Reducing TennCare Drug Costs:
A Proposal for Discussion

a legislative briefing paper by
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According to the Health Care Financing Administration, U.S. spending on prescription drugs increased from $51.3 billion in 1993 to $121.8 billion in 2000, a 137 percent increase. In contrast, overall health care spending grew by only 48 percent.[1] The annual increase in Medicaid prescription drug spending grew from 11 percent to 21 percent during that time.[2] Tennessee's prescription drug market and the TennCare program have reflected those trends. Based on data from the TennCare Bureau and Price Waterhouse Coopers, prescription drug costs will exceed $1.2 billion by the end of fiscal year 2002, representing over $400 million in state dollars. The Comptroller's Office of Research examined potential strategies for reducing pharmacy costs and slowing the growth rate for these costs. Generally, the Office evaluated strategies employed by private sector companies and other state Medicaid programs to determine which may apply to TennCare. This research included:

- A review of recent periodical articles addressing issues of rising drug costs;
- A review of pharmacoeconomic research in peer-reviewed journals;
- A review of research conducted by other organizations, including the National Institute for Health Care Management, the Kaiser Commission on Medicaid and the Uninsured, the National Governors Association, the National Conference of State Legislatures, the Robert Wood Johnson Foundation, the Rutgers Center for State Health Policy, the Tufts Center for Drug Development, the Idaho Department of Health and Welfare, and the Congressional Budget Office;
- A review of information on Medicaid pharmacy benefit cost-control mechanisms on state websites;
- Interviews of state officials connected with Medicaid programs in Georgia, Idaho, Maine, Massachusetts, Tennessee, Texas, and Vermont;
- Interviews of TennCare stakeholders including patient advocates, managed care organizations, pharmaceutical companies, physicians, pharmacists, and the TennCare Bureau.

This research process revealed a number of strategies that may reduce TennCare pharmacy costs while maintaining high quality standards of care for TennCare enrollees. The General Assembly and the TennCare Bureau may wish to consider the following proposal as an alternative to the existing structure of TennCare pharmacy services. This proposal should serve as a point of reference for discussing possible changes to TennCare, not a final recommendation for restructuring the program. Further research will provide more conclusive estimates of the potential savings these and other changes could produce. Finally, this proposal would require a revision of the *Grier Revised Consent Decree*.

[1] Health Care Financing Administration, "National Health Expenditures Tables—Table 9," http://www.hcfa.gov/stats/nhe-oact/tables/t9.htm (accessed June 7, 2002).
[2] Ibid.

Under the proposal, the state would:

Carve out pharmacy benefits from the managed care organizations (MCOs) and consolidate all pharmacy benefits into a single statewide program to maximize rebates from pharmaceutical companies. Federal law requires drug manufacturers to offer their "best price" to state Medicaid programs.[3] However, TennCare MCOs do not qualify for this "best price" provision because they are private companies buying drugs from capitation payments. Pharmaceutical companies give the Bureau rebates of about 20 percent for prescription drug purchases in the current carve-out providing drugs for behavioral health organizations and Medicare/TennCare dual eligibles. In contrast, the Price Waterhouse Coopers actuarial report assumes a rebate of seven percent for TennCare MCOs. If current MCO drug purchases received the same rebates as the Bureau, it could produce approximately $65 million in direct program savings. This translates into over $20 million state dollars.

Contract with a private pharmacy benefit manager (PBM) to administer many programs associated with a pharmacy benefit. Almost all private insurance companies and health maintenance organizations contract with pharmacy benefit managers or have in-house PBM services to create cost-effective drug programs. PBMs have a number of purposes:

- they work to ensure that patients are taking drugs necessary to treat their conditions;
- they try to prevent the use of redundant drugs or those that may cause adverse reactions in patients;
- they strive to eliminate unnecessary and excessive drug use;
- they encourage patients to use less costly drugs when they are equally effective as more expensive treatments; and
- they generally work to ensure pharmacy benefits are both adequate and cost-effective.

Several states, including Georgia and Maine, have contracted with private PBMs and have successfully slowed growth in pharmacy costs while maintaining standards of patient care. A TennCare pharmacy benefit manager could administer the pharmacy benefit, conduct drug utilization review (DUR), recommend changes to the pharmacy benefit structure, implement changes requested by the Bureau, and provide information to the state formulary committee. The cost of a PBM contract should not differ significantly from administrative costs associated with pharmacy benefits TennCare currently pays MCOs.

Pending a negotiated revision to *Grier*, create a preferred drug list (PDL) for the pharmacy carve-out. A PDL is a list of drugs patients and practitioners are encouraged to use. Insurance companies usually promote PDL drugs by charging patients much higher copays for drugs not on the list. Each TennCare MCO has its own preferred drug

[3] 42 USC 1396r-8(c). "Best price" provisions do not include prices paid by the Department of Veterans Affairs, state homes, the Public Health Service, or certain types of public clinics; prices charged under the Federal Supply Schedule; prices used by state pharmaceutical assistance programs; and depot prices and single award contract prices.

list. Doctors must receive prior authorization (PA) from the MCO before a patient can obtain a drug not included on the MCO's PDL. A single preferred drug list for all of TennCare would reduce hassles for doctors and pharmacists who currently negotiate different lists for various MCOs. Creating a PDL for a TennCare carve-out would probably be a multistep process. The following model is loosely based on the process the Georgia Department of Community Health followed in creating its formulary.

- First, the state would create a formulary committee comprised primarily of physicians but also including pharmacists and nurse practitioners. This committee would hold a series of open meetings for each drug class and recommend to the TennCare Bureau which drugs should be included on a preferred drug list. The formulary committee charter would contain ethics provisions to ensure the integrity and credibility of the committee.
- The state's pharmacy benefit manager would compile and present research to the formulary committee on drugs under consideration. This research would include information on drug utilization, effectiveness, and potential side effects of each drug. Though firm price data would not be available at this stage, the PBM should also share with the formulary committee the approximate price range of various products. All meetings of the formulary committee would be posted on the internet at least a month in advance, and pharmaceutical companies would have the opportunity to meet with the pharmacy benefit manager during this month to present any relevant information on their products.
- The TennCare Bureau pharmacy and therapeutics (P&T) committee would examine recommendations from the formulary committee, guidelines created by the TennCare Centers of Excellence, and drug prices and make final decisions about which products to include on the state preferred drug list. For example, the formulary committee might recommend that three drugs be covered from a group of eight. The P&T committee would then choose the three drugs from this list that appear most cost-effective. The formulary committee might also recommend that some drugs be available on a restricted basis only to patients suffering from certain conditions. If the pharmacy and therapeutics committee agreed, physicians would have to receive prior authorization (PA) from the state pharmacy benefit manager for these drugs before they could prescribe them.

After construction of a state preferred drug list, the formulary committee would continue to meet once every four months to evaluate possible changes in drug categories, either because new drugs have entered the market or because new studies have been released analyzing the effects of existing drugs. The formulary committee would then recommend changes in the preferred drug list to the TennCare pharmacy and therapeutics committee. If new drugs entering the market appear to offer major therapeutic benefits, the state pharmacy benefit manager could recommend that these drugs be included on the preferred drug list prior to a meeting of the state formulary committee. Again, the TennCare P&T committee would make the final decision.

Craft procedures to ensure patients have access to all drugs covered under Medicaid while maintaining the integrity of the formulary. TennCare recipients would still have access to all drugs covered by Medicaid through prior authorization (PA). A physician who felt his/her patient needed a restricted drug listed on the state PDL could call the state pharmacy benefit manager. The PBM would have pharmacists on call 24 hours a day to respond to these requests. The PBM pharmacist would ask the physician a series of questions to determine if the drug is covered for that purpose. If so, the physician could prescribe that drug. If not, the physician could appeal the decision to the pharmacy benefit manager. These appeals would include the reason the drug is necessary, evidence that unrestricted PDL drugs either are ineffective or produce adverse side effects, and relevant patient medical records. The PBM should render a decision within 24 hours of receiving this information. Meanwhile, patients would be entitled to 72-hour emergency supplies of the drug while awaiting a decision.

Physicians could also seek prior authorization for drugs not included on the state formulary. For these drugs, the doctor would be required to show medical necessity. As with appeals for restricted PDL drugs, the physician would be required to provide evidence that the drug is necessary and that unrestricted drugs either are ineffective or produce adverse side effects. Again, the pharmacy benefit manager should render a decision within 24 hours of receiving all relevant documents from the physician, and patients would be entitled to a 72-hour supply of the medication.

Contracts for TennCare MCOs and the state PBM should include incentives to promote compliance with these prior authorization processes. A preferred drug list with an effective PA process could produce program savings of over $240 million, approximately $80 million in savings to the state.

Implement a three-tier copay structure tied to the preferred drug list. A recent study found that three-tier copayment plans encouraged the use of less expensive drugs and reduced overall prescription drug spending in the plans without increasing costs in other areas.[4] Also, after an initial drop in prescription costs, the three-tier plan also showed slower growth than a two-tier plan. A tiered copayment would reduce state costs both by requiring patients to pay a portion of drug costs and by discouraging the use of unnecessary and more expensive drugs. The TennCare Bureau has already received clearance from the Center for Medicare and Medicaid Services (CMS) to charge patients three-tier copays for prescription drugs. The lowest copay is for generic drugs. The second tier is for brand-name drugs with no generic equivalent. The third tier consists of brand-name drugs with generic counterparts. A three-tier copay structure tied to a formulary would continue to charge the lowest copay for generic drugs. Preferred formulary brand-name drugs would comprise the second tier. The highest tier would consist of drugs not included on the formulary's preferred drug list.

[4] Brenda Motheral and Kathleen Fairman, "Effect of a Three-Tier Prescription Copay on Pharmaceutical and Other Medical Utilization," *Medical Care*, December 2001, p. 1293-1304.

Negotiate additional rebates from pharmaceutical manufacturers in conjunction with a state formulary. Federal law requires drug companies to offer state Medicaid programs their "best price" available to the private sector. However, it does not prohibit states from negotiating additional rebates beyond these provisions. Florida and Michigan have obtained waivers from the Center for Medicare and Medicaid Services that tie inclusion on state preferred drug lists to specific price or rebate requirements. Other states obtain additional rebates in a less formal manner. TennCare, a program of over 1.3 million enrollees has significant bargaining power. Some pharmaceutical companies would likely offer higher rebates in order to get the P&T committee to include their drugs on the state preferred drug list.

Create a drug discount program for senior citizens under 300 percent of the federal poverty level who are not covered under TennCare. Medicaid programs receive prescription drugs at significant discounts compared to market prices. Tennessee could apply for a Section 1115 waiver from CMS to create a discount program through which senior citizens under 300 percent of poverty could purchase drugs on the state PDL at the prices paid by the TennCare Bureau, a discount of approximately 20 percent. The TennCare budget would have to include funding to administer the program and probably a small subsidy. However, the inclusion of this group in the TennCare purchasing pool would offer even greater bargaining leverage to negotiate higher rebates from pharmaceutical companies. These extra rebates would apply to the entire TennCare population.

The following table provides a list of potential fiscal impacts of this proposal. Where possible, it includes rough estimates of these impacts. These impacts assume a single state formulary would be comparable to existing MCO formularies. Impacts are in program dollars, which include state and federal spending.

Changes yielding savings	**Estimated Savings**
"Best prices" for drug purchases currently under MCO plans	$65,000,000
MCO pharmacy-associated administrative costs	unknown
Preferred drug list for current MCO drug plans (*Grier* revision)	$69,500,000
Expanded prior authorization for current dual carve-out	$175,000,000
Expanded prior authorization for current BHO carve-out	unknown
Tiered copayments based on preferred drug list	unknown
Supplemental rebates from drug companies	unknown
Improved management through PBM	unknown

Changes yielding higher costs	**Estimated Costs**
PBM Contract	unknown
Compensation for state formulary committee	unknown
Costs associated with senior discount drug plan	unknown
Lost MCO management expertise and programs	unknown

Addendum

An alternative to the above approach would be to leave existing MCO pharmacy benefits with the MCOs. Pharmacies would charge the state for drugs covered under the MCO plans. The state would then charge the MCOs for the price paid by the state. This would allow TennCare to take full advantage of Medicaid "best price" provisions. Because MCO capitation rates are actuarially determined, in the long run savings from these rebates would accrue to the state and federal governments rather than MCOs. MCOs would continue to conduct pharmacy benefit management within their plans. The state pharmacy benefit manager would then be responsible for managing only those prescription drug purchases in the current carve-out.