PERFORMANCE AUDIT REPORT

Prescription Drugs: A K-GOAL Audit Reviewing What The Kansas Health Policy Authority Is Doing To Control Prescription Drug Costs in the Programs It Oversees

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
November 2010

10PA18

Legislative Post Audit Committee
Legislative Division of Post Audit

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LEGISLATIVE DIVISION OF POST AUDIT

800 SW Jackson
Suite 1200
Topeka, Kansas 66612-2212
Telephone (785) 296-3792
FAX (785) 296-4482
E-mail: LPA@lpa.ks.gov
Website: http://kslegislature.org/postaudit
Scott Frank, Legislative Post Auditor

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LEGISLATIVE DIVISION OF POST AUDIT

800 SOUTHWEST JACKSON STREET, SUITE 1200
TOPEKA, KANSAS 66612-2212
TELEPHONE (785) 296-3792
FAX (785) 296-4482
E-MAIL: lpa@lpa.ks.gov

November 15, 2010

To: Members, Legislative Post Audit Committee

Senator Terry Bruce, Chair	Representative John Grange, Vice Chair
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Senator Derek Schmidt	Representative Ann Mah
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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Prescription Drugs: A K-GOAL Audit Reviewing What the Kansas Health Policy Authority Is Doing To Control Prescription Drug Costs in the Programs It Oversees*.

This report also contains two appendices, which shows a list of Kansas agency programs that purchase prescription drugs and a list of potential prescription drug cost-saving strategies.

The report includes several recommendations for the Kansas Health Policy Authority to explore the implementing the strategies included in this audit and report to their oversight board and the Legislature on the feasibility of each strategy. The report also contains a recommendation for the Legislature to consider amending State law to allow the implementation of certain strategies. We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Scott Frank
Legislative Post Auditor

READER'S GUIDE

The Big Picture

Audit Highlights	The highlights sheet, inserted in each report, provides an overview of the audit's key findings
Conclusions and Recommendations	Located at the end of the audit questions, or at the end of the report
Agency Response	Included as the last Appendix in the report
Table of Contents, and lists of figures and appendices	Lets the reader quickly locate key parts of the report

The Details

"At-a-Glance Box"	Used to describe key aspects of the audited agency; generally appears in the first few pages of the main report
Side Headings	Point out key issues and findings
Charts, Tables, and Graphs	Visually help tell the story of what we found
Narrative Text Boxes	Highlight interesting information or provide detailed examples

This audit was conducted by Dan Bryan, Nathan Ensz, and Alex Gard. Chris Clarke was the audit manager. If you need any additional information about the audit's findings, please contact Dan Bryan at the Division's offices.

Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612

(785) 296-3792
E-mail: LPA@lpa.ks.gov
Web: www.kslegislature.org/postaudit

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Prescription Drugs: A K-GOAL Audit Reviewing What the Kansas Health Policy Authority Is Doing To Control Prescription Drug Costs in the Programs It Oversees

The Kansas Governmental Operations Accountability Law (K-GOAL) subjects any State agency or program to audits, reviews, and evaluations as determined by the Legislative Post Audit Committee. Through this process, the Legislature can, in the words of the Act, "retain and maintain appropriate and effective governmental operations, remediate defective governmental operations, and terminate inappropriate or obsolete government operations."

The Committee is required to direct at least four audits each year under the law; it has chosen to focus these audits primarily on efficiency and cost savings issues. The law states that such audits may determine whether the agency or program is still needed, whether another agency could effectively perform the functions of the agency or program, whether the agency or program could be operated more efficiently and still fulfill its intended purpose, and other factors as determined by the Legislative Post Audit Committee. The Committee has designated this audit of prescription drug costs as a K-GOAL audit.

The Kansas Health Policy Authority (the Authority) was created in 2005 as an independent State agency. The Authority is responsible for developing and maintaining a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion-oriented public health strategies. The goal of the Authority is to improve the health of Kansans by increasing the quality, efficiency, and effectiveness of health services and public health programs. The Authority has responsibility for the oversight of Medicaid, the State Children's Health Insurance Program (SCHIP), the State Employee Health Benefits Program, and State Workers' Compensation.

In recent years, the prescription drug components of the State's Medicaid program and State Employee Health Plan have been subject to several studies and audits, as summarized below:

- In 2000, Legislative Post Audit audited the State's Medicaid program and found that prescription drug spending had increased rapidly, and represented 25% of total Medicaid spending in 1999. That audit concluded that the increasing cost of prescription drugs merited putting resources toward avoiding excess costs wherever possible.

- In 2003, the Kansas Senate President formed the President's Task Force on Medicaid Reform (six State Senators and two Representatives) to examine cost savings measures in all aspects of the Kansas Medicaid program, including prescription drug costs. The Task Force's final report to the Legislature identified several strategies for containing escalating prescription drug costs.

- In 2004, Legislative Post Audit examined the accuracy of payments made by the State's pharmacy benefits manager for the State Employee Health Plan. Although the audit found only a few problems, we recommended the State improve its oversight and monitoring of claims and payments to decrease the risk of inappropriate payments.

All three of these reports identified several strategies that likely would reduce spending on prescription drugs. Further, a recent audit in Florida noted that its Medicaid agency had implemented several cost control measures related to prescription drug costs.

This performance audit answers the following questions:

1. **Can the State reduce its costs for prescription drug purchases in the Medicaid program?**

2. **Can the State reduce its costs for prescription drug purchases in the State Employee Health Plan?**

The Medicaid program and the State Employee Health Plan account for the vast majority of Kansas prescription drug expenditures. For reporting purposes we've divided the original audit question into two questions—one for each program. A copy of the original scope statement and audit question approved by the Legislative Post Audit Committee is available in ***Appendix A***.

To answer these questions, we interviewed Authority officials and collected documentation about the efforts they've made to implement recommendations from prior reports and implement other cost control measures. We interviewed prescription drug officials and professionals, and we reviewed literature to identify potential cost savings strategies. We analyzed claims data and worked with Authority officials to estimate potential cost savings from implementing selected strategies. Although the scope statement says we would explore combining the prescription drug component of the Medicaid and State Employee Health Plan, we didn't pursue this option. We found the two programs are very different in terms of needs and eligibility requirements, both of which limit opportunities to combine prescription drug purchases.

We conducted this performance audit in accordance with generally accepted government auditing standards with certain exceptions. We relied on the Authority to estimate potential cost savings from implementing several strategies. In addition, we didn't fully test Medicaid or State Employee Health Plan beneficiary claims data showing the number of prescriptions and costs.

The standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The reader should be aware that some cost savings are based on unaudited estimates from the Authority. However, except for these specific limitations, we don't believe that the data are grossly or systematically incorrect as to affect our findings.

Our findings begin on page 9, after a brief overview of the Kansas Health Policy Authority's prescription drug expenditures and programs.

Overview of the Kansas Health Policy Authority's Prescription Drug Expenditures and Programs

The Health Policy Authority Oversees About 94% of All Prescription Drug Expenditures

In fiscal year 2010, State agencies spent $243 million on prescription drugs from both State and federal funds. We identified nine agencies in Kansas that pay for prescription drugs. Of those, the Kansas Health Policy Authority (the Authority) accounted for $229 million (94%). Its two main prescription drug programs are the Medicaid program and the State Employee Health Plan. The Authority also purchases prescription drugs through the Workers' Compensation program, but because the amount is much smaller than the other two main programs, we excluded it from our analyses.

Appendix B provides a complete list of the agencies that pay for prescription drugs and the amount they spent.

The Authority's Medicaid Program Spent $52 Million in Fiscal Year 2010 On Prescription Drugs

The Medicaid program provides medical health care coverage for adults and children who fall below certain monthly income thresholds. Prescription drug benefits are not required in Medicaid, but Kansas has chosen to include prescription drug coverage in its program.

This audit focuses only on prescription drug expenditures for the fee-for-service portion of Medicaid. Many Medicaid clients receive health care services through a capitated managed-care program called HealthWave. In that program, managed-care organizations receive a fixed rate to provide services. As such, prescription drug costs are rolled into one rate for health services and aren't separately available. Further, the managed care provider, not the Authority, is responsible for managing prescription drug costs in managed care.

The Authority and the federal Medicaid agency share program costs and negotiating responsibilities. The federal government matches State spending on Medicaid. The federal Medicaid agency—Centers for Medicare and Medicaid Services (CMS) — is responsible for about 60% of the program's total cost, but that percentage varies each year. In fiscal year 2010, Kansas' fee-for-service Medicaid prescription drug costs totaled $166 million. CMS paid about 70% of the costs, or $114 million. The State's share of Medicaid prescription costs that year was $52 million.

The Authority administers Medicaid subject to oversight by CMS. Federal law outlines basic minimum requirements that all state Medicaid programs must meet. However, states have broad authority to define eligibility, benefits, provider payment, delivery systems and other aspects of the program.

In this joint program, both CMS and the Authority can negotiate with pharmaceutical manufacturers, as described below:

- **CMS negotiates rebates on behalf of Kansas and other states**. Federal law enables the federal government to use its leverage as a large purchaser of prescription drugs to secure some of the lowest prices available.

- **Kansas negotiates additional rebates with prescription drug manufacturers**, which further reduce the prescription drug costs for the Medicaid program.

Regardless of who negotiates rebates, both the federal government and the State receive part of these rebates because Medicaid is a joint program.

Figure OV-1 on page 6, illustrates the differing roles and responsibilities for various players in Kansas' Medicaid prescription drug benefit program.

As the figure shows, Medicaid beneficiaries pay a copayment for most prescription drugs they receive–currently $3 per prescription. The federal government prohibits the Authority from requiring the beneficiary to pay the copayment. However, if the beneficiary doesn't pay the copayment, the loss in revenue affects the pharmacy, not the State.

The State Employee Health Plan Spent $46 Million In Calendar Year 2009 On Prescription Drugs

The State Employee Health Plan provides medical health care coverage for State employees, retirees, and their dependents. Prescription drug coverage is one component of the program.

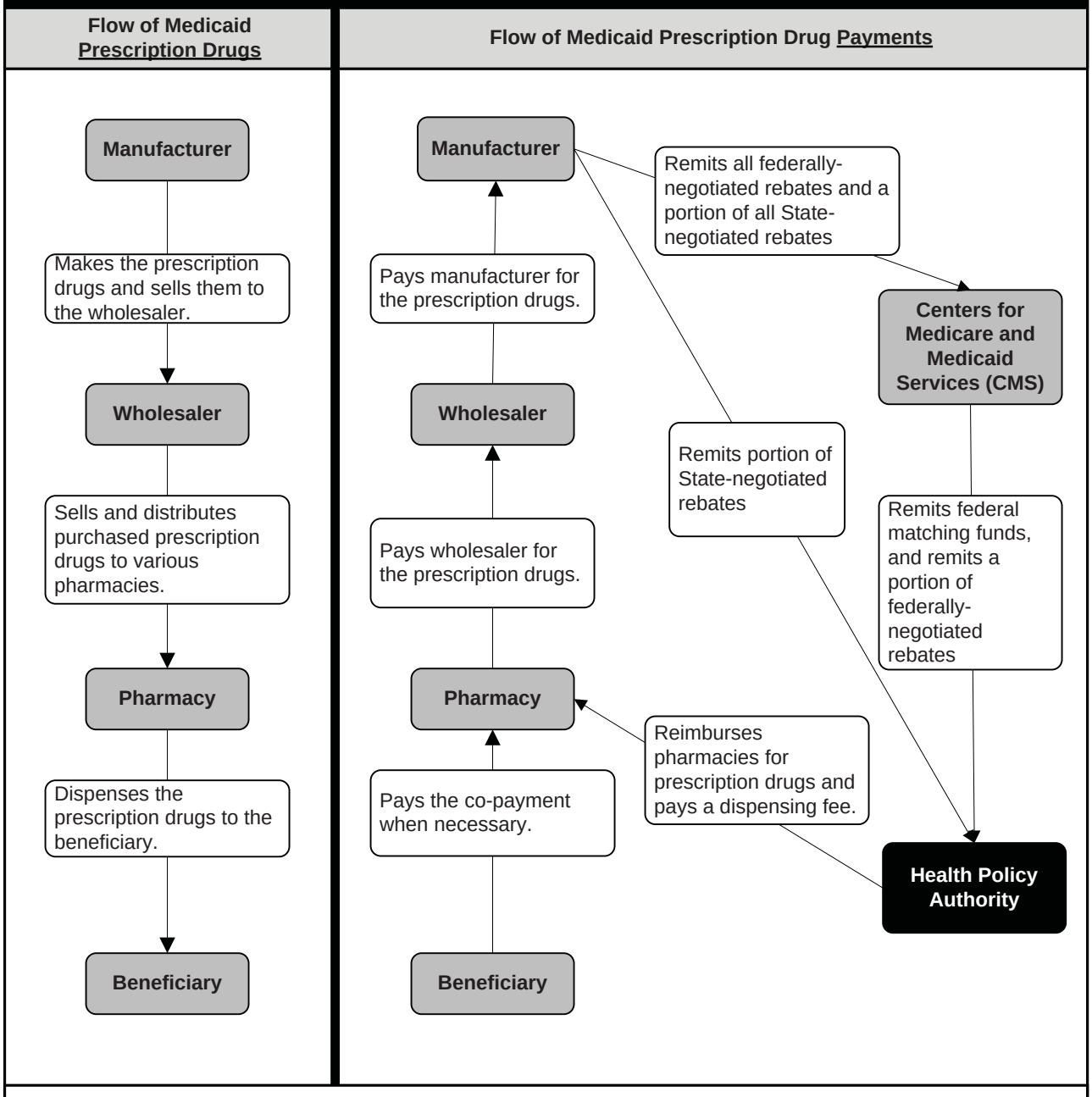
Authority officials contract with Caremark to administer the prescription drug benefit. Caremark is a pharmacy benefits manager that negotiates prescription drug prices with prescription drug manufacturers. Entities—such as the Authority—can contract with Caremark to purchase prescription drugs at the negotiated prices. As the State's pharmacy benefits manager, Caremark is also responsible for developing and managing a network of pharmacies, and for processing prescription drug claims. Kansas pays Caremark a fee—currently 95 cents—for each claim it processes.

Health Plan beneficiaries pay a certain percentage of the total cost of each prescription—also known as coinsurance. The percentage varies depending on the type of prescription drug purchased. This is discussed in more detail in Question 2. In 2009, the Health Plan and its beneficiaries spent $83 million on prescription drugs, more

than half of which (a little more than $46 million) were State dollars. (2009 was the most recent year for which data were available.)

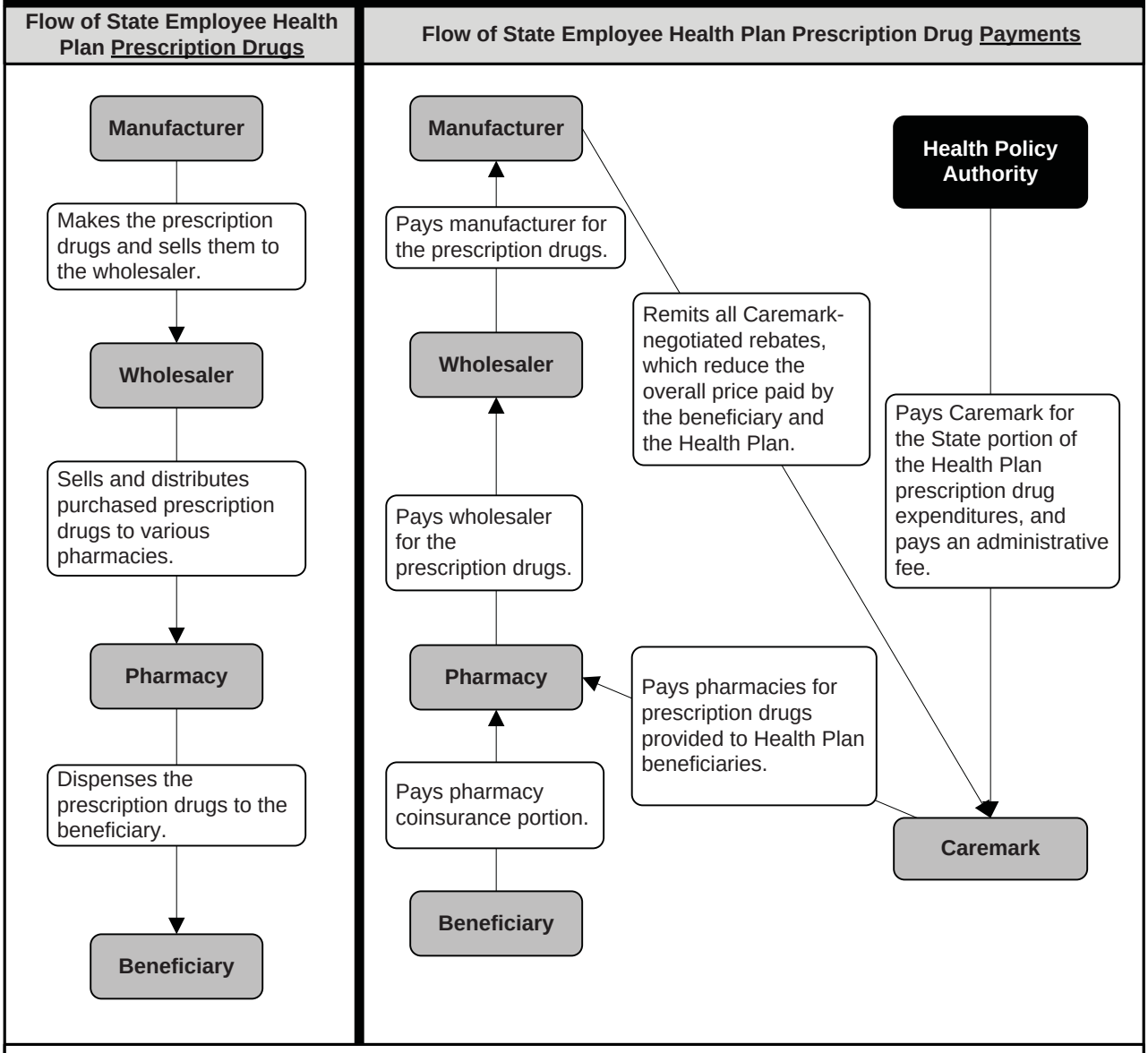
Figure ***OV-2*** on the next page, shows the different roles Caremark, the Authority, and the beneficiaries play in paying for prescription drugs under the Health Plan.

Figure OV-1
How Medicaid Prescription Drugs Are Paid For and Dispensed



Source: KHPA officials' explanation of the Medicaid prescription drug process.

Figure OV-2
How State Employee Health Plan Prescription Drugs Are Paid For and Dispensed



Source: KHPA officials' explanation of the State Employee Health Plan prescription drug process.

Prescription Drug Costs Generally Can Be Controlled In Three Areas

In the course of our audit work, we discovered that most cost savings approaches fell into one of three different areas. These are described more fully in the report, and summarized below:

- **Savings can come from controlling the type and quantity of prescription drugs that are prescribed.** Strategies in this area could target physicians' or beneficiaries' behaviors. For example, increasing the maximum number of days for which a prescription may be written may change how physicians write prescriptions. Other strategies affecting co-insurance may encourage beneficiaries to switch to a generics or lower-cost drugs.

- **Savings can be generated by controlling how much money is paid to the pharmacies.** Strategies in this area could include reducing dispensing fees—a fixed fee that is paid to pharmacies for every prescription that is filled—or having the Pharmacy Benefit Manager (PBM) negotiate a lower reimbursement rate with the pharmacies.

- **Savings can come from negotiating for larger rebates from the drug manufacturers.** The Authority staff (for the Medicaid program) and Caremark (for the state Employee Health Plan) negotiate with manufacturers for rebates on prescription drugs in an effort to reduce overall costs. Negotiating larger rebates would drive down costs.

Definitions of Terms Found in This Report

Beneficiary — A person who is eligible to receive and is a consumer of prescription drugs.

Coinsurance — The percent of the prescription drug cost the beneficiary must pay. The co-insurance amount paid increases or decreases with the cost of the prescription drug. For example, if co-insurance was 30%, the beneficiary's out of pocket cost for a $12 prescription ($4) is less than for a $30 prescription ($9).

Co-payment — The fixed dollar amount of the prescription drug cost the beneficiary must pay. A co-payment doesn't increase or decrease with the cost of the prescription drug.

Dispensing Fee — The amount paid to pharmacists to cover the costs of filling a prescription for a beneficiary. These costs include things such as the prescription bottle, label, staff time, and the building. The dispensing fee doesn't cover the cost of the drug dispensed.

Multi-State Consortium — An organized group of states that pool together beneficiaries and leverage the larger prescription drug buying power to achieve more rebates on prescription drugs.

Pharmacy Benefits Manager — An entity that is responsible for administering the pharmacy benefit program. Administration can include processing beneficiaries' prescription drug claims, developing a preferred drug list and contracting with pharmacies to provide prescriptions to beneficiaries.

Preferred Drug List (also known as a Formulary) — A list of prescription drugs approved for use and covered by the drug plan. Beneficiaries typically pay varying amounts for generic drugs, preferred drugs, and non-preferred drugs. Preferred drug lists likely cover at least one drug in each drug class (such as blood pressure medications), and encourages generic use.

Prior Authorization — A cost containment strategy that requires doctors to obtain permission to prescribe certain medications. This generally is used to deviate from the preferred drug list.

Rebates — Discounts on prescription drug costs negotiated directly with prescription drug manufacturers. Typically, the pharmacy benefits manager is responsible for negotiating rebates. In the Medicaid program both the State and the federal government negotiate rebates.

Step Therapy — A cost containment strategy that requires beneficiaries begin with the most cost effective prescription drugs and progress to other more costly or therapies. The "steps" can be between different drugs (such as a generic antihistamine and a name-brand antihistamine) or between different types of prescription drug therapies (such as pills or liquids).

Question 1: Can the State Reduce Its Costs For Prescription Drug Purchases In the Medicaid Program?

Answer in brief: *The Health Policy Authority has implemented several strategies to control prescription drug costs in the Medicaid program. We identified five additional strategies that potentially could save the Authority between $3.8 million and $4.6 million per year. These savings include the following: more than $2.2 million by joining a purchasing consortium, about $1.5 million from regulating mental health prescription drugs, about $470,000 from reducing dispensing fees paid to pharmacists, at least $140,000 by implementing a step therapy program and up to $300,000 by allowing pharmacies to dispense more than a one-month supply of prescription drugs. These and related findings are discussed in the sections that follow.*

The Health Policy Authority Has Implemented Several Strategies To Control Prescription Drug Costs In the Medicaid Program

Both our 2000 audit of the Medicaid program and the 2003 President's Task Force on Medicaid Reform looked at prescription drug costs in the Medicaid program. Those reports identified 12 cost-saving strategies, and included recommendations to the Department of Social and Rehabilitation Services, which administered the Medicaid program at the time. Upon its creation in 2005, the Kansas Health Policy Authority assumed responsibility for the Medicaid program and controlling prescription drug costs.

The Authority has implemented five of six prescription drug cost control measures identified by the two prior reports. For valid reasons, the Authority didn't implement six of the 12 strategies. For example, a recommendation to expand over-the-counter coverage wasn't implemented because the Legislature subsequently directed the Authority to reduce over-the-counter coverage. The Authority has implemented five of the six remaining strategies that could be implemented, as shown in the top part of ***Figure 1-1*** on page 10. The one strategy Authority officials haven't implemented involves joining a multi-state prescription drug-purchasing consortium. We discuss this strategy in more detail on page 11.

In addition to these prior recommendations, the Authority has developed and implemented several other cost-saving measures. The bottom portion of ***Figure 1-1*** on page 10, summarizes these actions and the estimated cost savings (when available). As the figure shows, Authority officials estimate they've saved $9.1 million per year through the implementation of these prior recommendations and through the implementation of additional cost savings measures.

Figure 1-1
Cost-Controlling Strategies KHPA Has Already Implemented
For Medicaid Prescription Drugs

Strategy	Brief Description of What KHPA Has Done to Implement This	Estimated Annual Savings
Strategies Implemented From Prior Recommendations		
Decrease the Amount the State Pays	KHPA officials use several techniques to keep costs lower, such as capping the maximum amount the State will pay for a prescription drug.	$5.5 million
Expand Prior Authorization	Prior authorization means beneficiaries first must try a preferred prescription drug, which generally is less-expensive, before receiving authorization for a different prescription drug. The number of prescription drug categories requiring authorization from KHPA staff has increased over the last four years.	$1.3 million
Counsel Beneficiaries with Chronic Conditions	The managed care portion of Medicaid provides counseling to patients with chronic conditions to better educate patients on how to manage their conditions in a safe and cost-effective manner.	Unknown
Expand Provider Outreach	Health professionals review prescription drug claims of beneficiaries to identify potentially inappropriate prescription drug therapies. When a problem is identified, the physician receives a letter from the Kansas Drug Utilization Review Board explaining the errors and offering a better course of action for the future.	$174,000
Use Starter Doses	More expensive prescription drugs have a 15-day starter dose instead of a typical 31-day dose to prevent the waste that occurs when a prescription drug doesn't work as expected.	$84,000
Other Strategies Implemented By KHPA		
Ensure the Claims System Has Checks and Balances	KHPA officials routinely check the claims data to ensure the accuracy of claims processing, ensure staff have the tools and training necessary to do these checks, and collect any penalties due from the vendor if claims are paid to ineligible people.	Unknown
Use Generic Prescriptions Drugs Whenever Possible	KHPA officials developed methods that encourage or require beneficiaries to use less-expensive generic prescription drugs prior to using more-expensive name-brand prescription drugs.	Unknown
Implement a Lock-In Program	This program restricts the choice of medical service providers (for example, a beneficiary can only get prescriptions filled at one pharmacy) to prevent dangerous practices, such as drug misuse .	$267,000
Reduce Over the Counter Medication Coverage	KHPA officials reduced the number of over-the-counter drugs for allergy treatments and cough and cold treatments that are covered.	$71,000
Privatize Claims Processing	Since 1978 the State has used a private vendor to process Medicaid claims to forgo the cost of administering the program. Hewlett-Packard is the current vendor.	Unknown
Obtain Prescription Drug Rebates	Centers for Medicare and Medicaid Services negotiate prescription drug rebates with manufacturers for all states. Additionally, KHPA officials negotiate with prescription drug manufacturers for additional supplemental rebates.	$1.4 million (a)
Reduce Payments to Doctors	KHPA officials have reduced payments to physicians for physician-administered drugs.	$315,000
Limit Number of Prescriptions	Beneficiaries are limited to five name-brand non-preferred prescription drugs per month unless they receive prior authorization to exceed that limit.	Unknown
Total Savings		**$9.1 million**

(a) The amount listed is the State savings negotiated by KHPA officials. The federal government negotiates an additional $18.9 million annually.

Source: Unaudited information provided by KHPA officials.

Five Additional Strategies To Control Medicaid Prescription Drug Costs Could Save the State Between $3.8 to $4.6 Million Per Year

In addition to the cost savings strategies noted above, we identified other cost-saving measures the State could use to reduce prescription drug expenditures. To identify strategies, we reviewed past audit and task force reports, and interviewed state officials and medical professionals in Kansas and other states. We compiled a list of potential strategies and asked Authority officials to identify which strategies they've implemented. We then selected the five strategies that appeared most likely to yield cost savings for further analysis. ***Figure 1-2*** below, shows those strategies and the estimated cost savings.

Figure 1-2
Five Additional Cost Savings Strategies Kansas Could Implement in the Medicaid Program

Proposed Strategy	Estimated Savings
Participate in a Multi-State Consortium	$2.2 million
Regulate Mental Health Drugs	$800,000 - $1.5 million
Reduce the Dispensing Fee Paid to Pharmacies	$470,000
Regulate Prescriptions Through Step Therapy Programs	$140,000
Increase the Maximum Supply of Maintenance Drugs to 60 or 90 days	$140,000 - $300,000
Total	**$3.8 million - $4.6 million**

Source: LPA analysis of unaudited KHPA data.

In the following sections, we provide more information about each strategy and the potential for cost savings. Our cost-savings analyses focus on saving State money; we excluded the federal share from the calculations. A complete list of the strategies we identified is available in ***Appendix C***. In addition, a brief discussion of how federal health care reform affects Medicaid and these strategies is presented in the box on page 12.

The Authority Could Save More Than $2.2 Million Per Year By Negotiating Better Prescription Drug Rebates For Medicaid Through A Multi-State Consortium

As discussed in the overview, the Centers for Medicare and Medicaid Services (CMS) negotiate prescription drug rebates for all states. States can negotiate additional rebates with prescription drug manufacturers on their own—known as supplemental rebates. Some states choose to participate in consortiums that pool together beneficiaries and leverage even larger buying power to achieve better supplemental rebates. In 2004, the State looked into joining a consortium but decided against it.

How Federal Health Care Reform Affects the Authority's Two Largest Programs

In March 2010, the federal government passed a health care reform bill that will require most Americans to have health insurance by 2014. The provisions of the health reform laws will be implemented on a staggered basis, with some provisions effective immediately, but most going into effect in 2014. Health care reform's effect on the Authority's two largest prescription drug programs is summarized below:

- **Medicaid**—The federal health care reform requires states, by January 1, 2014, to extend Medicaid eligibility to nearly all people under the age of 65 with income below 133% of the federal poverty line. As a result, millions of low-income adults who currently cannot qualify for coverage will be eligible for Medicaid. From 2014 through 2016, the federal government will pay 100% of the cost of the newly eligible adults. Beginning in 2016, the federal funding will decrease to 90%.

- **State Employee Health Plan**—The federal health care reform, which will take effect in the Plan January 1, 2011, requires insurers to allow young adults to remain on their parent or guardian's policy until they are 26 years old, regardless of financial dependency, residency, student status, employment status, or marital status. Currently, the dependents must be 22 years old or younger and must meet certain criteria including being non-married and receiving financial support from a parent.

We spoke with Authority officials about how the health care reform will affect the Medicaid program and the State Employee Health Plan. While officials told us the law would likely increase costs for both programs by making more beneficiaries eligible for coverage, they also told us it shouldn't affect the Authority's ability to implement the cost saving strategies we've identified in this audit.

About half of all states have joined a multi-state consortium to negotiate better supplemental rebates from drug manufacturers. We identified 26 states and the District of Columbia that purchase prescription drugs for their Medicaid programs through multi-state consortiums. Kansas doesn't belong to a consortium, but it does negotiate its own supplemental prescription drug rebates, which represent a little more than 2% of its total prescription drug costs ($1.4 million in fiscal year 2009). We were able to get information from one state that participates in a multi-state consortium (Iowa) and learned that it receives supplemental rebates that represented about 6% of its total prescription drug costs in 2009. If Kansas were able to match Iowa and achieve 6% in supplemental rebates by joining a consortium, we estimate the Authority could receive an additional $2.2 million annually.

Although Iowa gets better supplemental rebates than Kansas, we can't be sure whether it's because Iowa is in a consortium, or some other reason. For example, some of Iowa's rebates may be for mental health drugs. Because Iowa includes mental health prescription drugs on its preferred drug list, it can negotiate better rebates for those drugs. As explained more fully in the next section, Kansas law prohibits the Authority from having mental health prescriptions on its Medicaid preferred drug list.

Authority officials were concerned that joining a multi-state consortium could require high membership fees and could conflict with Kansas statute. While multi-state consortiums may allow Kansas to obtain larger negotiated prescription drug rebates, Authority officials expressed the following concerns:

- **Consortiums have high membership fees**—Authority officials told us that consortium membership fees could offset savings from larger supplemental rebates. However, Iowa officials reported paying about $30,000 annually to participate in the Sovereign State Drug Consortium and achieved $3.9 million in supplemental rebates in fiscal year 2010.

- **Consortiums may conflict with Kansas law, which prohibits regulation of mental health prescription drugs**—Authority officials also said that joining a consortium may require the Medicaid program to adopt a common preferred drug list that includes mental health prescription drugs. As discussed in the following section, State statute prohibits the Authority from including mental health prescription drugs on a preferred drug list. We found that although some consortiums may require members to use a common preferred drug list, others don't, and allow members to set their own preferred drug lists.

Kansas Could Save Up to $1.5 Million Per Year By Regulating Mental Health Prescription Drugs Like Most Other States

In addition to prescriptions for physical illness, the Medicaid prescription drug benefit also covers prescriptions for mental illness. These prescriptions can be for common conditions such as depression, and for more severe conditions, such as schizophrenia. Kansas spent almost $22 million in fiscal year 2010 on mental health prescription drugs, which is almost half of the total State's share of Medicaid fee-for-service prescription drug cost ($52 million).

State law prohibits the Health Policy Authority from regulating mental health prescription drugs for Medicaid beneficiaries by any means, including the use of a preferred drug list. A preferred drug list generally requires beneficiaries to try less expensive prescription drug treatments before moving to more expensive non-preferred alternative drug. Although, Authority officials have established a preferred drug list for most types of prescriptions, current law prevents the Authority from establishing a preferred drug list for mental health prescription drugs. Authority officials proposed legislation during the 2009 session to allow it to regulate mental health prescription drugs using a preferred drug list, but the bill wasn't passed out of committee.

More than half of all states regulate mental health prescription drugs for Medicaid beneficiaries with a preferred drug list. Some states only regulate mental health prescription drugs for more common conditions such as depression. Other states regulate

all mental health prescription drugs, including antipsychotics for conditions such as schizophrenia. Each scenario could reduce Kansas' prescription drug costs.

- **Kansas could potentially save $800,000 each year by implementing a preferred drug list for common mental health prescription drugs like 39 other states.** Authority officials told us regulating more common mental health prescription drugs is a logical first step toward regulating all mental health prescription drugs. They estimated the savings from requiring beneficiaries to try a less-expensive prescription drug before a more expensive alternative, based on a preferred drug list for conditions such as attention deficit hyperactivity disorder (ADHD) and depression. This estimate assumes only 50% of the mental health prescriptions would adhere to the preferred drug list. The other 50% would continue to receive the more expensive non-preferred perscriptions.

- **Kansas could potentially save $1.5 million each year by regulating all mental health prescription drugs.** Regulating all mental health prescriptions, including antipsychotics, is more difficult because the beneficiaries on those medications have more severe conditions such as schizophrenia. To account for that, the cost savings estimate again assumes only 50% compliance with the preferred drug list. Although this strategy is more difficult, we found 32 states regulate all mental health prescription drugs.

A Kansas Foundation for Medical Care official said one benefit of a preferred drug list is that beneficiaries would be prescribed mental health prescription drugs that have evidence-based results. The official said that general physicians don't regularly prescribe medication based on clinical studies, but rather based on what they've prescribed in the past. The Authority's mental health prescription drug advisory committee would likely select prescription drugs for the mental health preferred drug list based on clinical studies and results.

Conversely, critics of regulating mental health prescription drugs claim that for every dollar saved in prescription drugs, $17 is spent on other social services (increased emergency room visits, mental health center visits, and hospitalizations). Critics cite a 1994 study on New Hampshire as evidence. We reviewed that study and found that it wasn't on point. That study found increased costs in other areas such as mental health center visits and hospitalizations resulted from imposing a three-drug maximum cap, not from regulating mental health prescriptions drugs through a preferred drug list. A more on-point study, which assessed the impact of imposing a mental health preferred drug list, came from Georgia in 2007. That study found the state's regulation of Medicaid mental health prescription drugs with a preferred drug list resulted in no offsetting costs.

The Authority Could Save Almost $470,000 Per Year By Reducing the Dispensing Fees It Pays to Pharmacies

The purpose of a dispensing fee is to cover the costs incurred by a pharmacist for filling a prescription. This includes costs such as the prescription bottle, label, staff time, and overhead, but not the cost of the drug itself. The Authority pays the dispensing fee in addition to paying for the cost of the prescription drug.

In Kansas, the Medicaid dispensing fee is $3.40 per prescription, but there's evidence that suggests it could be lowered. Kansas' fee currently is less than the national average of $4.27. However, we noted the lowest Medicaid dispensing fee paid by any state is $1.75 (New Hampshire). Further, the Kansas State Employee Health Plan's current dispensing fee is $1.50, and is set to decrease to $1.00 by 2012.

Reducing the dispensing fee by $1 per prescription would result in cost savings of about $470,000 per year. We used a one-dollar reduction to illustrate the potential savings from reducing the dispensing fee. Reducing the dispensing fee is the decision of the Authority's board and Authority officials indicated that reducing the Medicaid prescription drug-dispensing fee to $2.40 is feasible. However, Authority officials said pending federal changes (as discussed below) and political pressure would make reducing the dispensing fee difficult.

A Kansas Pharmacists Association official told us reducing the dispensing fee might cause pharmacies to opt out as Medicaid providers. The official thinks that the decreased revenues will cause pharmacies to stop providing prescription drugs to Medicaid beneficiaries. Another potential problem he raised is that pharmacists may be more likely to fill prescriptions with more expensive brand-name prescription drugs—with larger profit margins— rather than generic prescription drug options. The box on page 18 provides more detail about the amount of discretion pharmacists have when they fill prescriptions.

Potential changes pending at the federal level could indirectly affect the Authority's dispensing fee. The Centers for Medicare and Medicaid Services (CMS) is developing more accurate estimates of prescription drug costs to aid states in their price negotiations with drug wholesalers. At this time, the effect of these new price estimates on Kansas isn't known, but it potentially could lower the overall payment to pharmacies, which could lead to requests to increase the dispensing fees paid to pharmacies.

Kansas Could Save At Least $140,000 Per Year By Regulating Prescriptions Through More Aggressive Step Therapy Programs

Medical conditions often can be resolved through various courses of action or various treatment alternatives. One way to control prescription drug costs is to require beneficiaries to try less expensive alternatives before more expensive ones. This is known as step therapy.

Step therapy can be defined in two ways. One requires a beneficiary try a specific drug before another specific drug. The other requires beneficiary try a specific therapy before an alternate therapy. These two forms are described more fully, as follows:

- **Drug**—Step therapy can require a beneficiary to try a preferred **drug**, such as a generic prescription drug, before receiving authorization for a more expensive alternative, such as a non-preferred brand name prescription drug. For example, a beneficiary would be required to try a $20 antihistamine tablet before a $30 antihistamine tablet.

- **Therapy**—Step therapy also may require a beneficiary to fail on a less-expensive **therapy** before moving to a completely different therapy. For example, a beneficiary would be required to try a $20 antihistamine tablet before a $30 nasal steroid spray.

State law currently allows the Authority to regulate steps for drugs, but not for progressive therapies. Statute prevents the Authority officials from requiring beneficiaries to fail on a less-expensive prescription drug therapy before getting a more expensive therapy. Regulating both therapies and drugs would broaden the cost savings by affecting more beneficiaries. The Legislature hasn't taken any recent action to expand what's currently allowed as step therapy. We contacted officials in Iowa and Colorado, and both states report that their Medicaid prescription drug programs have implemented both versions of step therapy as a cost-saving measure.

Using the State Employee Health Plan as a model, we estimate that Medicaid could save more than $140,000 annually by implementing a more aggressive step therapy program for only one type of prescription drug. Because the more expansive version of step therapy isn't allowed under State law, Authority officials haven't developed any policies or savings estimates for it. However, we estimated the potential cost savings to Medicaid if the Authority could implement an aggressive step therapy program for blood pressure medications, similar to the one used by the State Employee Health Plan. We estimate that Medicaid could save more than $140,000 annually with such a program.

Aside from the statutory prohibition on this more expansive type of step therapy, health care professionals we talked to didn't identify any significant barriers to implementing this type of step therapy program in Medicaid. However, one professional said the pharmaceutical lobby would oppose step therapy because it encourages less-expensive prescription drugs be tried first.

The Authority Could Save Between $140,000 and $300,000 Per Year By Allowing Pharmacies To Dispense More Than a One-Month Supply For Certain Prescription Drugs

Some prescription drugs are for acute or ad hoc conditions. Other prescription drugs are for long-term or chronic conditions, and are commonly known as maintenance drugs. As described earlier, each time a beneficiary obtains or refills a prescription, the State pays the pharmacy a dispensing fee. In Medicaid, the current maximum supply allowed for maintenance drugs is 31 days, which means the State pays a dispensing fee monthly. In fiscal year 2009, the State paid $2.3 million in dispensing fees.

We looked into the possibility of increasing the supply allowed, which would decrease the number of refills and dispensing fees the State must pay. To decide what's reasonable, we looked at the limits in the State Employee Health Plan. In that plan, beneficiaries taking the same prescription drug on a regular basis can receive a 60-day supply (Authority officials are considering increasing that maximum to 90 days).

For the Medicaid program, we estimate that the Authority would save at least $140,000 annually by increasing the maximum supply to 60 days. Further, if the supply is increased to 90 days, the Authority would save up to $300,000 annually. Both of these estimates assume that 50% of the people currently taking maintenance drugs would switch to a larger supply. Further, the estimates are based on the current dispensing fee; any change in the dispensing fee could have a significant effect on savings.

Pharmacists Have Some Flexibility When Filling Prescriptions

A health care provider examines the beneficiary and, if needed, writes a prescription detailing the type of medication needed, the proper dosage, and duration it should be taken. A pharmacist is responsible for providing the beneficiary the medication, but often has some flexibility in how it's dispensed, as described below:

- **Pharmacists can, in certain instances, substitute less-expensive prescription drugs in place of more-expensive options.** According to State law, a pharmacist is required to fill a prescription exactly as written if the health care provider directs the pharmacist to do so. The health care provider typically indicates this with the "Dispense as Written" check box on a prescription. If the health care provider writes the prescription for a name brand medication but doesn't mark "Dispense as Written", the pharmacist has the option of substituting a less-expensive but equivalent generic medication.
- **Pharmacists also can dispense a smaller supply of the prescription drug than was originally prescribed by the physician.** For instance, if a physician prescribes a 60-day supply of a prescription drug, a pharmacist can fill the prescription for 30 days and then require the beneficiary to refill the remaining 30 days later.

Authority officials and health care professionals said allowing more than a one-month supply of medication could have drawbacks, including an increased potential for waste and fraud. Health care professionals and Authority officials cited some issues with increasing the limit, as described below:

- The savings may not be achieved because pharmacists don't have to dispense 60- or 90-day supplies, as discussed on the previous page.
- Medicaid eligibility is determined monthly which means a beneficiary could be eligible for prescription drug benefits one month but not the next. With a larger supply of prescription drugs, beneficiaries could receive a supply that lasts into a period in which they are no longer eligible.
- Pharmacies would lose the dispensing fee and may lose additional money because there are fewer chances for pharmacies to collect beneficiaries' copayments.

The conclusion and recommendations for this audit are presented beginning on page 25.

Question 2: Can the State Reduce Its Costs For Prescription Drug Purchases In the State Employee Health Plan?

Answer in Brief:

The Health Policy Authority has implemented several strategies to control prescription drug costs in the State Employee Health Plan. We identified four additional strategies that potentially could save the Authority up to $3 million per year. These savings include the following: $2.8 million per year by reducing coverage on some or all prescription drugs, $126,000 per year by allowing pharmacies to dispense a three-month supply of certain drugs, and $74,000 per year from implementing a 15-day starter dose policy. The Authority potentially could also reduce costs by limiting the number of prescriptions a beneficiary can receive each month. Finally, we found the Authority's Medicaid staff and State Employee Health Plan staff could do more to coordinate with each other on cost savings strategies. These and related findings are discussed in the sections below.

The Health Policy Authority Has Implemented Several Strategies To Control Prescription Drug Costs in the State Employee Health Plan

In 2004 we conducted an audit examining the accuracy of prescription drug payments in the State Employee Health Plan. As part of that work, we recommended four cost savings strategies to the Department of Administration, which administered the Health Plan at the time. In 2006, the Kansas Health Policy Authority assumed responsibility for the Health Plan.

Since then, the Authority has implemented all four prescription drug cost control measures we recommended in our 2004 audit as well as several other cost saving measures. According to Authority officials, the Health Plan has saved about $3 million annually through the implementation of these various strategies, which are summarized in ***Figure 2-1*** on page 20.

Many Smaller Kansas Agencies Leverage Their Prescription Drug Purchasing Power Through the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP)

The Medicaid program and the State Employee Health plan account for the vast majority of Kansas prescription drug purchases. But other agencies also purchase prescription drugs and are taking some steps to control costs. One common cost control measure agencies are taking is joining a prescription drug purchasing consortium called the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). This consortium leverages purchasing power of more than $1 billion per year for state and local entities in 46 states. The consortium negotiates volume discounts on the prescription drugs most commonly purchased by its members.

Any State agency or local government entity—including cities, counties, and school districts—is eligible to purchase prescription drugs using MMCAP's contract prices. MMCAP doesn't charge membership fees but entities purchasing prescription drugs through MMCAP must register with the program and pay an administrative fee up to 3% per purchase to cover overhead costs. In 2009, 20 Kansas agencies—including executive agencies, universities, and county health departments—purchased about $6.8 million in prescription drugs through MMCAP.

Figure 2-1
Cost-Controlling Strategies KHPA Has Already Implemented
For State Employee Health Plan Prescription Drugs

Strategy	Brief Description of What KHPA Has Done To Implement This	Estimated Annual Savings (a)
Implemented Strategies From Prior Recommendations		
Increase the Maximum Supply of Maintenance Drugs	Increase the maximum supply of maintenance drugs from 30 days to 60 days in order to reduce the overall dispensing fees paid. Maintenance drugs are any medication taken over an extended period of time to treat a chronic disease or condition.	Unknown
Check the Accuracy of Claims Data	Routinely check the data to ensure the accuracy of claims processing (paying correct amount, paying for covered prescriptions, etc.), and ensure staff have the training and tools needed to conduct these checks.	$137,000
Check Beneficiary Eligibility	Along with Caremark, cross-check eligibility accuracy, ensure complete updates are made on a timely basis, and check whether claims were paid for ineligible people.	
Collect Penalties for Inaccurate Claims	Collect payment and penalties for inaccurate claims from Caremark.	
Other Strategies Implemented By KHPA		
Reduce the Number of Drugs Covered	Reduce the number of drugs covered under the State Employee Health Plan. For example, prescription antihistamines are no longer covered.	$1,200,000
Reduce Dispensing Fees	Reduce the dispensing fees received by pharmacies for every prescription dispensed.	$180,000
Implement a Wellness Program (b)	Discuss health issues with beneficiaries by a monthly newsletter and administer wellness activities such as smoking cessation.	$454,000
Implement Step Therapy for Common Prescription Drugs	Require beneficiaries to try a less expensive prescription drug option before a more-expensive alternative.	$650,000
Implement Step Therapy for Specialized Prescription Drugs (c)	Require beneficiaries taking one of two types of prescription drugs (rheumatoid arthritis and human growth hormone drugs) to try a less-expensive drug option before a more-expensive alternative.	$228,000
Monitor Members' Drug Usage and Provide After-the-Fact Training to Physicians	Monitor beneficiary prescription drug usage to identify potential misuse or overuse. Using that information, Caremark communicates with the beneficiary's health care provider to determine whether to make changes that patient's regimen and other prospective patients with similar circumstances.	$157,000
Allow Mail Order Prescription Drugs	Allow beneficiaries the option of receiving prescription drugs via mail at a lower cost.	$61,000
Use Prior Authorization	Require a physician override before a patient can receive a more-expensive non-generic drug if a less-expensive alternative is available.	Unknown
Privatize the Prescription Drug Plan	Contract with a third-party to process claims and negotiate prices to reduce the State's overhead costs.	Unknown
Provide Counseling for Chronic Illnesses or Conditions	Require beneficiaries with chronic illnesses or conditions to work with a case manager to determine the most appropriate treatment options.	Unknown
	Total Savings	**$3,067,000**

(a) These savings are based on annual savings in the first year of implementation. However, we found that some strategies, such as the wellness program, show an increase in savings over time.
(b) Estimated saving are based on only one component of the wellness program--smoking cessation.
(c) Annual savings for this strategy were not available. Authority officials estimate three-year savings at $685,000 and we calculated the one-year savings.

Source: LPA analysis of unaudited KHPA data.

Four Additional Strategies To Control Prescription Drug Costs For the State Employee Health Plan Potentially Could Save the State Up To $3 Million Per Year

As mentioned in ***Question 1***, we compiled a list of potential strategies to reduce prescription drug expenditures and selected four strategies for further audit work that appears most likely to yield cost savings for the State Employee Health Plan. ***Figure 2-2*** below, shows those strategies and the estimated cost savings.

Figure 2-2
Four Additional Cost Savings Strategies KHPA Officials Could Implement in the State Employee Health Plan

Proposed Strategy	Estimated Savings
Reduce Coverage on Some or All Prescription Drugs	$2.2 million - $2.8 million
Increase the Maximum Supply of Maintenance Drugs	$126,000
Implement a Starter Dose for Certain Prescription Drugs	$74,000
Limit the Number of Prescriptions Beneficiaries Can Receive Per Month	Unknown
Total	$2.4 million - $3.0 million

Source: LPA analysis of unaudited KHPA data.

In the following sections, we provide more information about each selected strategy and the potential cost savings. A complete list of the strategies we identified is available in ***Appendix C***. In addition, a brief discussion of how federal health care reform affects the Employee Health Plan and these strategies is available in the box on page 12 of Question 1.

The State Could Potentially Save Up to $2.8 Million Per Year By Reducing Coverage On Some or All Prescription Drugs

The State Employee Health Plan requires beneficiaries to pay a certain percent of the total cost for prescription drugs—known as coinsurance. The percent of coinsurance the beneficiary is responsible for varies depending on the category of the prescription drug. For example, employees are only required to pay 20% of the cost of a prescription if it's for a generic drug, but as much as 60% of the cost for a non-generic.

One way for the State to save money on prescription drugs is to increase the coinsurance for some or all prescriptions, thus shifting some of the costs on to the employees. ***Figure 2-3*** on page 23, illustrates how this would work for a couple of different options. As the figure shows:

- **Reducing the State's coinsurance share by 5% on <u>all</u> prescription drugs would save the State more than $2.8 million each year by shifting costs to beneficiaries.** For example, in this scenario, the State would now pay 75% of the cost of generic prescriptions (instead of 80%), and the plan beneficiary would be responsible for the remaining 25%. The State saves by shifting more of the cost for both generic and non-generic prescription drugs on to State employees.

- **Reducing the State's coinsurance coverage by 5% on non-generic prescription drugs would shift some costs and might encourage State employees to use more generic drugs, saving the State an estimated $2.2 million each year.** A slightly different approach is to reduce coverage on non-generic prescription drugs to make less-expensive generics more attractive. Missouri did this in 2007 to encourage generic usage. In Kansas, Health Plan beneficiaries currently select generic prescription drugs about 72% of the time. As ***Figure 2-3*** on the next page, illustrates, if reducing coverage on non-generic prescription drugs caused 1% of all prescriptions to move to generic, it could reduce the total cost of prescription drugs by about $950,000. Overall, the State would save a total of $2.2 million, because this would shift an additional $1.3 million in costs on to those beneficiaries who still received non-generics. The reader should keep in mind that these calculations are theoretical and were created to illustrate the potential impact of this strategy. There is no guarantee that reducing coverage by 5% on non-generics would cause a corresponding increase in the generic fill rate.

Authority officials and a Kansas Organization of State Employees official said high beneficiary coinsurance levels and recent cost increases are barriers to implementing this strategy. A 2010 Kaiser Family Foundation report found that Kansas' State Employee Health Plan beneficiaries pay a higher coinsurance rate for prescription drugs than the national average—which includes both public and private entities. Additionally, Authority officials told us there could be resistance due to recent increases in State employees' cost of health insurance.

The Authority Potentially Could Save More Than $126,000 Per Year By Allowing Pharmacies To Dispense a 90-Day Supply For Certain Prescription Drugs

As discussed in Question 1 on page 17, some long-term or chronic conditions require the use of medications commonly referred to as maintenance drugs. Each time a beneficiary fills or refills a prescription, the State pays the pharmacy a dispensing fee. Increasing the amount of prescription drugs a beneficiary can get at one time decreases the amount the State pays in dispensing fees.

Kansas has a 60-day limit on maintenance drugs, which is less than three other states we contacted. We contacted officials from Missouri, Colorado, and Nebraska to ask what their limits were on maintenance drugs for their state employee health plan. Officials in those states reported limits ranging from 90 to 180 days.

If the limit on maintenance drugs were increased to 90 days, the State could potentially save $126,000 per year. In 2009, Health Plan beneficiaries received a 60-day supply for more than 100,000 out of the 1.2 million total prescriptions filled. If half of these 60-day prescriptions were instead filled for 90 days, the State could save $126,000 per year. Authority officials said they plan to

Figure 2-3
Estimate of Savings by Adjusting Coinsurance (a)

Strategy	Employee Share	State Share	# of Prescriptions	% of Total Prescriptions	Cost of Prescriptions	Employee Share of Costs	State Share of Costs
Current							
Generic	20%	80%	872,598	72%	$21,777,615	$4,339,598	$17,438,017
Non-Generic (Preferred)	35%	65%	278,227	23%	$29,677,692	$10,038,304	$19,639,388
Non-Generic (Non-Preferred)	60%	40%	53,565	4%	$4,992,213	$2,982,794	$2,009,419
		Total	**1,204,390**	**100%**	**$56,447,520**	**$17,360,696**	**$39,086,825**
Decrease State Share by 5 Percentage Points on All Types (assumes no change in behavior)							
Generic	25%	75%	872,598	72%	$21,777,615	$5,428,479	$16,349,136
Non-Generic (Preferred)	40%	60%	278,227	23%	$29,677,692	$11,522,188	$18,155,504
Non-Generic (Non-Preferred)	65%	35%	53,565	4%	$4,992,213	$3,232,404	$1,759,809
		Total	**1,204,390**	**100%**	**$56,447,520**	**$20,183,071**	**$36,264,449**
			Change in Costs vs. Current		**$0**	**$2,822,376**	**($2,822,376)**
Decrease State Share by 5 Percentage Points on Non-Generics (assumes 1 percentage point increase in generics)							
Generic	20%	80%	884,642	73%	$22,078,197	$4,399,495	$17,678,703
Non-Generic (Preferred)	40%	60%	268,127	22%	$28,600,405	$11,103,938	$17,496,467
Non-Generic (Non-Preferred)	65%	35%	51,621	4%	$4,810,998	$3,115,069	$1,695,928
		Total	**1,204,390**	**100%**	**$55,489,600**	**$18,618,502**	**$36,871,098**
			Change in Costs vs. Current		**($957,920)**	**$1,257,807**	**($2,215,727)**

(a) Analysis excludes asthma, diabetes, discount tier and specialty drugs. Adjusted employee and State shares were rounded.
Source: LPA Analysis of KHPA prescription drug claims and coinsurance data.

explore this strategy beginning in January 2011 with any potential changes taking effect by January 2012. These estimates also use the current dispensing fee, which is set to decrease over the next two years. Decreases in the dispensing fee will reduce future cost savings estimates.

Authority officials and health care professionals suggested there may be barriers that could inhibit the success of this strategy. Health care professionals expressed concerns that giving beneficiaries larger supplies of prescription drugs could result in more waste, if the prescription drug doesn't work as planned. Authority officials also noted that pharmacists often have the flexibility to dispense a lesser amount than prescribed to the beneficiary. This flexibility is discussed further in the box on page 18. In addition, because beneficiaries are required to pay a percentage of the total cost up front, their actions could affect any potential savings. Beneficiaries could either ask their doctors to write their prescriptions for time periods shorter than 90 days, or ask the pharmacist for a smaller supply. In either case, savings could be minimized.

We Identified Two Additional Strategies Used In the Medicaid Program That the State Employee Health Plan Could Use To Reduce Costs

We looked to Medicaid for some other ideas the State Employee Health Plan could use to reduce costs. We found two strategies that Medicaid uses that the Health Plan could also use, as described below:

- **The Authority could potentially save $74,000 annually by implementing a starter dose for certain prescription drugs.** A starter dose is a prescription, which is initially filled for fewer than the standard 30-days to reduce waste from unexpected drug interactions and ineffectiveness. For fiscal year 2011, Medicaid is implementing a 15-day starter dose, which will save an estimated $84,000 per year. If the State Employee Health Plan adopted 15-day starter dose and the savings were similar, the Authority could save about $74,000 per year. Authority officials told us they haven't considered implementing a similar starter dose, but may consider implementing it in the future.

- **The Authority could reduce costs by limiting the number of prescriptions beneficiaries can receive each month.** Under Medicaid, beneficiaries are limited to five brand name prescriptions per month (drugs that are included on the program's preferred drug list don't count against the limit). On the other hand, the State Employee Health Plan doesn't place any limits the number of prescriptions a beneficiary can receive. Authority officials told us they haven't considered implementing a prescription limit for the Health Plan, and don't plan to because it would limit beneficiaries' access to prescription drugs and could increase other costs associated with hospitalizations and emergency room visits. Because Medicaid has imposed a limit, this strategy seems feasible for the State Employee Health Plan, as well. Medicaid officials haven't estimated cost savings from implementing this strategy.

Staff from the Medicaid program and the State Employee Health Plan could do more to coordinate with each other on cost savings strategies. As mentioned earlier, we identified two strategies used by Medicaid to reduce prescription drug costs that hadn't been considered by Health Plan officials. We spoke with officials from both programs who said there was no mechanism to formally or regularly share knowledge between the two programs. Officials also said they do not generally compare the effectiveness or usefulness of cost savings strategies that have been implemented in their program's counterpart.

Conclusion:	The State spent almost $243 million on prescription drugs in fiscal year 2010, with the overwhelming majority of those expenditures coming from two programs—Medicaid and the State Employee Health Plan. The Health Policy Authority is responsible for both programs, and officials have taken numerous steps over the last several years to control prescription drug costs in each program. However, as our findings show, there are additional strategies the State could adopt to achieve even greater cost savings. The Authority could adopt some of these strategies on its own, while others would require changes to current State law. Additionally, the Authority's staff who are responsible for managing prescription drug costs in Medicaid and the State Employee Health Plan could do more to work together to develop cost savings strategies that could benefit both programs.

Recommendations for Executive Action	1. To help the Medicaid program reduce prescription drug costs, the Kansas Health Policy Authority should explore implementing the following strategies and report back to the Authority's oversight board and the Legislative Post Audit Committee on the feasibility of each strategy by May 1, 2011: a. participating in a multi-state purchasing consortium b. reducing the dispensing fee paid to pharmacies c. increasing the allowable supply of certain prescription drugs above the current maximum of 31 days

2. To help the State Employee Health Plan reduce prescription drug costs, the Kansas Health Policy Authority should explore implementing the following strategies and report back to the Authority's oversight board and the Legislative Post Audit Committee on the feasibility of each strategy by May 1, 2011:

   a. adjusting coinsurance levels
   b. increasing the allowable supply of certain prescription drugs above the current maximum of 60 days
   c. implementing a starter dose for new medications
   d. limiting the number of prescription drugs beneficiaries can receive per month

3. Because the Health Policy Authority was created to coordinate health care issues, and because its staff are responsible for both the Medicaid program and the State Employee Health Plan, Authority officials should implement a specific plan for these programs to regularly share ideas and knowledge. For example, staff from the programs could conduct regularly scheduled joint planning sessions to go over issues and solutions of similar program components, such as prescription drugs. Staff could then address the Board on a routine basis with their findings.

Recommendations for Legislative Consideration

1. To help ensure that the State is operating the Medicaid prescription drug program cost-effectively, the Legislative Post Audit Committee should consider introducing legislation that would do the following:

   a. allow the Authority to implement a preferred drug list for mental health prescription drugs. This is currently prohibited by K.S.A. 39-7,121b.
   b. allow an expansion of step therapy for the Medicaid program. This is currently prohibited by K.S.A. 39-7,121(c).

APPENDIX A

Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on April 27, 2010. This audit was requested by the Legislative Post Audit Committee.

Prescription Drugs: Reviewing What the Kansas Health Policy Authority Is Doing To Control Prescription Drug Costs in the Programs It Oversees

The Kansas Health Policy Authority (KHPA) was created in 2005 as an independent State agency. KHPA is responsible for developing and maintaining a coordinated health policy agenda that combines effective purchasing and administration of health care with health promotion-oriented public health strategies. The goal of KHPA is to improve the health of Kansans by increasing the quality, efficiency, and effectiveness of health services and public health programs. The KHPA has responsibility for the oversight of the Medicaid, SCHIP, State Employees Health Benefits Program, and State Workers Compensation.

In 2000, Legislative Post Audit did an audit of the State's Medicaid program that found that prescription drug spending had increased rapidly, and in 1999 it represented 25% of total Medicaid spending. That audit concluded that the increasing cost of prescription drugs merited putting resources toward avoiding excess costs wherever possible. In that audit we recommended increasing the use of over-the-counter medications, increasing the requirement for prior authorizations, paying pharmacists to split larger-dose tablets, and reducing the level of reimbursement for drugs.

In 2003, the President's Task Force on Medicaid Reform (six State Senators and two Representatives) made a final report to the Legislature. That report identified several strategies for containing escalating prescription drug costs. Those strategies included such things as forming a multi-state purchasing co-op, determining the actual cost of drugs, reviewing whether Medicaid recipients are eligible for Veteran's Administration assistance, and increasing the level of scrutiny of Medicaid claims for over-prescribing, high usage, and potential fraud.

In 2004, Legislative Post Audit did another audit examining the accuracy of payments by the State's pharmacy benefits manager (at the time Advance PCS) for the State employee health program. Although the audit found only a few problems, we recommended that the State improve its oversight and monitoring of claims and payments to decrease the risk that the State is paying inappropriately.

A recent audit in Florida noted that its Medicaid agency had implemented several cost control measures which include: placing monthly limits of the number of prescriptions a patient can fill, implementing a drug management program for patients who are high users of prescribed drugs, lowering drug ingredient prices, and implementing a preferred drug list.

A performance audit of this topic would answer the following question:

1. **Can the State reduce its costs for prescription drug purchases?** To answer this question we would follow up with KHPA staff as to whether prior recommendations from our 2000 and 2004 audits, and from the 2003 Task Force had been implemented. We would search for best practices for controlling drug costs and other state audits to see what they recommended as cost containment strategies. We would interview KHPA officials and review relevant records to determine whether the agency is employing those cost containment strategies, and if not, why not. We would explore whether the prescription drug component of Medicaid, SCHIP, State Employee Plan and Worker's Compensation could be combined to achieve efficiencies. In addition, we would review relevant records to determine whether KHPA is taking advantage of all discounts available such as the Federal 340B drug-pricing program. We would conduct other test work as needed.

Estimated Resources: 3 staff for 12-15 weeks (plus review)

APPENDIX B

List of State Programs That Purchase Prescription Drugs and Estimated Prescription Drug Expenditures

This appendix contains a list of State programs we identified that purchase prescription drugs, and agency officials' cost estimates of the total amount spent on prescription drugs in the previous year including any State, federal, county, city, or other funding source.

List of Programs That Purchase Prescription Drugs and Estimated Total Prescription Drug Expenditures (Fiscal Year 2010)

Agency/Department	Program	Estimated Expenditures	Estimated % of Total State Prescription Drug Spending
Kansas Health Policy Authority	Medicaid	$166,400,000	68.5%
	State Employee Health Plan (a)	$61,600,000	25.4%
	Workers' Compensation (SSIF)	$750,000	0.3%
Corrections	Medical Care for Inmates	$4,200,000	1.7%
Board of Regents	University Student Health Centers	$2,380,000	1.0%
Social and Rehabilitation Services	Larned State Hospital	$3,370,000	1.4%
	Osawatomie State Hospital	$1,380,000	0.6%
	Rainbow Mental Health Facility	$210,000	0.1%
	Kansas Neurological Institute	$270,000	0.1%
	Parsons State Hospital	$80,000	0.0%
	Community Mental Health Centers	$470,000	0.2%
Health and Enviornment	Immunization Program (b)	$810,000	0.3%
	Tuberculosis Control and Prevention Program (b)	$100,000	0.0%
	STD Program (a) (b)	$30,000	0.0%
Veterans' Commission	Kansas Soldiers' Home - Fort Dodge	$160,000	0.1%
	Kansas Veterans' Home - Winfield	$460,000	0.2%
Juvenile Justice Authority	Juvenile Correctional Facilities	$150,000	0.1%
Kansas School for the Deaf	School Medical Supplies	< $1,000	0.0%
Kansas School for the Blind	School Medical Supplies	< $1,000	0.0%
	Total Expenditures	**$242,820,000**	**100.0%**

(a) Estimate for Calendar Year 2009
(b) Includes expenditures from State General Fund only

Source: LPA analysis of unaudited, self-reported expenditure data from listed State agencies.

APPENDIX C

List of Potential Prescription Drug Cost Saving Strategies

This appendix contains a complete list of all cost savings strategies we identified in this audit, including strategies we didn't select for additional follow-up audit work. We gathered these strategies from KHPA and other State agency officials, health care experts, audit reports, and other literature.

List of Potential Prescription Drug Cost Saving Strategies			
Strategy	**Description**	**Implemented in Medicaid?**	**Implemented in the State Employee Health Plan?**
Strategies Discussed in This Audit			
Regulate Mental Health Drugs	Allow for the management of mental health prescription drugs in Medicaid through a preferred drug list.	No	N/A
Join a Multi-State Consortium	Join a multi-state purchasing consortium.	No	No
Reduce Dispensing Fees	Reduce dispensing fees.	No	Yes
Require Step Therapy	Require a client to fail on a less expensive drug therapy before receiving a more expensive version. The same can be said about requiring generic drugs (in the same class) to be used before allowing a brand name drug to be used.	No	Yes
Increase Maximum Supply of Prescription Drugs	Increases the total number of days for which a maintenance prescription may be filled. This saves money by decreasing the total amount paid in dispensing fees.	No	Yes
Change Copayment Structure	Increase the amount of prescription drug co-payment or co-insurance paid by beneficiary.	No	No
Starter Dose	Require a "starter dose" (smaller doses to ensure the drugs are working prior to supplying the full month of drugs).	Yes	No
Limit the Total Number of Prescriptions Covered	Limit the number of prescriptions an individual may have at one time, such as a maximum of five prescriptions per month.	Yes	No
Other Cost Saving Strategies			
Checks and Balances	Routinely check the data to ensure the accuracy of claims processing, ensure staff have the tools and training necessary to do these checks, and collect any penalties due from the vendor if claims are paid to ineligible people.	Yes	Yes
Counsel Clients With Chronic Conditions	Provide counseling to clients with chronic conditions or diseases so they can better manage those conditions.	Yes	Yes
Eliminate Coverage	Discontinue over-the-counter coverage such as for cough, cold, and cosmetic drugs.	Yes	Yes
Encourage PDL Compliance	Develop methods to encourage compliance with the preferred drug list.	Yes	Yes
Evaluate Board Outreach	Evaluate the effectiveness of the Board's outreach to Medicaid providers to determine whether educational activities should be altered or enhanced.	Yes	N/A
Health Information Exchange	Create a health information exchange to keep someone from going to two doctors and getting the same prescription from both. This could include an e-Prescribe system in which physicians would be provided with electronic devices to assist them in locating the best preferred drug from the preferred drug list while still protecting the health of the customer.	No	Yes
Increase Use of Prior Authorization	Expand the use of prior authorization, which requires the Department to authorize usage before medications can be dispensed.	Yes	No
Limit Available Pharmacies	In an effort to prevent fraud, allow some Medicaid beneficiaries to only obtain their prescriptions from a single pharmacy. This would apply only to those deemed necessary to be "locked-in."	Yes	N/A

List of Potential Prescription Drug Cost Saving Strategies			
Strategy	**Description**	**Implemented in Medicaid?**	**Implemented in the State Employee Health Plan?**
Mail Order	Set up mail order options to get prescription drugs.	No	Yes
Negotiate Supplemental Rebates	Seek or enhance supplemental rebates to lower the price paid for prescription drugs.	Yes	N/A
Pay Pharmacists To Encourage Generic Prescription Drug Use	Compensate pharmacies more to dispense/fill using generic drugs instead of name-brand prescriptions. One way could be a higher dispensing fee for generic drugs.	No	Yes
Payer of Last Resort	Ensure the State is the payer of last resort.	Yes	No
Preferred Drug List	Implement a Preferred Drug List to encourage the use of less-expensive prescription drugs.	Yes	Yes
Price Negotiations	Explore ways to maximize purchasing power to drive down the costs of drugs. Examples include setting a price ceiling or profit limit on prescription drugs, negotiating prices with a manufacturer based on its entire line of drugs instead of by individual drugs, determining the actual cost of drugs to maximize purchasing power, and requiring negotiations between pharmacy benefit managers and drug manufacturers to be more transparent.	Yes	Yes
Privatize Health Care System	Pay a private contractor to administer the health care system to minimize the overhead KHPA needs to administer its programs.	Yes	Yes
Provider Education on Prescription Drug Alternatives	Provide doctors with scientifically-based prescription drug information instead of making doctors rely only on prescription drug manufacturer marketing.	No	Yes
Provider Training	Provide additional training to providers in order to help avoid unnecessary prescriptions.	Yes	Yes
Reduce Overall Coverage	Reduce the number of drugs that are covered as part of the prescription drug plan or just not offer coverage at all if possible.	No	Yes
Reduce Payments to Doctors	Reduce payments to physicians for physician administered drugs.	Yes	No
Structured Copayments	Structure co-payments so a patient pays less for a generic version of important life-saving drug and more for a quality-of-life drug such as one designed to remedy hair loss, enhance sexual function or relieve seasonal allergy symptoms.	No	Yes
Use Generic Prescriptions Drugs Whenever Possible	Develop methods that encourage or require beneficiaries to use less-expensive generic prescription drugs prior to using more-expensive name brand prescription drugs.	Yes	Yes
Wellness Programs	Implement wellness programs which promote healthy living and reduce overall reliance on prescription drugs.	No	Yes
Expand Coverage	Expand coverage of over-the-counter drugs, which could reduce the need for prescription drugs.	No	No
Pay Pharmacists to Split Tablets	Pay pharmacists to split larger-dose tablets into smaller-dose tablets.	No	No
Unused Medication Act	Expand the Unused Medication Act, K.S.A. 65-1668 et seq., to allow mail-order pharmacies to donate sealed, unused drugs for mental health and low income need.	No	No

Source: LPA interviews with agencies, health care professionals, and literature review.

APPENDIX D

Agency Response

On November 3, 2010, we provided copies of the draft audit report to the Kansas Health Policy Authority. Their response is included as this appendix. The Authority generally concurred with the report's findings, conclusions, and recommendations, but they did raise a concern about the State Employee Health Plan strategy of limiting the number of prescription drugs beneficiaries can receive per month. Authority officials believe that cost-sharing responsibilities in this program likely already limit the number of expensive brand-name prescriptions a beneficiary receives. While that may be the case, we think Authority officials should fully explore the costs and benefits of this strategy and report to their board on the feasibility of implementation.

Coordinating health & health care
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KANSAS HEALTH POLICY AUTHORITY

November 12, 2010

Mr. Scott Frank
Legislative Post Auditor
800 SW Jackson Street, Suite 1200
Topeka, KS 66612-2212

Dear Mr. Frank:

The Kansas Health Policy Authority (KHPA) received the Legislative Division of Post Audit's (LPA) report regarding *Prescription Drugs: Reviewing What the Kansas Health Policy Authority Is Doing to Control Prescription Drug Costs in the Programs It Oversees*. I appreciate the opportunity to respond to the findings and recommendations included in the report.

Recommendations for Executive Action:

1. To help the Medicaid program reduce prescription drug costs, the Kansas Health Policy Authority should explore implementing the following strategies and report back to the Authority's oversight board and the Legislative Post Audit Committee on the feasibility of each strategy by May 1, 2011:

   a. Participate in a multi-state purchasing consortium

   The Health Policy Authority will explore the possibility of joining one of the multi-state purchasing pools, including what requirements, if any, participation in a purchasing pool would impose upon the Formulary maintained by Kansas Medicaid.

   b. Reducing the dispensing fee paid to pharmacies

   The Health Policy Authority is actively investigating the replacement of the Average Wholesale Price (AWP) based pricing currently used by the Agency, in anticipation of the discontinuation of AWP publication in September 2011. Adjustment of the dispensing fees paid to pharmacies is a component of the strategies being examined. Any adjustments to dispensing fees paid to pharmacies requires the approval of a State Plan Amendment by CMS.

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health
Benefits and Plan Purchasing:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

c. Increase the allowable supply of certain prescription drugs above the current maximum of 31 days.

The Health Policy Authority will examine the feasibility of implementation of this recommendation.

2. To help the State Employee Health Plan reduce prescription drug costs, the Kansas Health Policy Authority should explore implementing the following strategies and report back to the Authority's oversight board and the Legislative Post Audit Committee on the feasibility of each strategy by May 1, 2011:

a. Adjusting coinsurance levels

The current plan design provides for higher member cost share than other most other employer plans administered by Caremark. Any increase in cost sharing would need to be reviewed by the Kansas State Employees Health Care Commission and staff will provide this information to them as part of their annual review of other cost sharing provisions of the health plan.

b. Increasing the allowable supply of certain prescription drugs above the current maximum of 60 days

The Health Policy Authority has already begun examining the feasibility of implementation of this recommendation and will present the idea to the Kansas State Employees Health Care Commission for consideration.

c. Implementing a starter dose for new medications

The Health Policy Authority will examine the feasibility of implementation of this recommendation and present the idea to the Kansas State Employees Health Care Commission for consideration.

d. Limiting the number of prescription drugs beneficiaries can receive per month

Unlike the Medicaid pharmacy program, which is limited by Federal law in their ability to impose cost-sharing requirement on beneficiaries, the SEHP utilizes a system of incentives to encourage members to use as few branded medications as possible. Cost-sharing responsibilities are significantly less for generic medications than for brands. The Agency believes the administrative cost of reviewing requests for additional brand medications would outweigh the benefit, since the cost incentives already ensure that if a member is using more than a few brand-name medications, it is likely because there is not a generic medication that could provide adequate therapy, and most requests for additional branded medications would therefore ultimately be approved.

3. Because the Health Policy Authority was created to coordinate health care issues, and because its staff are responsible for both the Medicaid program and the State Employee Health Plan, Authority officials should implement a specific plan for these programs to regularly share ideas and knowledge. For example, staff from the programs could conduct regularly scheduled joint planning sessions to go over issues and solutions of similar program components, such as

prescription drugs. Staff could then address the Board on a routine basis with their finding.
The Executive Team members who supervise the SEHP and Medicaid teams meet routinely and assess the success of Agency programs and potential avenues for improvement. Additionally, through use of the Data Analytic Interface, cost and utilization data for Medicaid and the SEHP can easily be compared, allowing staff to identify potential areas of improvement within their respective programs.

Thank you for the opportunity to respond to the draft audit report.

Sincerely,

Dr. Andrew Allison
Executive Director