Developed processes to make pharmacy claims information available to the PH-MCOs
- Modernized the management policies and procedures related to the Medicaid drug benefit
- Established a Pharmacy and Therapeutics Committee (P&T)

***The Department has made significant investments to increase staffing, enhance program management and improve operational processes***

***Pharmacy data is the easiest data to transmit electronically with the Department currently processing over 16 million pharmacy claims a year***

## Simplicity, transparency and cost savings

In summary, transitioning payment responsibility for the Medicaid drug benefit from the MCOs to the Department is expected to save money without reducing Medicaid benefits/eligibility and be transparent to the consumer and simpler for the providers. This initiative will no doubt require enhanced collaboration between the Department and its contracted vendors; a path that the Department has actively embraced through current data and information sharing initiatives. The Department's management staff knows that being accountable as a good steward of the Medical Assistance Program means

- ***Higher rebates and substantial savings***
- ***Standard/uniform policies for providers***
- ***Continued quality for consumers***

evaluating options, making decisions and following through to ensure the goals sought after are indeed achieved.

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## Background

Pennsylvania's Medical Assistance Program continues to operate under the reality that Medical Assistance consumes 20 percent of the Commonwealth's general fund<sup>1</sup> and is growing. Second only to education, Medical Assistance is the most significant expenditure within the Commonwealth's budget. It is a simple fact that the Commonwealth does not have an endless source of money and difficult choices are sometimes required.

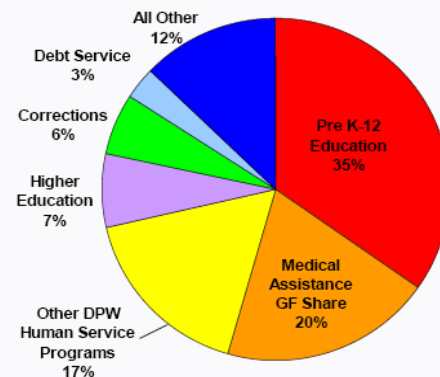
The management staff tasked with operating the Medical Assistance Program is on the front line of balancing the

medical needs of the most vulnerable citizens with the budget reality that choices have to be made to ensure the overall integrity, viability and sustainability of this important program. The Department has generally been able to avoid cutting benefits or reducing the number of people eligible for medical assistance as other states have done. Indeed, the Commonwealth has actually been able to extend coverage to more low-income children<sup>2</sup>. Nonetheless, needs do not subside, Medical Assistance enrollment continues to increase, and funding options wane as the federal government seeks to reign in Medicaid expenditure growth, all of which have made the recent and upcoming years the most challenging and difficult. Against this backdrop, the Department continues to look for and implement innovative solutions.

At the request of the Department, Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, undertook the task of producing a

### 2008-09 General Fund Expenditures

The 2008-09 General Fund budget is \$28.3 billion, an increase of \$1.1 billion, or 4.2 percent, over 2007-08.



Spending on Education, Medical Assistance, other Department of Public Welfare programs, Corrections and Debt Service comprises 88 percent of total General Fund expenditures.

**Total GF Expenditures: \$28.3 Billion**

<sup>1</sup> Governor's Office of the Budget 2008-09 Proposed Budget Slide Presentation; [www.budget.state.pa.us](http://www.budget.state.pa.us)

<sup>2</sup> U.S. Approves State's Cover All Kids Program, February 23, 2007, Pittsburgh Post-Gazette Mercer

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supplement to the December 18, 2006, financial evaluation comparison report<sup>3</sup> on the merits of moving payment responsibility for the Medicaid drug benefit from the contracted Medicaid MCOs to the Department. This supplement does not replace the original financial evaluation, as we believe the information presented in the December 2006 report is still relevant, stands on its own and provides useful information to those in decision-making roles. Instead, this supplement discusses operational aspects of the Department's pharmacy program and the key elements that are required to support such an initiative. Additionally, this supplement presents more recent facts and figures that were not available at the time of the earlier report.

## The challenge

By most accounts, health care spending is increasing<sup>4</sup>. Advances in medicine, an aging population, new technologies and higher consumer demands are just some of the factors influencing spending<sup>5</sup>. Total spending is not just a function of the price of goods and services, but also changes in the volume of services provided, as well as the mix of high and low cost items all moving in different degrees, that strain budgets and require those in leadership positions to evaluate options and new ideas.

The Department knows that quality health care and coordination of that medical care is a cornerstone of a sustainable public assistance program. Managed care, whether delivered through programs like HealthChoices or ACCESS Plus, has been and continues to be an integral part of the Department's efforts to ensure Medical Assistance recipients receive appropriate and effective care.

Managing the care and delivery of medical services requires effort, action, diligence, oversight and collaboration on the part of the Department, contracted vendors, providers and consumers. The Department has over 10 years experience in doing this and the near \$15 billion Medical Assistance Program price tag places Pennsylvania in the top five of the largest programs in the United States<sup>6</sup>. Serving nearly two million Pennsylvanians, the Department's challenge is developing innovative solutions that maximize limited resources to ensure the sustainability of the Medical Assistance Program for those who depend most on the provided services and supports.

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<sup>3</sup> Financial Evaluation of a Pharmacy Carve-out from the Capitated MCO Program to the FFS Program, Mercer Government Human Services Consulting, December 18, 2006

<sup>4</sup> Health Insurance Cost, National Coalition on Health Care, [www.nchc.org/facts/2007%20updates/cost.pdf](http://www.nchc.org/facts/2007%20updates/cost.pdf)

<sup>5</sup> Medicaid Expenditures and State Budgets: Past, Present, and Future. J. Marton & D.E. Wildasin, National Tax Journal, June 2007

<sup>6</sup> Kaiser Family Foundation, Total Medicaid Spending, FY2006; [www.statehealthfacts.org](http://www.statehealthfacts.org)  
Mercer

## Finding the right solution

Given the size, purchasing power, updated clinical policies and successful rebate program of the Department's Medical Assistance Program, it makes logical sense to evaluate how these unique advantages can be used to obtain a high rate of return for those who pay the bills and a high level of quality for those who receive the benefits. In one particular service item – pharmaceutical products – the Department's Medical Assistance Program has an advantage that is exclusive to state Medicaid agencies: federally-mandated rebates on drugs purchased by a state Medicaid program. In essence, drug manufacturers are required by law to give money back (i.e., rebates) to the Department<sup>7</sup> on both brand and generic drugs. And as will be presented later, these dollars are not trivial by any means.

There is, however, one requirement to this arrangement: for the Department to receive rebates from drug manufacturers, current federal law requires that the Department must directly pay for each prescription dispensed. The Department cannot delegate/assign responsibility for prescription drugs to a third-party (e.g., a contracted MCO) and expect the drug manufacturers to honor the rebate agreement. The goal is to develop a solution that will take advantage of the Department's management experience and preferred financial terms.

A seemingly simple solution would be to allow the MCOs to collect pharmacy rebates in the same manner and extent as the Department and other state Medicaid agencies. Indeed, this concept is not foreign to those who live and work in the Medicaid arena. Efforts have been made in the last two decades to change federal law, however, each time the proposal was unsuccessful.

The Association for Community Affiliated Plans (ACAP) recently voiced their support of extending Medicaid rebates to Medicaid MCOs because of the enormous amount of rebate savings lost under current rebate law. The fact that ACAP acknowledges the tremendous savings associated with Medicaid rebates, as compared to what MCOs are able to obtain today, indicates that that the Department is on the right track in terms of pursuing a policy that has real financial savings attached to it. Through its own efforts, the Department is seeking to claim some of these savings for the benefit of the program.

## Moving forward

Absent an abrupt change in federal law, the Department must venture forward to overcome its own challenges. Accordingly, the Department continues to look at the amount of drug dollars included in the Medicaid MCO program and the potential savings in foregone drug manufacturer rebates as one component of the Department's overall strategy to maintain the fiscal integrity and sustainability of the Medical Assistance Program.

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<sup>7</sup> Pub. L. No. 101-508, §4401, 104 Stat. 1388, 1388-143-161 (codified at 42 U.S.C. §1396r-8 (2000)).  
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Since the Department cannot collect the large pharmacy rebate money from the drug manufacturers unless it pays for the prescription itself, the recourse requires the Department to revise its Medical Assistance policies on who pays for and manages the drug benefit. By transitioning responsibility from the contracted MCOs to the Department, the Department can collect tens of millions of dollars in rebates from drug manufacturers, thus lessening the fiscal burden of the entire program. The Department's Medical Assistance Program management staff is also aware that being fiscally responsible and a good steward does not simply mean managing cost, but also supporting care management and coordination efforts as will be described in more detail in later sections of this report.

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## Choosing a successful solution

The pharmacy drug benefit is a major expense component of the Medical Assistance Program. Within the Medicaid MCO program (HealthChoices), the MCOs collectively spend over \$850 million on drugs annually, representing over 20 percent of the approximate \$4 billion total annual HealthChoices budget. The MCOs and their subcontracted vendors collectively employ tools and techniques, with varying degrees of success, to coordinate and manage the care of their enrolled members while maintaining their provider networks and relations. As noted previously, the MCOs' large volume of drug spend is excluded from the superior rebate agreements that are available to the Department.

The solution chosen by the Department combines the Medicaid agency's management skills with the significant financial benefit afforded under federal law with the benefits being:

- Higher rebates and substantial savings
- Consistency and uniformity for providers
- Continued quality for consumers

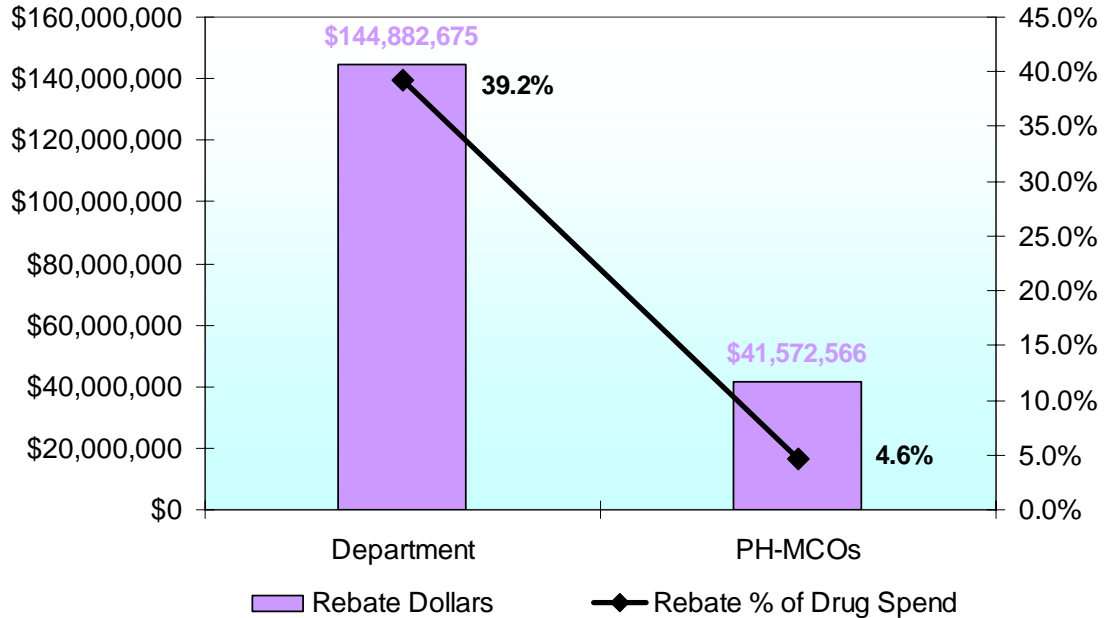
## Financial advantages

On their own or through the use of third-party pharmacy benefit managers (PBMs), the MCOs individually negotiate pharmacy rebates with drug manufacturers. In comparison to the rebates available to the Department, the MCOs' rebate levels are small relative to the volume of drug spend. For example, the MCOs' collectively reported \$41.6 million in rebates in the July 2006 to June 2007 time period; expressed as a percentage of gross drug spend, the MCOs averaged approximately 4.6 percent in rebates. For the same time period, the Department's Pharmacy Division reports collecting \$144.9 million in total drug rebates; expressed as a percentage of gross drug spend, the Department averaged approximately 39.2 percent in rebate savings (i.e., pharmacy costs were reduced by 39.2 percent). Changes in drug volume and/or drug mix can influence the Department's pharmacy rebate dollars and percentage in any given time period; however, these results point to the substantial savings the Department can achieve in its pharmacy expenditure.

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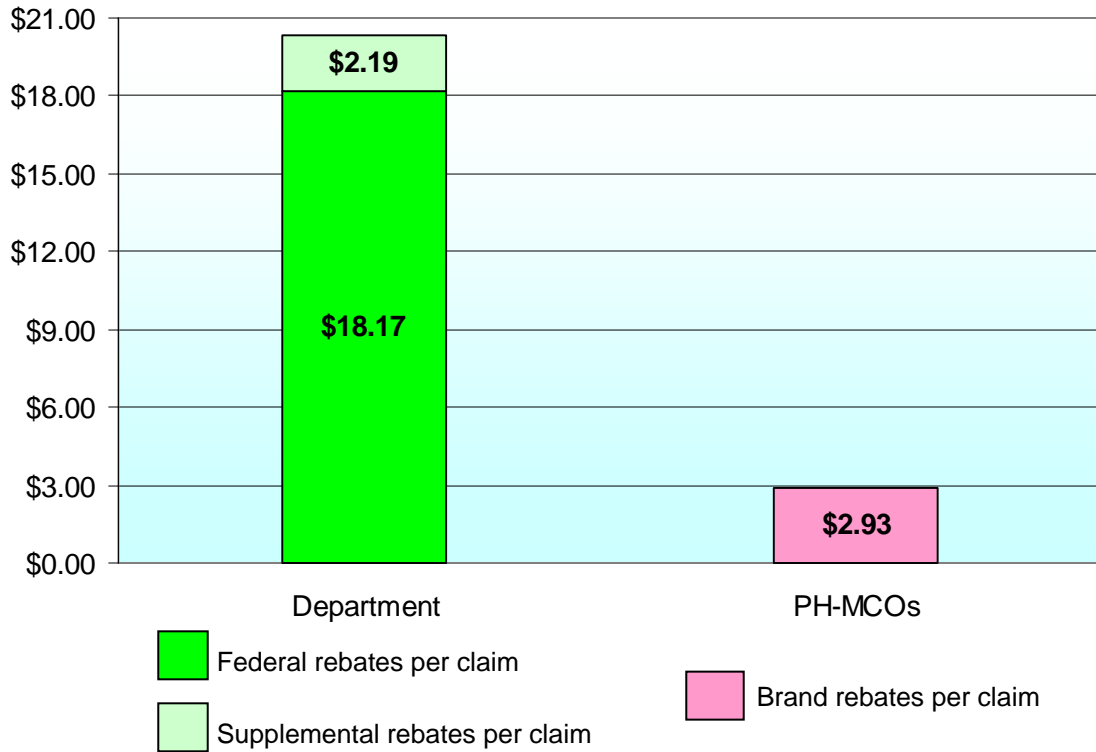
Although differences exist between the two programs, Exhibit 1 shows that the Department is able to collect many times more than the MCOs in drug rebate dollars on a smaller amount of drug spend. This fiscal advantage was achieved simply because the drugs were paid for directly by the Department.

Exhibit 1: SFY 06-07 Actual drug rebate dollars collected and rebates as a percent of drug spend by payer



Through this pharmacy initiative, the Department would assume payment and management responsibility for drugs in lieu of the MCOs, and further collaborate with the MCOs in support of their management of enrolled members. The shift in responsibility would subject the MCOs' drug volume to the higher rebate levels that the Department can collect. Assuming a conservative 25 percent rebate savings on the MCOs' approximate \$850 million annual drug spend, it is easy to see that the budget savings estimate from last year of \$94 million was reasonable.

Exhibit 2 on the following page shows a comparison of the HealthChoices MCOs' and the Department's average rebate per pharmacy claim for the second quarter of calendar year (CY) 2007; which is the most recent quarter available that provided sufficient time for rebate collections to be documented. Although differences exist between the two payers, Exhibit 2 shows the purchasing power and fiscal advantage the Department has over the MCOs with the Department's total rebates being nearly seven times the value reported by the MCOs.

Exhibit 2: Average rebate per pharmacy claim by payer<sup>8</sup> (2Q2007)

From a fiscal perspective alone, this is what makes this initiative compelling to the decision-makers responsible for solving the challenges facing the Medical Assistance Program: Savings can be achieved without reducing Medicaid benefits or eligibility.

## Operational enhancements

From a program management perspective, the Department has made equally aggressive moves to modernize management of the Medicaid drug benefit to ensure that overall drug spend is contained and quality of care is retained and enhanced. In order to achieve this balance, key initiatives included development of a PDL, implementation of quality and patient safety claims processing edits and obtaining input from consumers and providers on the development of relevant Medical Assistance policies and requirements (see Section 5 for additional specifics).

Furthermore, the Department believes, and has indeed received positive feedback from physician and consumer groups, that this form of a pharmacy management model will ease the administrative burden placed on providers who today have to track multiple MCO formularies, varying prior authorization requirements and claims processing requirements. A standardized set of policies and procedures, maintained by the Department with input from consumers and providers, simplifies the Medical Assistance pharmacy program.

<sup>8</sup> One of the PH-MCOs did not compute its average rebate per claim using a methodology consistent with the other PH-MCOs, and was therefore not included in the PH-MCOs' overall average rebate per claim

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## Resolving the concerns

This initiative has been proposed before and the outcome was no change to the status quo. Previous dialogue has been helpful in identifying primary concerns resonating from interested stakeholders (e.g., MCOs, lobbyists, drug manufacturers). Much discussion involved comparing and contrasting the information presented in the earlier report to other reports, opinions and assumptions. As stated previously, the December 2006 report stands on its own; however, with the passage of time, a few key items can be revisited.

### Use of “older data” for study purposes

The previous report used 2004 HealthChoices MCO experience data to estimate pharmacy costs in the future state fiscal year (SFY) 06–07 time period for purposes of completing the comparative analysis. Opponents stated that the use of older data renders the report’s observations irrelevant, but even the opponents cited work that is now several years old<sup>9</sup>.

Most health care studies and reports cannot effectively rely on real-time data due to the requirements of the particular study, timing of when work is completed, the need for a complete and accurate set of data to work with and simple production time. As shown in the following Exhibit 3, a simple comparison of the estimated SFY 06-07 MCO drug spend, MCO rebate dollars and MCO rebate percentage in the original December 2006 report to actual reported data from the MCOs shows that the estimates were not unreasonable.

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<sup>9</sup> The Lewin Group’s November 2003 paper, Analysis of Pharmacy Carve-out Option for the Arizona Health Care Cost Containment System, was based on data that is now 7 years old  
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Exhibit 3: Comparison of estimated MCO drug spend and actual MCO drug spend

Data element	Estimated MCO amount in December 2006 report	Actual MCO self-reported amount <sup>10</sup>
Drug Spend	\$810,112,758	\$858,675,415
Drug Rebate Dollars	\$36,839,405	\$41,752,566
Gross Drug Spend	\$846,952,163	\$900,247,981
Drug Rebate %	4.35%	4.62%

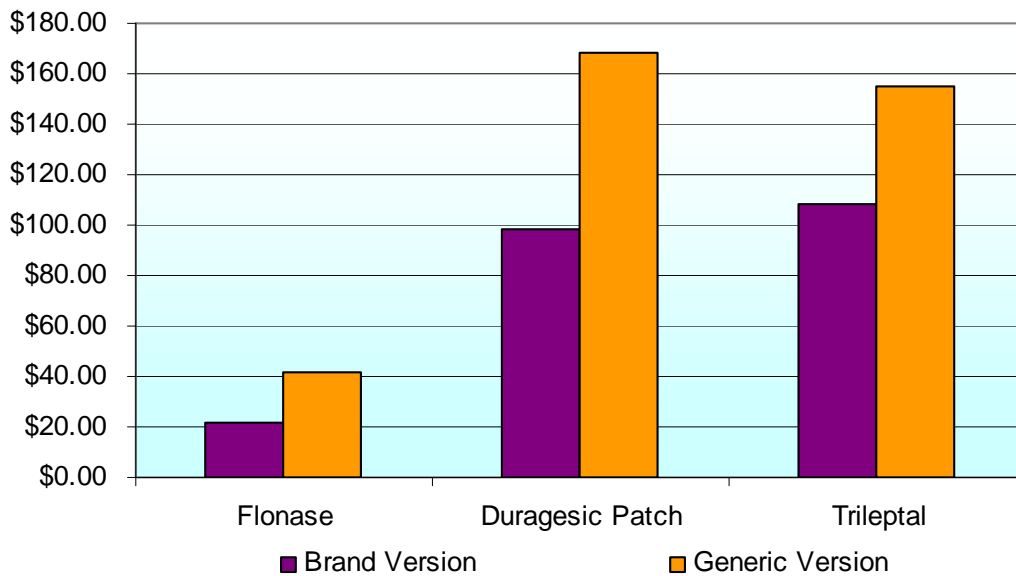
Note: Actual MCO self-report pharmacy dollars include expenses for drugs not included in the December 2006 report (e.g., physician administered drugs), so the MCOs' self-reported amounts are expected to be higher.

### How important are generics in the big picture?

Those that expressed opposition to this initiative stressed that generics were the most important tactic to control costs. For the MCOs this may be true; however, for the Department this is simply not true, not always fiscally sound policy and clouds the picture. Because of the unique purchasing power of the Department (refer to Exhibit 1 and 2) and huge rebate dollars available on both brand and generic drugs, the Department should not focus solely on generic drug use – a concept that is foreign to most MCOs. Instead, the Department must employ a strategy that produces the lowest overall total cost (e.g., best bottom line) without compromising quality of care. For the Department, this is the bigger and better picture: lowest total cost.

The concept of lowest total cost, as opposed to generics only, is illustrated in Exhibit 4 that shows where the Department's cost of a brand drug is actually cheaper than the generic equivalent because of the applicable rebates.

Exhibit 4: Department's net cost for brand version and generic version



<sup>10</sup> Derived from the HealthChoices MCOs' 3Q2007 financial claims lag report

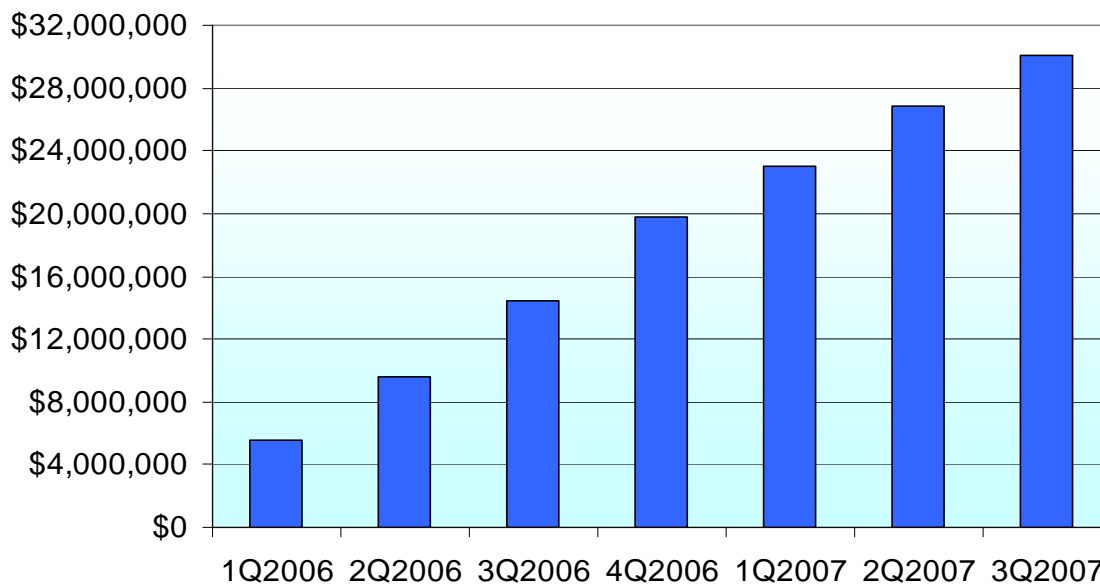
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The Department does recognize that appropriate use of generics is still an important component of an effective pharmacy benefit management strategy. Based on data provided by the Department's Pharmacy Division for a comparable population (e.g., dual eligibles and long-term care residents excluded), the Department has significantly increased its prescription drug generic dispensing rate to over 60 percent since the CY 2004 time period when the MCOs repeatedly pointed out that it was only 44 percent. In the third quarter of 2007, the Department's prescription drug generic dispensing rate was 65.1 percent.

### Supplemental state rebate dollars

The MCOs and Milliman also commented that there was "no evidence of the ability of the State to obtain additional [state supplemental] rebates at this time<sup>11</sup>." On the contrary, the Pharmacy Division actively tracks the Department's pharmacy rebate submittals and collections and can document the collection of significant state-supplemental rebates. The actual amount of rebates collected in any given quarter will fluctuate based on such things as drug mix and prescription volume, but Exhibit 5 shows that the Department has accumulated a substantial amount of actual collected supplemental rebates from drug manufacturers. This represents real savings to the Medical Assistance Program obtained through the Department's purchasing power.

Exhibit 5: Department's cumulative dollar savings in supplemental rebates by quarter



<sup>11</sup> Milliman's Observations Regarding the Mercer Report Issued December 18, 2006 entitled "Financial Evaluation of Pharmacy Carve-out from the Capitated MCO Program to the FFS Program", Milliman, May 30, 2007, page 13.

## Sharing pharmacy claims information

Finally, concern was expressed that this initiative would fragment the health care system because the MCOs would not have ready access to the pharmacy claims information to integrate into care management plans. The Department acknowledges this concern and has stated previously that this initiative is not intended to create cost increases elsewhere in the health care system, which would diminish the financial benefit achieved.

Fortunately, pharmacy claims information is widely recognized as the most reliable and easily transmitted health care data available. For example, even today the Department's computer servers currently act as a conduit between the HealthChoices physical health MCOs and behavioral health MCOs to share pharmacy data. Furthermore, the Department is already providing its contracted management vendor of the ACCESS Plus program a weekly pharmacy data file for purposes of care coordination and management.

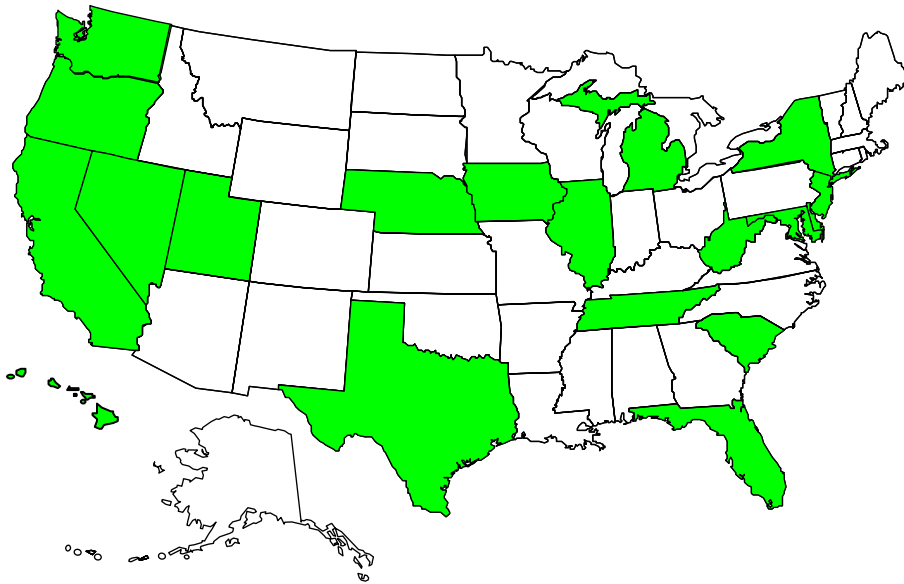
Additionally, staff within the Department's Bureau of Data and Claims Management have implemented processes to automate weekly pharmacy data transfers with the behavioral health MCOs and are working to implement an on-line, secure intranet portal for the physical health MCOs to access and use medical/pharmacy claims information on their new and current members to ensure the managed care plans have readily available information to meet quality of care goals and objectives.

The Department's Medical Assistance system currently processes over 16 million non-HealthChoices pharmacy transactions in a year, most of which are processed within 10 seconds or less due to providers' use of the Department's point-of-sale system. In many ways, the Department would become the MCOs' pharmacy data/management liaison; supplying pharmacy information to the MCOs much the same way as many MCOs receive claims data from their PBMs, other contracted claims processors or other entities for purposes of care management. This type of pharmacy model is not unique, being structured similar to the PBM type of model that most private health insurers, including some of the HealthChoices MCOs, employ today.

## Other states have the same policy

Finally, this initiative is not unique. Many states have elected to pay for and manage the Medicaid drug benefit within their respective programs. According to a recent report released by the National Association of State Medicaid Directors/American Public Human Services Association<sup>12</sup>, 10 states plus the District of Columbia have removed all drugs from their MCO capitation rates (e.g., Texas, New York, Illinois), while nine additional states have payment responsibility for selected drug classes (e.g., Florida, California, Michigan). This report also stated that seven additional states reported considering taking over payment responsibility for all drugs in the past year. Exhibit 6 highlights the states noted in the report that fully or partially managed the drug benefit for enrollees in MCOs. Also note that two of the HealthChoices PH-MCOs participate in some of these highlighted states' Medicaid managed care programs. Since the release of the report, Wisconsin has begun to transition payment responsibility for drugs to the State from the MCOs.

Exhibit 6: States having full or partial payment responsibility for the Medicaid drug benefit



<sup>12</sup> 2007 State Perspectives Medicaid Pharmacy Policies and Practices, November 2007  
Mercer

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## Continuous improvement

Over the last couple of years, the Department has made significant investments in time and resources to increase staffing levels and modernize its tools and techniques used in managing the Medicaid drug benefit. The managed care industry served as a source of information to draw upon and leverage successful practices and policies, incorporating these strategies into the Department's own systems and Medical Assistance Program policies and requirements.

Although we observe that the Department has opportunities to continue to improve, the achievements made to date show a considerable dedication and adeptness for integrating better and more aggressive management techniques. We asked the Department to document the key program enhancements made to the Medical Assistance Program. Exhibit 7 provides evidence that the Department takes its responsibilities seriously in being a good steward of public resources.

Exhibit 7: Key actions taken by the Department to improve its management of the pharmacy benefit

November 2004 – ongoing	Division of Pharmacy established and hired an experienced pharmacist as OMAP Pharmacy Director
December 2004 – ongoing	Established Pharmacy Call Center for all prior authorization and provider inquiries staffed with certified pharmacy technicians
January 2005 – ongoing	Implemented “dynamic drug pricing” payment methodology – pay lesser of average wholesale price (AWPs) provided by three national pricing vendors (First DataBank, MDX, MediSpan)
June 2005 – ongoing	Expanded Pharmacy Call Center with hire of 14 additional pharmacy technicians and a medical internist to review provider inquiries
June 2005 – ongoing	Established P&T Committee meeting to develop and maintain PDL and other pharmacy clinical programs
August 2005 – ongoing	Implemented change in drug payment methodology for brands and generics
August 2005 – ongoing	Implemented an aggressive state maximum allowable cost (MAC) pricing list for generic and over-the-counter drugs

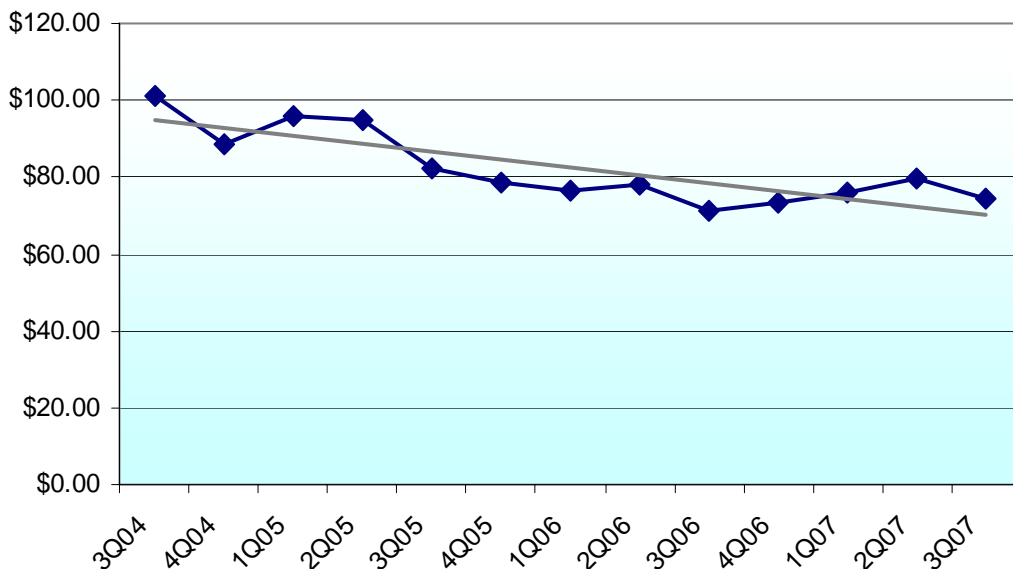
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August 2005 – ongoing	Implemented pharmacy point-of-sale edits (e.g., quantity limits, prior authorization, dose optimization)
September 2005 – ongoing	Begin PDL development – including collaborative work with PDL vendor, Provider Synergies
October 2005 – ongoing	Expanded Pharmacy Call Center with hire of additional clinical pharmacist and hired adult and child psychiatrist reviewers for behavioral health pharmacy inquiries
February 2006 – ongoing	Finalized implementation of PDL and transitioned to PDL maintenance; introduced additional utilization controls
February 2007– ongoing	Joined Provider Synergies multi-state pooling program (TOP\$) for maximization of supplemental rebates
April 2007 – ongoing	Developed Specialty Pharmacy Drug Program – all specialty drugs must be obtained by two preferred providers

From both a fiscal and operational perspective the Department has modernized its pharmacy management program and continues to do so with on-going programs, edits and enhancements. Because the Department has aggressively tackled its own operations first, making many significant improvements in its management policies and furthering its financial advantage with bulk purchasing and enhanced rebate collections, it is appropriate to take a hard look at the feasibility of changing the status quo.

To demonstrate that the improvements implemented by the Department have translated into savings, the Department provided Exhibit 8 that plots the Department's declining per member per month (PMPM) cost of the Medicaid drug benefit, with an overlaid trend line, for the non-dual eligible population. The Department's success comes at a time when the annual increase in national prescription drug expenditure averaged 7.1 percent<sup>13</sup>.

Exhibit 8: Department's pharmacy non-dual eligible PMPM trends (does not reflect federal and supplemental rebates)



<sup>13</sup> CMS NHE Table 2, 2004 to 2006, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>

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## Conclusion

Rarely in the realm of health care does anything come easy or is an absolute. Progress is achieved through solving problems, discussion and debate, testing new ideas and replicating successful ventures. The Department has an enormous challenge to address: maintaining the fiscal stability and integrity of a quality Medical Assistance Program. A near \$15 billion program that serves almost two million citizens is no small burden; however, as described in this supplement, the Department has made significant strides in its management of the pharmacy benefit. The Department has:

- Created, staffed and expanded a new Pharmacy Division
- Negotiated and collected millions of dollars in state-supplemental rebates, in addition to the already substantial federally-mandated rebates
- Implemented changes to payment methodologies
- Implemented a PDL with related quality controls
- Modernized the management policies and procedures related to the Medicaid drug benefit
- Increased the prescription drug generic dispensing rate to over 60 percent
- Developed a specialty pharmacy drug program to save additional money
- Established a P&T Committee
- Developed data transfer processes to ensure that pharmacy claims information is readily available to the contracted MCOs for care management

The Department has conveyed that the purpose of this initiative is not to dismantle the HealthChoices program, but instead to take advantage of the Department's purchasing power and unique ability as a state Medicaid agency, just as it did in securing supplemental rebates from drug manufacturers. The leadership within the Department's Medicaid agency communicated to Mercer that it has put all the necessary supports in place for effective management of the pharmacy benefit to ensure quality, access and fiscal accountability; all of which are good for taxpayers, good for providers and good for consumers.

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