Approved: 3-6-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 3:30 p.m. on February 13, 2003 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research
Norman Furse, Revisor of Statutes
Ann McMorris, Secretary

Conferees appearing before the committee:
Audrey Nogle - Legislative Research
Bob Day, Dept. Of Social and Rehabilitation Services
Janis DeBoer, acting secretary, Department of Aging
Barb Hinton, Legislative Post Audit
Rosa Molina, Executive Director, Medical Services Bureau, Wichita
Bob Williams, Kansas Pharmacists Association
Jonathan Brunswig, Lakin (pharmacist)
Steve Smith, Hiawatha (pharmacist)
Brad Smoot, Blue Cross-Blue Shield of Kansas
Jim Cleland, Pharmacist - WaKeeney

Chairman Clark introduced Brian Leugs, Regional Director, Rocky Mountain Region, PhRMA, Denver who stood available for questions. Mr. Leugs introduced Nancy Zogleman of Pfizer and Barbara Belcher of Merck who also were available for questions.

Others attending: See attached list

Presentations on Medicaid Pharmaceutical Issues

Audrey Nogle of Legislative Research provided data on (1) Consensus Caseload Estimate for November 6, 2002 on nursing facilities, nursing facilities-mental health, temporary assistance to families, general assistance, regular medical, foster care contract and adoption contract. She cited the increase in regular medical in 2003 was due to the downturn in the economy; and (2) Caseload Expenditures for FY 1995-FY 2004 is a comparison for nursing facilities, nursing facilities-mental health, temporary assistance to families, general assistance, regular medical, foster care contract and adoption contract. (Attachment 1)

Robert Day, Director, Medical Policy/Medicaid presented a slide presentation on Kansas Medicaid: Focus on long term care and prescription. (Attachment 2) He provided information on CMS proposed Medicaid reform but cautioned that this information was preliminary and not complete. (Attachment 3) A paper containing Population Definitions, Acronyms and Definitions, Poverty Guidelines, Medicaid mandatory and optional coverage groups and services and Kansas medicaid preferred drug list was handed out to the committee. (Attachment 4).

Commentary on the slide presentation follows: (Attachment 2)
This is an overview of the Medicaid Program which will include both long term and regular medical. Not included are the 30,000 in the children's health insurance program and the Medikan program which is a state only program.

First few slides dealt with number of Medicaid enrollees per month, enrollees by population, eligibility groups covering various periods of time - primarily increased because of the Temporary Assistance to Families (TAF) population and the softening of the economy which drops people into a lower income category. The 1991 to 1995 growth is due to adding of children and pregnant women at the federal level; 1996 is a peak; and then a drop which are primarily TAF people; 1999 starts the climb and this is related to the children's health insurance program. In 2004 there is another dramatic increase in TAF/PLE (Poverty Level Eligibility) population and slight rise in the aged and disabled population.

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Mr. Day then moved to the cost growth by population for Medicaid and long term care and annual growth in long term care costs . Cost growth is driven by increased numbers of people coming into the program and by medical inflation and in utilization of services. Medicare on the acute care side is not a health program but a sickness program. Compare growth in population and growth in utilization and there is an increase each year. Total medical expenditures by service from 1991 to projected 2004 show pharmaceuticals are the largest cost driver. Long term care costs are significant and these include institutions and home costs. Community based services is one of the most significant and successful programs. These programs provide significant assistance to people and have changed their lives in many ways. Federal rules covering pharmacy coverage and percent pharmacy expenditures by population in FY 2002 were discussed.

Considerable discussion on copay set in federal regulation. Average monthly prescription costs FY 1998 thru FY 2002 showed aged, blind and disabled to be considerably higher than TAF/PLE. The list of the ten top drugs by expenditure in FY 2002 for all populations was discussed. Cost control measures implemented in the pharmacy program and the drug utilization in the nursing home setting were considered. In his concluding comments, Mr. Day noted that Medicaid is second only to public education in the number of citizens impacted by its services. Federal Medicaid dollars in the Kansas health system will total over $1.058 billion in FY 2004.

Janis DeBoer, acting secretary, Department of Aging distributed material on (1) long term care services, nursing facility and home and community based services for frail elderly (Attachment 5); (2) Kansas senior pharmacy assistance program (Attachment 6). Ms. DeBoer elaborated on the Department of Aging funding sources, their FY 2002 expenditures, customers served and their HCBS/FE waiting list of 1,036 on 1/31/03. She quoted monthly medicaid averages on customers served and expenditures per customer in FY 1998 through FY 2002 and had comparison graphs. Research on whether home and community-based services were less costly than nursing home care and whether home and community-based services reduce nursing home placement was presented.

Barb Hinton of Legislative Post Audit summarized the issues relating to drugs paid for by Kansas' Medicaid Program from the Performance Audit, Reviewing the Medicaid Program's use of Generic Drugs. Control of the type of drugs prescribed to help ensure that the program pays for the most cost-effective drug therapy for client's medical conditions was discussed. Control of the types of drugs prescribed to help ensure that the program pays for only the amount of drugs clients need and can or should use and controlling what the state pays for Medicaid prescriptions to help ensure that the program doesn't pay more than it needs to are areas of great concern and have been monitored closely. SRS is working on the issues identified by Post Audit. (Attachment 7)

Rosa Molina, executive director, Medical Service Bureau, Wichita described the three programs provided by MSB: (1) the non-profit pharmacy program; (2) the Voucher Program and (3) the Pharmaceutical Drug Program (PDP). She identified income guidelines for the different programs. She provided a listing of the MSB 2002 statistics. (Attachment 8)

Bob Williams, Kansas Pharmacists Association, handed out his testimony (Attachment 9) which contained the following ideas:

1. Maximizing rebates from drug companies
2. Pharmacy dispensing fees
3. Generic and therapeutic substitution
4. Step therapy
5. Limits on number of prescriptions
6. Prior authorization
7. Drug Utilization and Review (DUR)
8. Disease management programs
9. Beneficiary cost sharing (co-payments)

Mr. Williams then introduced Jonathan Brunswig, President, Kansas Pharmacists Association from Lakin, KS., who provided some background on how he opened two pharmacies in Leoti and Lakin and described the role these pharmacies play in providing pharmacy services to long term care patients. He addressed the process of providing medications to these patients using bubble packs. He described the relationship with physicians and the role the pharmacist plays in providing medications and helping reduce drug cost per patient. (Attachment 10)

Steve Smith, Pharmacist, Hiawatha, Kansas, said he has been a pharmacist for 33 years but is still on the cutting edge of many things. Many years we tried to address the cutting of costs with the white paper that were given by Medicaid and alluded to as the starter dose program and have checked the number of prescriptions that should be allowed and the use of generics. In patient hospital cost has maintained the same proportion expressed as a percentage of the total medicaid budget and the pharmacists' cost of medications is going up. You have to give drug manufacturer's credit - some of these new drugs that are out are fantastic. I have people who are now walking into my store who used to be institutionalized and when you see that level line on inpatient hospitalization, you can see the increased cost of medication. There is a correlation of costs. SRS is going to implement the five prescription brand names. We have some problems - we are working with the physicians. In the nursing home settings, I service patients in eight nursing homes and quite often we use the same drugs in different strengths at different time. When we trigger those people with 9 prescriptions, we will need to work through it. SRS is now looking at their outliers - 20 to 30% of their patients are driving 80% of the budget. We created a type of care form in our town. When someone comes out of the hospital, I receive a FAX so I start working on this patient's history and medication so that I can better serve the patient and look at the cost factors involved. Sometimes you have to use the high dollar drug as it does the best job. I have a reason on the form why the doctor wants to give a particular medication and we can counsel the patient correctly. Also a question on whether the prescription should be filled or should he get samples? We've set up a system, the physician, pharmacist and the patient to work on the cost factor. You have got to get into managed care to control cost.

Brad Smoot, Kansas Blue Cross-Blue Shield, provided information on the current trends in health care costs. He elaborated on several cost-driving forces that are causing the increases in health care costs and the corresponding insurance premium costs; (1) our aging populations; (2) lifestyle choices; (3) prescription drugs; (4) government regulation; (5) cost shifting and the uninsured; (6) expansion of services; and (7) use of new medical technologies. He noted that in 2000, Kansas ranked ninth in the per capita use of prescription drugs reporting an average of 10.62 scripts per year and BCBS concern in the ability of Kansans to continue to afford health insurance. (Attachment 11)

Jim Cleland, Pharmacist, WaKeeney - Mr. Cleland told the committee that the executive director of the Pharmaceutical Board has a degree in Library Science. He mentioned that the Pharmacy Inspectors are pharmacy technicians not licensed pharmacists. He recommended that the Legislature allow the Board of Pharmacy enough of a budget for a adequate qualified staff to enforce the provisions of the Kansas Pharmacy Act. The State of Kansas is the largest purchaser of drugs in Kansas. Average Wholesale Price (AWP) no longer reflects cost of drugs. Few wholesalers for drugs remain. He brought many bottles of various types of medicines and held up the medicine he was referring to and read the cost information from the label. (Attachment 12)

Heartburn/Prevacid	Average Wholesale Price	*Maximum Allowable Cost*	
Medicaid	AWP	(MAC)	Actual Cost
Ranitidine	1.56	.34	.06
Zantac	780.00/500	170.55	27.19 (5 ½ cents each)
1/day Prevacid	4.63 a pill		3.76

Drugs on Medicaid Preferred list are like owning Boardwalk & Park Place with 4 hotels and 3 houses. They don't need the general population. If you can't afford them, they will just give them to you free at the doctor's office from the drug companies' white sack.

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Antibiotics/Allergies			
Zyrtec	3.23		2.55
Claritin	2.11		1.67
Chlorpheniramine	.11		.04

BC-BS and Medicaid - $90 for a runny nose. Kansas Medicaid annual expense $268 Million on Drugs – $20 million rebate. Agree to never charge more than $3.40/prescription. Proposal - state pay acquisitions cost. Think how much you can bring the cost of drugs down. How much if you "hum on the phone"

	244.20/150	198.,29	98.00
			93.00
Cephelexin	600.69	222.00 - 95.07	40.37
After 90 days			
Prevacid	30mg 4.63	3.76	
Cut to	15mg 4.54	3.69	

Notice - one-half the medication but the price is only reduced by 9 or 7 cents each.

National Democratic Convention paid and sponsored by the Pharmaceutical Industry, so was the Republican Convention.

Itch - Hydroxyzine	95.37	14.59
now	823.14	550.00 (bought up competition)

Wants $10 to fill prescriptions on name brand; $15 to fill prescriptions on generics
$5 copay - send rebate home - set yourself free. People talk to us (pharmacists), they trust us. Doctor asks - how are you doing? Are you taking all your medicines? They lie to the doctor. Pharmacists ask -How are you doing - we find out that they are short of breath. We are the only health care provider that they can walk into without being charged. They trust us.

Antibiotic - go to the emergency room $50 - only give you 1 dose/day
go to the emergency room again - fill out the chart again.
Non-preferred drugs - good enough for the rest of you; not good enough for medicaid

Heartburn - Zyrtec	2.11	1.67	
Chlorpheniramine			.04

$30 coupon - rebate for those that holler

Schizophrenia – use Risperdal which is very expensive. Pill can be broken in half - the only people that get risperdal are on Medicaid or have insurance. He told about Dave who enlisted and was sent to Vietnam. When he returned he had to be hospitalized and heard voices/had bad dreams and nightmares. Takes halodol – 10mg 2xday at 16 cents per day. David worked in local hospital maintenance for 20 years. Halodol keeps the dreams back. Bought brand new 4x4 Dodge PU - making payments on it. Mother died. He took a wonderful drug - 4mg Risperdal/ 4mg adjust dosage/6mg/ added 7mg/8mg. He started worrying about cost which was about $500/month. He got rid of truck/afraid at nights. Admitted to nursing home so he could be watched. Went back home - put gun in mouth. New isn't always better.

Mother in law - 1927 - aggressive behavior - we use powerful new drugs for aggressive behavior. Risperdal was developed for schizophrenia not to drug people to manage behavior problems. Think boldly doesn't always work.

Runny nose/cold			
Erythromycin	94.45/500	40.82/500	8 cents

Viaxin comes only in 7 day supply bubble pack. It's advertised on TV. Physician wrote prescription for a 10 days supply. Mr. Cleland sent patient back to doctor explaining that the medication is only available in a 7 day supply. Returned with a prescription for 14 days. Mr. Cleland's cost for 14 day supply was $120.08. Medicaid patient paid $3.00 for

the $120.08 medication. The blue collar worker has little choice but to use the 8 cent pills.

He proposed that the state negotiate a preferred manufacturer of drugs and durable medical equipment and that the state use its buying power to negotiate lower pharmecutical prices for all pharmacies in the State and also use its buying power to negotiate lower prices for durable medical equipment.

He ended by urging the consideration of the committee on the effect Medicaid has on the pharmacists.

At the close of presentations and the round table discussion, Chairman Clark encouraged the participating audience to provide the committee with more recommendations for the committee's consideration.

The next meeting of the President's Task Force on Medicaid Reform will be on February 17 where long term care will be discussed.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 12

Conferee Recommendations to be considered:

1. Maximizing rebates from drug companies
2. Pharmacy dispensing fees
3. Generic and therapeutic substitution
4. Step therapy
5. Limits on number of prescriptions
6. Prior authorization
7. Drug Utilization and Review (DUR)
8. Disease management programs
9. Beneficiary cost sharing (co-payments)

(Recommendations 1 thru 9 from Bob Williams, Ks. Pharmacists Assn.)

10. Starter dose program (Steve Smith, Pharmacist, Hiawatha)
11. We created a type of care form in our town. When someone comes out of the hospital, I receive a FAX so I start working on this patient's history and medication so that I can better serve the patient and look at the cost factors involved. Sometimes you have to use the high dollar drug as it does the best job. I have a reason on the form why the doctor wants to give a particular medication and we can counsel the patient correctly. Also a question on whether the prescription should be filled or should he get samples? We've set up a system, the physician, pharmacist and the patient to work on the cost factor. You have got to get into managed care to control cost. (Steve Smith, Pharmacists, Hiawatha)
12. He recommended that the Legislature allow the Board of Pharmacy enough of a budget for adequate qualified staff to enforce the provisions of the Kansas Pharmacy Act. (Cleland)
13. Proposal - state pay acquisitions cost. (Cleland, WaKeeney)
14. Wants $10 to fill prescriptions on name brand; $15 to fill prescriptions on generics (Cleland)
15. $5 copay - send rebate home - set yourself free. (Cleland)
16. He proposed that the state negotiate a preferred manufacturer of drugs and durable medical equipment and that the state use its buying power to negotiate lower pharmecutical prices for all pharmacies in the State and also use its buying power to negotiate lower prices for durable medical equipment. (Cleland)

President's Task Force on Medicaid Reform

DATE: FEBRUARY 13, 2003

Name	Representing
Brian Leugs	PhRMA
Susan Kannarr	KS Health Institute
Linda Lukensky	KS Home Care Assoc
Scott Bann	Eldy
Todd Bledsoe	Eli Lilly bledsoeta@lilly.com
Mike Hammond	Association of Cmties of KS
Ryan Schlink	KS Pharmacists Assoc.
NANCY CORKINS	KS Pharm. Assn./Dillons
Julie Helm	Helm Law Firm
Susan Mahoney	for Pat Hubbell
Robert Day	SRS
Bob St. Peter	KHI
Bob Harder	UMC-KS
[illegible]	KAHS
James [illegible]	myself
Erin Harvey	Gandpa
[illegible]	Myself

President's Task Force on Medicaid Reform

DATE: FEBRUARY 13, 2003

Name	Representing
Jonathan Brunswig	Kansas Pharmacists Assn.
Steve Smith	✓ ✓ –
Barbara Belcher	Merck
Nancy Zogleman	Pfizer
[illegible]	Kansas Assoc. for the Medically Underserved
Bob Alderson	Ks. Pharmacy Service Corp.
Don Hill	House of Rep. 60th Dist
Barb Hinton	Post Audit
[illegible]	SRS
[illegible]	KBDSA
Christy Lane	KDOA
Shelly Stay	KMHC, KSOS
Annette Graham	Central Plains Area Agency on Aging
Rosa Molina	Medical Service Bureau
[illegible]	KS AREA AGENCIES ON AGING ASSOC.
RYAN GILLILAND	BILL SNEED

Consensus Caseload Estimate

November 6, 2002

	FY 2003 Approved		FY 2003 Consensus Estimate		Difference from Approved		Change From Approv		FY 2004 Consensus Estimate		Difference from FY 2003		Change From FY 20	
	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF
Nursing Facilities	$ 313,111,728	$ 125,244,691	$ 313,111,728	$ 125,244,691	$ -	$ -	0.00%	0.00%	$ 331,620,600	$ 132,648,240	$ 18,508,872	$ 7,403,549	5.58%	5.58%
Nursing Facilities - Mental Health	12,687,500	9,023,483	13,656,360	9,727,425	968,860	703,942	7.64%	7.80%	13,100,000	8,927,650	(556,360)	(799,775)	-4.25%	-8.96%
Temporary Assistance to Families	53,500,000	30,293,070	54,598,875	30,293,070	1,098,875	0	2.05%	0.00%	59,756,160	30,293,070	5,157,285	0	8.63%	0.00%
General Assistance	7,045,000	7,045,000	6,900,000	6,900,000	(145,000)	(145,000)	-2.06%	-2.06%	7,800,000	7,800,000	900,000	900,000	11.54%	11.54%
Regular Medical	894,241,825	297,846,072	950,000,000	319,542,223	55,758,175	21,696,151	6.24%	7.28%	1,070,000,000	366,423,645	120,000,000	46,881,422	11.21%	12.79%
Foster Care Contract	95,000,000	41,474,011	93,000,000	40,600,080	(2,000,000)	(873,931)	-2.11%	-2.11%	95,000,000	41,473,200	2,000,000	873,120	2.11%	2.15%
Adoption Contract	34,000,000	15,988,425	34,600,000	16,279,300	600,000	290,875	1.76%	1.82%	36,000,000	16,938,000	1,400,000	658,700	3.89%	3.89%

	FY 2003 Approved		FY 2003 Consensus		Difference from Approved		Change From Approv		FY 2004 Consensus Estimate		Difference from FY 2003		Change From FY 20	
	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF
TOTAL	$1,409,586,053	$ 526,914,752	$1,465,866,963	$ 548,586,789	$ 56,280,910	$ 21,672,037	3.99%	4.11%	$1,613,276,760	$ 604,503,805	$ 147,409,797	$ 55,917,016	10.06%	10.19%

President's Task Force on Medicaid Reform
February 13, 2003
Attachment 1-1

Caseload Expenditures
FY 1995 - FY 2004

	FY 1995 Actuals		Percent Change		FY 1996 Actuals		Percent Change		FY 1997 Actuals		Percent Change		FY 1998 Actuals		Percent Change		FY 1999 Actuals		Percent Change	
	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds
Nursing Facilities	$86,299,600	$215,749,000	n/a	n/a	$88,805,600	$222,014,000	2.90%	2.90%	$88,717,200	$221,793,000	-0.10%	-0.10%	$95,869,200	$239,673,000	8.06%	8.06%	$100,219,200	$250,548,000	4.54%	4.54%
Nursing Facilities - Mental Health	$9,752,444	$13,359,512	n/a	n/a	$8,257,593	$11,311,771	-15.33%	-15.33%	$6,382,166	$7,983,509	-22.71%	-29.42%	$8,206,037	$11,277,258	28.58%	41.26%	$8,923,933	$12,462,579	8.75%	10.51%
Temporary Assistance to Families	$48,056,726	$117,276,923	n/a	n/a	$42,392,710	$103,325,804	-11.79%	-11.90%	$26,041,564	$83,166,723	-38.57%	-19.51%	$36,621,511	$55,453,842	40.63%	-33.32%	$35,335,999	$45,389,148	-3.51%	-18.15%
General Assistance	$9,016,514	$9,018,624	n/a	n/a	$6,298,593	$7,753,593	-30.14%	-14.03%	$5,556,285	$6,021,246	-11.79%	-22.34%	$4,390,098	$4,390,098	-20.99%	-27.09%	$748,809	$4,249,672	-82.94%	-3.20%
Regular Medical	$121,937,683	$462,385,653	n/a	n/a	$123,199,385	$455,463,197	1.03%	-1.50%	$154,609,060	$493,440,867	25.49%	8.34%	$147,572,437	$467,059,580	-4.55%	-5.35%	$175,993,456	$544,327,399	19.26%	16.54%
Foster Care Contract	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$10,373,929	$24,684,823	n/a	n/a	$24,289,575	$68,351,173	134.14%	176.90%	$18,572,600	$111,939,355	-23.54%	63.77%
Adoption Contract	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	$4,241,284	$7,068,807	n/a	n/a	$3,439,867	$9,899,778	-18.90%	40.05%	$17,720,400	$25,708,098	415.15%	159.68%
TOTAL	$275,062,967	$817,789,712	n/a	n/a	$268,953,881	$799,868,365	-2.22%	-2.19%	$295,921,488	$844,158,975	10.03%	5.54%	$320,388,725	$856,104,729	8.27%	1.42%	$357,514,397	$994,624,251	11.59%	16.18%
SRS Only	$188,763,367	$602,040,712			$180,148,281	$577,854,365	-4.56%	-4.02%	$207,204,288	$622,365,975	15.02%	7.70%	$224,519,525	$616,431,729	8.36%	-0.95%	$257,295,197	$744,076,251	14.60%	20.71%

	FY 2000 Actuals		Percent Change		FY 2001 Actuals		Percent Change		FY 2002 Actual		Percent Change		FY 2003 Estimate		Percent Change		FY 2004 Estimate		Percent Change	
	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds	SGF	All Funds
Nursing Facilities	$109,549,600	$273,874,000	9.31%	9.31%	$103,317,671	$291,282,135	-5.69%	6.36%	$120,800,000	$302,000,000	16.92%	3.68%	$ 125,244,691	$ 313,111,728	3.68%	3.68%	$ 132,648,240	$ 331,620,600	5.91%	5.91%
Nursing Facilities - Mental Health	$8,998,630	$13,017,723	0.84%	4.45%	$9,729,413	$13,458,062	8.12%	3.38%	$7,571,792	$14,174,329	-22.18%	5.32%	9,727,425	13,656,360	28.47%	-3.65%	8,927,650	13,100,000	-8.22%	-4.07%
Temporary Assistance to Families	$30,293,070	$42,660,075	-14.27%	-6.01%	$30,293,053	$44,674,252	0.00%	4.72%	$30,293,120	$57,263,454	0.00%	28.18%	30,293,070	54,598,875	0.00%	-4.65%	30,293,070	59,756,160	0.00%	9.45%
General Assistance	$4,183,237	$4,183,237	458.65%	-1.56%	$4,805,508	$4,938,765	14.88%	18.06%	$5,960,000	$5,972,720	24.02%	20.94%	6,900,000	6,900,000	15.77%	15.53%	7,800,000	7,800,000	13.04%	13.04%
Regular Medical	$211,429,181	$611,358,315	20.13%	12.31%	$219,650,842	$686,297,853	3.89%	12.26%	$270,206,869	$824,614,283	23.02%	20.15%	319,542,223	950,000,000	18.26%	15.21%	366,423,645	1,070,000,000	14.67%	12.63%
Foster Care Contract	$11,100,295	$84,365,918	-40.23%	-24.63%	$29,807,609	$94,039,453	168.53%	11.47%	$37,785,517	$91,940,259	26.76%	-2.23%	40,600,080	93,000,000	7.45%	1.15%	41,473,200	95,000,000	2.15%	2.15%
Adoption Contract	$8,967,498	$21,876,347	-49.39%	-14.90%	$15,893,064	$40,304,937	77.23%	84.24%	$15,349,323	$28,156,398	-3.42%	-30.14%	16,279,300	34,600,000	6.06%	22.89%	16,938,000	36,000,000	4.05%	4.05%
TOTAL	$384,521,511	$1,051,335,615	7.55%	5.70%	$413,497,160	$1,174,995,457	7.54%	11.76%	$487,966,621	$1,324,121,443	18.01%	12.69%	$548,586,789	$1,465,866,963	12.42%	10.70%	$604,503,805	$1,613,276,760	10.19%	10.06%
SRS Only	$274,971,911	$777,461,615	6.87%	4.49%	$310,179,489	$883,713,322	12.80%	13.67%	$367,166,621	$1,022,121,443	18.37%	15.66%	$423,342,098	$1,152,755,235	15.30%	12.78%	$471,855,565	$1,281,656,160	11.46%	11.18%

Kansas Department of

Social and Rehabilitation Services

Janet Schalansky, Secretary

President's Task Force on Medicaid Reform
February 13, 2003

Kansas Medicaid: Focus on Long Term Care and Prescription Drugs

Division of Health Care Policy
Robert Day, Director, Medical Policy/Medicaid

For additional information contact:
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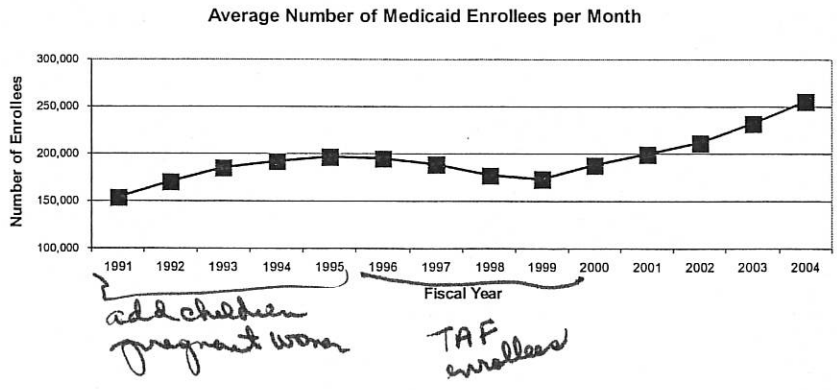
President's Task Force on
Medicaid Reform
February 13, 2003
Attachment 2-1

Cost Growth in Kansas Medicaid: Focus on Long Term Care and Prescription Drugs

Robert M. Day, Ph.D.
Health Care Policy Division
Kansas Department of SRS
February 13, 2003

Average Number of Medicaid Enrollees per Month



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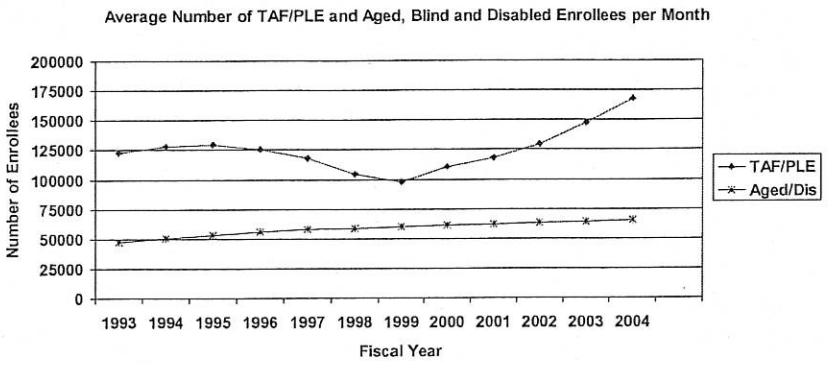
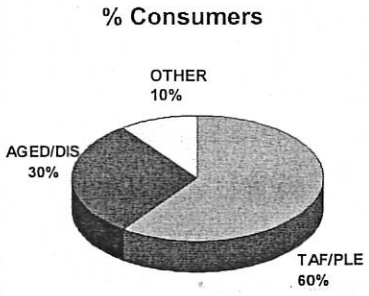
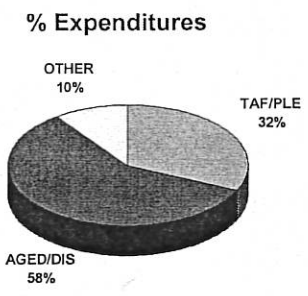
Average Number of Medicaid Enrollees per Month by Population



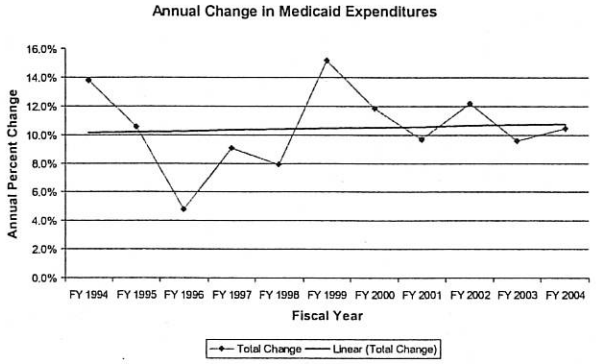
Eligibility Groups by % Consumers and % Expenditures, FY 2002





Annual Change in Total Medicaid Expenditures FY 1994 – 2004

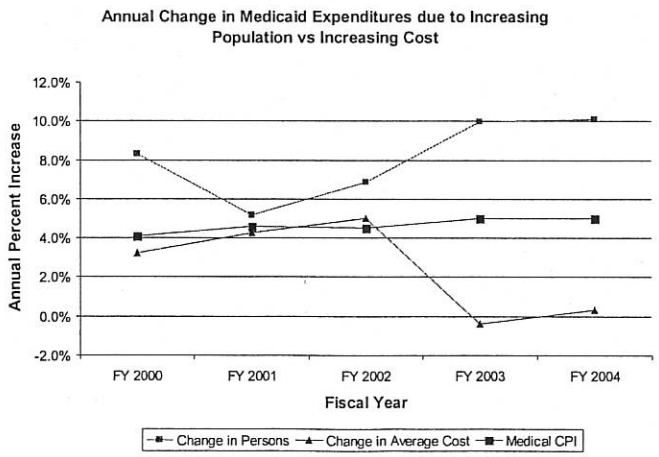
includes long term care



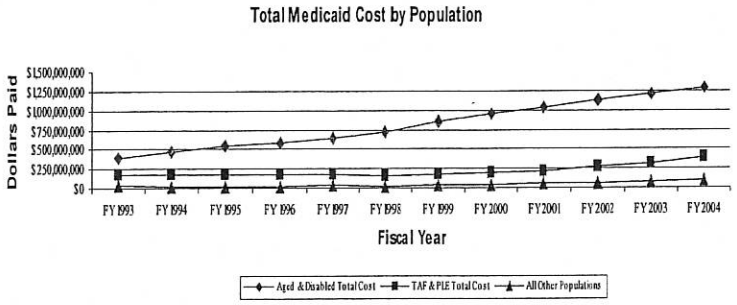
Trend indicates a 10.8% annual increase by the year 2005.

Annual Change in Total Medicaid Expenditures FY 2000 – 2004: Population vs. Cost

includes long term care

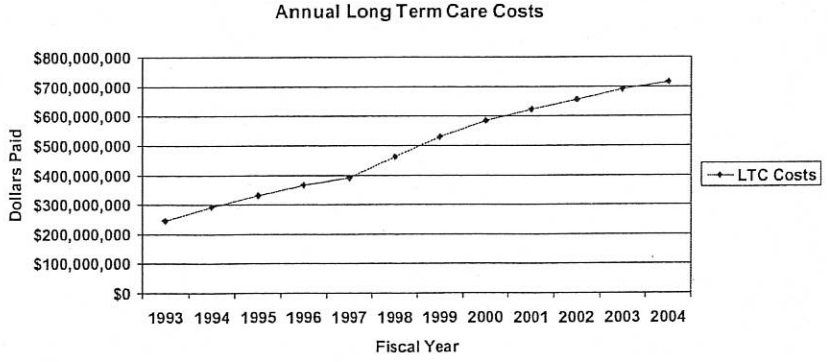


Comparison Medicaid Cost Growth by Population, FY 1993 – FY 2004

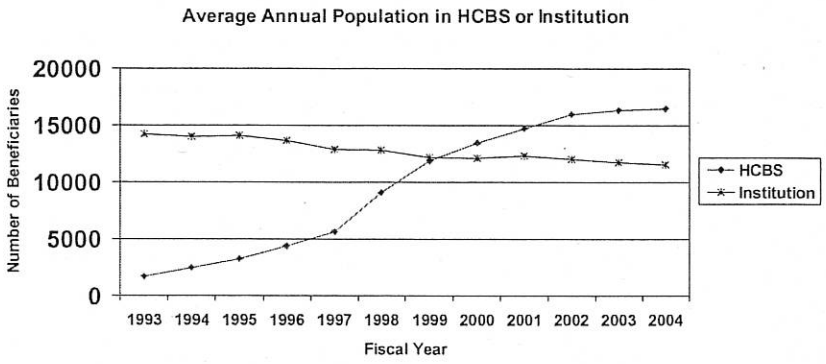


Annual Growth in Long Term Care Costs

includes both institutions and HCBS

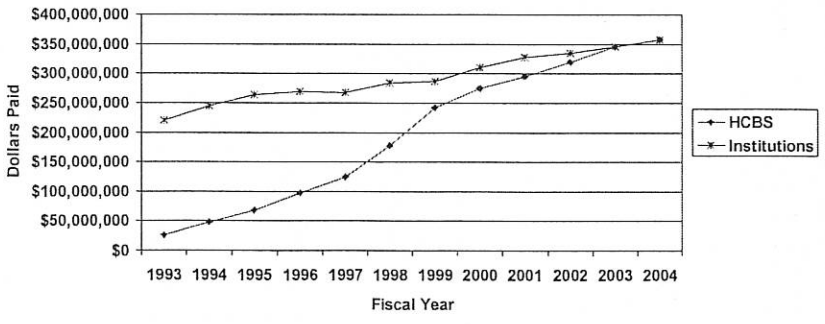


Change in Long Term Care Population, FY 1993 - 2004

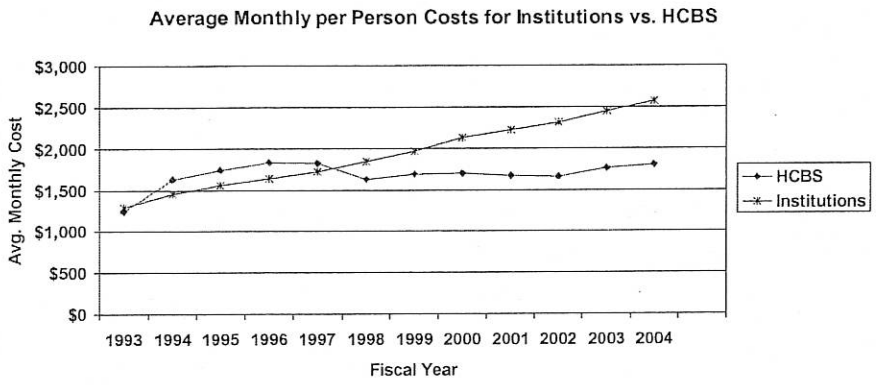


Home Community Based Services

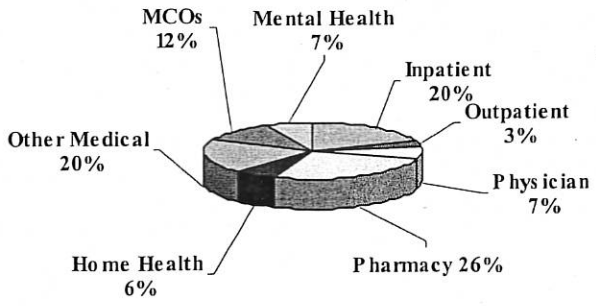
Cost Growth Comparison between Institutions and HCBS, FY 1993 - 2004



Average Monthly per Person Costs for Institutions vs. HCBS, FY 1993 - 2004



Total Medical Expenditures by Service Type, FY 2002



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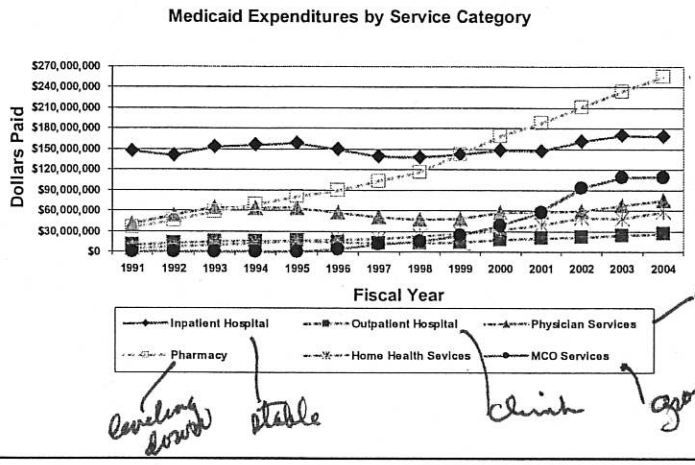
Total Medical Expenditures by Service Type FY 1991 to 2001, Projected to 2004



pharmacy 1st. inpatient 2nd

go to hospices

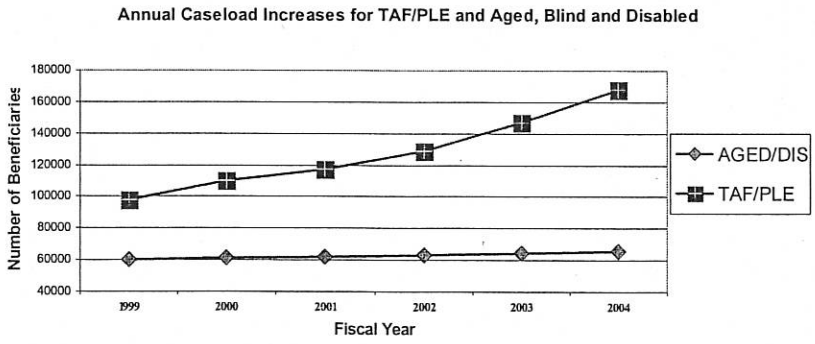
declining downward

stable

climb

growing

Caseload Increases for TAF/PLE and Aged, Blind and Disabled FY 1999 – FY 2004



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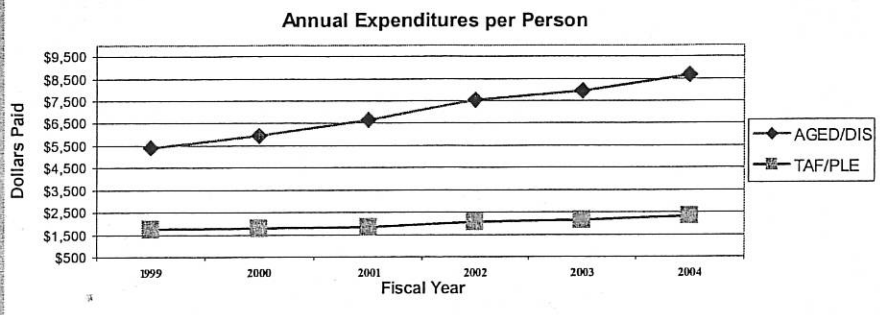
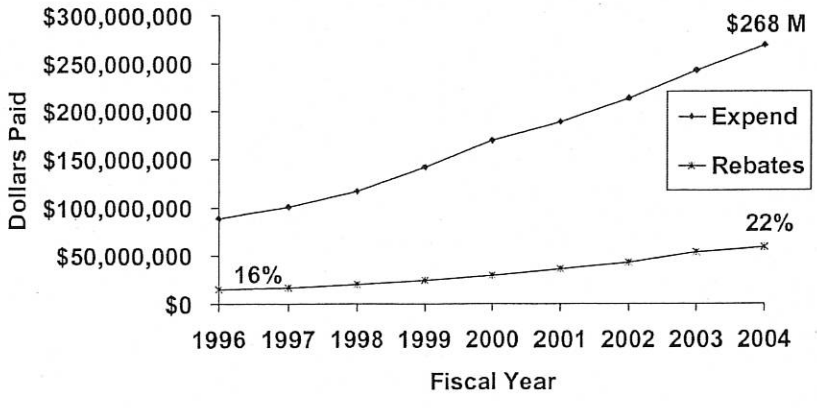
Expenditures for TAF/PLE and Aged, Blind and Disabled FY 1999 – 2004

Does not include long term care expenditures.



Pharmacy Expenditures and Rebates FY 1996 – FY 2004



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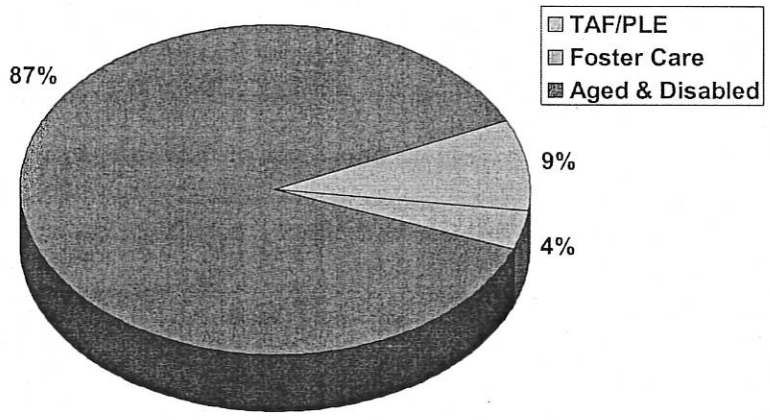
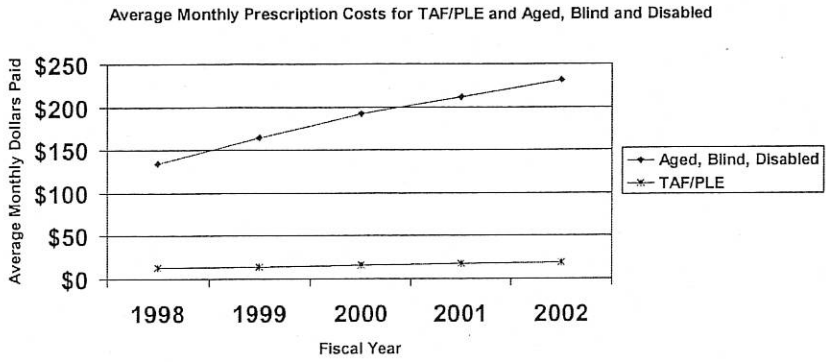
Federal Rules Governing Pharmacy Coverage

- OBRA-90 requires open formulary in exchange for rebates from pharmaceutical manufacturers
- States may use prior authorization to assure appropriate utilization
- Copay set in federal regulation – maximum of $3 per $50
- Exempted from copay are: children, pregnant women, nursing home residents and HCBS beneficiaries

Percent Pharmacy Expenditures by Population, FY2002



Average Monthly Prescription Costs for TAF/PLE and Aged,Blind and Disabled, FY 1998 – FY 2002



Top Ten Drugs by Expenditure FY 2002 for all Populations

Drug Name	Description	Total Paid Amount
Zyprexa	Atypical Antipsychotic	10,139,269
Risperdal	Atypical Antipsychotic	5,032,484
Seroquel	Atypical Antipsychotic	4,380,149
Prilosec	Anti-ulcer agent	4,071,493
Prevacid	Anti-ulcer agent	3,919,730
Neurontin	Anticonvulsant	3,041,504
Zoloft	SSRI Antidepressant	2,979,347
Celebrex	COX-2 inhibitor NSAID	2,963,347
Depakote	Anticonvulsant	2,653,716
Celexa	SSRI Antidepressant	2,443,324

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Cost Control Measures Implemented in the Pharmacy Program

Budgeted Savings: $17,221,249 AF ($6,835433 SGF) in FY 2003 and $31,990,000 AF ($12,694,600 SGF) in FY 2004

- Implementation of a preferred drug list
- Mandated use of generic medications
- Placement of additional medications on prior authorization
- Reduction of days supply allowed per prescription from 34 days to 31 days
- Copay increased from $2 per Rx to $3 per Rx

Cost Control Measures Implemented in the Pharmacy Program, continued

- Reimbursement reduction from AWP – 10% to AWP – 11% for brand-name drugs and AWP –27% for generics
- Further reimbursement reduction on brand name drugs from average wholesale price (AWP) less 11% in fiscal year 2002 to AWP less 13% in fiscal year 2003.
- Reduced dispensing fee from $4.50 per prescription to $3.40 per prescription.
- Limit of 5 brand-name prescriptions per month, unlimited generic use

average wholesale price

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Annual Per Person Pharmacy Expenditures in Long Term Care Setting

Living Arrangement	Total Pharmacy $ Paid	Total Beneficiaries	Average Annual Paid Amount Per Person
HCBS PD	$22,505,234	4,665	$4,824
Nursing Facility	$44,671,163	15,801	$2,827
HCBS DD	$16,501,207	6,025	$2,738
HCBS FE	$21,263,301	7,928	$2,682

Drug Utilization in the Nursing Home Setting

- Study by researchers at the Landon Center on Aging and School of Pharmacy completed Feb. 03
- Using Beers criteria, found some short-term use (less than one month) of inappropriate meds, but very little chronic use (2-3%)
- Less than 2% of total drug expenditures were for drugs determined inappropriate for use in the elderly
- Future plans – use this information to target outlier providers and nursing homes for education

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Concluding Comments

- Medicaid is second only to public education in the number of citizens impacted by its services.
- In a twelve-month period, Medicaid and SCHIP will cover 350,000 Kansans.
- Preventive services comprise a small portion of total health care expenditures.
- Costs in Medicaid and SCHIP are driven by acute and chronic illness.

Concluding Comments

- When people are sick, they seek care.
- Without insurance, that care is provided in the most expensive setting.
- Health care insurance costs reflect, in part, the costs of uncompensated care.
- Federal Medicaid dollars in the Kansas health care system will total over $1.058 billion in FY 2004.

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Medicaid Reform

CMS has proposed a reform of Medicaid that would include the following

- It would be optional for the state as to whether in choose to participate
- The proposal is built upon a ten year projection of 9% annual growth in medicaid
- The program would front load this growth for the first seven years and then lower it for the last three years
- The program would include both medicaid and SCHIP
- The money would be in the form of an allotment similar to SCHIP
- The state would be obligated to a MOE which would include increasing its participation beyond the base year by the medical CPI
- The money would be allocated into three pots acute care, long-term care and administration
- Ten percent of the money can be moved between long-term care and acute care
- Mandatory services and mandatory population would be protected but all other services and population would have flexible rules

Population Definitions

Aged, Blind, and Disabled This refers to groups of individuals who are categorically eligible for Medicaid because they receive Supplemental Security Income (SSI) or are "medically needy." Federal SSI status is based on age, disability and income. Anyone receiving SSI is automatically eligible for Medicaid if they apply. Medicaid programs are mandated to cover this group.

"Medically needy" aged or disabled people are individuals who meet all the criteria except income for being on SSI. Individuals in the group must meet spenddown requirements in order for services to be covered by Medicaid. Coverage of this population is optional for Medicaid programs.

TAF/PLE Temporary Assistance for Families/ Poverty Level Eligibility: Anyone receiving or eligible for TAF is eligible for Medicaid. Most families receive TAF for an average of less than 12 months. Nearly half of all medical expenditures for this group involve childbirth and newborn care.

Acronyms and Definitions

AWP Average Wholesale Price

FFP Federal Financial Participation refers to the amount of Federal dollars provided for the state Medicaid program

FMAP Federal Medical Assistance Percentage refers to the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures.

HCBS Home and Community Based Services: Waiver programs that allow states to cover home- and community-based health and support services to Medicaid-eligible people who are eligible for an institutional setting. The HCBS waiver supports people only in community settings, including apartments, small group homes and family homes. HCBS recipients include those who are eligible for nursing homes or other institutional settings.

LTC Long Term Care: This includes HCBS and institutional care.

MCO Managed Care Organization: A managed care organization is a health care plan designed to manage health care costs by providing medical services through groups of doctors, hospitals and specialty providers. Medicaid has two forms of managed care: Primary Care Case Management (PCCM) and Health Maintenance Organization (HMO).

Medical CPI Medical Consumer Price Index: Medical care is one of the major item groups within the Consumer Price Index (CPI). This major group consists of medical care commodities and medical care services. Medical care services, the dominant component of medical care, is organized into two expenditure categories (EC's), professional medical services and hospital and related services. (An additional expenditure category for health insurance is part of medical care services but is not published separately.) Medical care commodities, comprised of prescription drugs and nonprescription medical equipment and supplies, is the other major component of medical care.

Regular Medical This covers such services as outpatient care, pharmacy, mental health, transportation, and durable medical equipment.

Poverty Guidelines
Annual Income Guidelines for 1-5 Member Households (HH)

Selected SRS Services	% of 2002 FPL*	HH-1	HH-2	HH-3	HH-4	HH-5
TAF and GA-Cash & Medical	32%	$2,853	$3,844	$4,836	$5,828	$6,819
Elderly/Disabled Persons on SSI-Medical	72%	6,372	8,587	10,802	13,017	15,232
Children 6-18 Medicaid and Medicaid Waivers**	100%	8,860	11,940	15,020	18,100	21,180
Food Assistance and Energy Assistance	130%	11,518	15,522	19,526	23,530	27,534
Children Age 1-5 - Medicaid	133%	11,784	15,880	19,977	24,073	28,169
Pregnant Women & Infants - Medicaid	150%	13,290	17,910	22,530	27,150	31,770
Child Care Subsidy***	185%	16,391	22,089	27,787	33,485	39,183
Children's Health Insurance Program	200%	17,720	23,880	30,040	36,200	42,360

*FPL is the Federal Poverty Level.
**For the remaining months of FY 2003, the % of 2002 FPL for Medicaid Waiver is 87.4%.
*** For the remaining months of FY 2003, the % of 2002 FPL for the Child Care Subsidy is 150%

Medicaid Mandatory and Optional Coverage Groups

In addition to defining the population within the group, Medicaid rules also specify a level of eligibility for coverage. This specific level of coverage is usually selected by the State from an allow able range of incomes. The minima l level of coverage must be provided or Medicaid funding may be sacrificed. If an optional group is selected the conditions of the coverage group often depend upon a minimal level of coverage as well. These required levels are also included below:

MANDATORY COVERAGE GROUPS	OPTIONAL COVERAGE GROUPS
Temporary Assistance for Families (TAF) - Must cover families below 32% FPL ▸ Low-income families with children, eligible at TAF income levels ▸ Families moving from TAF to work ▸ Families moving from TAF to child support	**HCBS waivers -** The protected income level cannot be lower than the medically needy standard: ▸ Expanded coverage through higher protected income level of $716.00 per month ▸ Required disregard of parental income and resources
Poverty Level Eligibles - PLE - Must cover pregnant women and children of specific ages at 1989 levels ▸ Pregnant Women up to 150% ▸ Children at the following levels ▸ birth to one year up to 150% ▸ one to five years up to 133% ▸ six to eighteen up to 100% FPL	**Medically Needy -** Minimal protected income level is $475/month; through a spenddown, persons contribute to the cost of care: ▸ Pregnant women and children ▸ Elderly, disabled and blind persons
Foster Care/Adoption Support - Must cover children in custody under IV-E: ▸ foster care ▸ adoption ▸ juvenile justice	**Women with Breast or Cervical Cancer -** Must cover at level of the FREE to Know program ▸ Uninsured persons up to age 65 ▸ Income level is currently 250% FPL
Supplemental Security Income Recipients - Must cover all SSI recipients ▸ Persons who are disabled or blind ▸ Persons who are elderly	**Working Healthy -** Must cover persons with disabilities with incomes up to 300% of FPL
Medicare Savings Plans (QMB/LMB) - required to cover Medicare premiums and other cost sharing	**MediKan Coverage -** State funded group for persons who are receiving General Assistance or seeking federal disability benefits

Medicaid Mandatory and Optional Services

The following table compares adult Medicaid beneficiaries only. It is inappropriate to include children in these comparisons because federal regulations of Early Periodic Screening, Diagnostic, and Treatment (EPSDT) preclude significant reduction or elimination of medically necessary services for children. Kansas, like other states provides EPSDT coverage for children to age 20.

Federally Mandated Services[1]	State Option Services
• **Emergency Medical Services for Alien Individuals** • **Family Planning Services and Supplies** • **Home Health Services** • **Inpatient General Hospital Services** • **Laboratory and X-Ray Services** • **Medical Transportation** • **Outpatient General Hospital Services** • **Physician Services.** This includes pregnancy related services, and some physician extender (i.e., nurse-midwife and nurse practitioner) services.	• **Alcohol and Drug Abuse Treatment** • **Attendant Care for Independent Living** • **Audiological Services** • **Behavior Management** • **Community Mental Health Center and Psychological Services** • **Dental Services.** Limited to KAN Be Healthy consumers (children), except for medically necessary extractions. • **Durable Medical Equipment, Medical Supplies, Orthotics, and Prosthetics** • **Early Childhood Intervention** • **Health Clinics** • **Home or community-based services** • **Hospice Services** • **Inpatient Psychiatric Services.** For individuals under age 21 • **Intermediate care facility (ICF/MR) services** • **Local Education Agencies** • **Local Health Department Services** • **Nursing Services (ARNP)** • **Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.** • **Prescribed Drugs** • **Pediatric Services** • **Respiratory care for ventilator-dependent individuals.** • **Services for Special Disorders** • **Targeted Case Management for Assistive Technology** • **Vision Services**

[1] Federal rules require that when services are reduced or eliminated, they must be reduced or eliminated for all adults covered by Medicaid. However, federal rules for Early Periodic Screening, Diagnostic, and Treatment do not allow for significant reduction or elimination of medically necessary services for children.

Each service is provided only when medically necessary to the beneficiary. In addition, each provided service must be defined in the Kansas State Plan.

Kansas Medicaid Preferred Drug List

Therapeutic Drug Class	Coverage Code
Proton Pump Inhibitors	
Lansoprazole (Prevacid®)	X
Pantoprazole (Protonix®)	X
Omeprazole (Prilosec®)	PA
Esomeprazole (Nexium®)	PA
Rabeprazole (Aciphex®)	PA

Therapeutic Drug Class	Coverage Code
H_2 Antagonists	
Ranitidine (Zantac®)	X
Cimetidine (Tagamet®)	NP
Nizatidine (Axid®)	PA
Famotidine (Pepcid®)	X

Therapeutic Drug Class	Coverage Code
HMG - CoA Reductase Inhibitors	
Atorvastatin (Lipitor®)	X
Simvastatin (Zocor®)	X
Pravastatin (Pravachol®)	PA
Fluvastatin (Lescol®)	NP
Lovastatin (Mevacor®)	NP

Key:

X - Preferred drug covered

NP - Non-preferred drug, but PA not required

PA - Prior authorization required

Therapeutic Drug Class	Coverage Code
Non-Sedating Antihistamines	
Cetivizine (Zyrtec®)	X
Fexofenadine (Allegra®)	PA
Desloratadine (Clarinex®)	PA
Loratadine (Claritin®)	PA
Generic OTC Antihistamines	NP

Therapeutic Drug Class	Coverage Code
Intranasal Corticosteroids	
Fluticasone (Flonase®)	X
Flunisolide (Nasalide®)	X
Flunisolide (Nasarel®)	X
Budesonide (Rhinocort®)	PA
Budcsonide (Rhinocort AQ®)	PA
Mometasone (Nasonex®)	PA
Belcomethasone (Beconase®)	PA
Belcomethasone (Vancenase®)	PA
Triamicinolone (Nasacort®)	PA

Therapeutic Drug Class	Coverage Code
Triptans	
Sumatriptan (Imitrex®)	X
Rizatriptan (Maxalt®)	X
Naratriptan (Amerge®)	PA
Zolmitriptan (Zomig®)	PA
Almotriptan (Axert®)	PA

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Kansas Department on Aging

President's Task Force on
Medicaid Reform
February 13, 2003
Attachment 5-1

Long-Term Care Services: Nursing Facility and Home and Community Based Services for Frail Elderly

President's Task Force on Medicaid Reform
February 13, 2003
Janis DeBoer, Acting Secretary

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Doug Farmer, Assistant Secretary
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Kansas Department on Aging
FY 2002 Funding Sources

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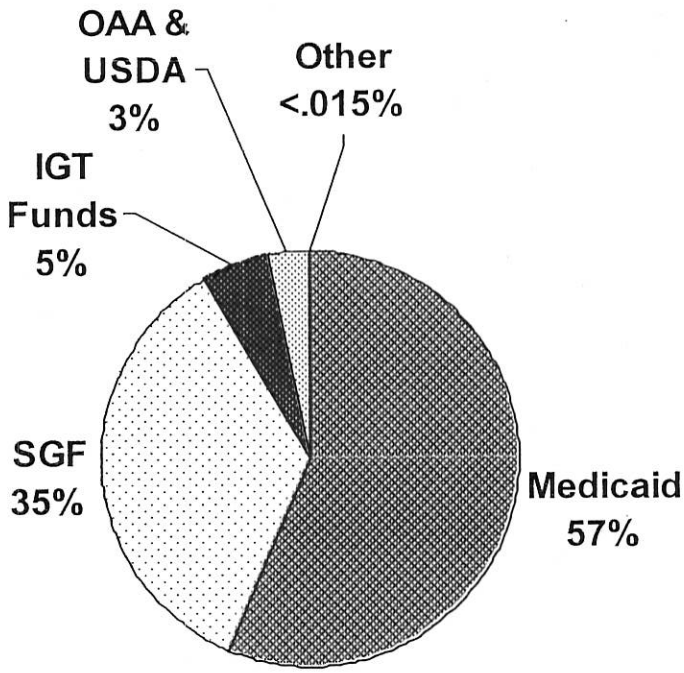
Medicaid	**$223,272,190**
State General Fund	**$140,824,187**
IGT Funds	**$21,089,830**
OAA & USDA	**$11,312,578**
Other	**$328,013**
Total	**$396,826,798**



Kansas Department on Aging
FY 2002 Expenditures

Nutrition **$8,840,080**

- Congregate
- Home Delivered Meals

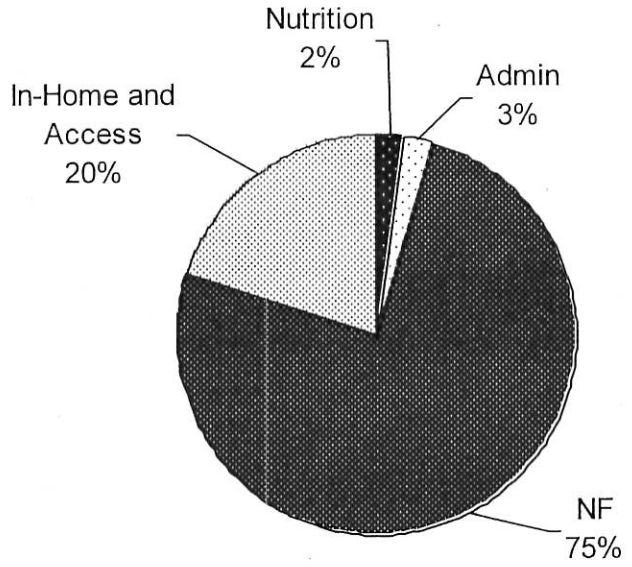
Access and In-Home **$78,881,780**

- Older Americans Act (OAA)
- Senior Care Act (SCA)
- Income Eligible (IE)
- Home and Community Based Services for Frail Elderly (HCBS/FE)
- Targeted Case Management (TCM)
- Senior Pharmacy Program
- Partnership Loan Program

Nursing Facility **$298,201,922**

Administration **$10,249,130**

- Includes Client, Assessment, Referral and Evaluation (CARE)



KDOA Customers Served FY 2002

HCBS/FE	**5,697**
Nursing Facility	**10,979**
CARE	**13,324**

- As of 1/31/03, HCBS/FE waiting list: 1,036

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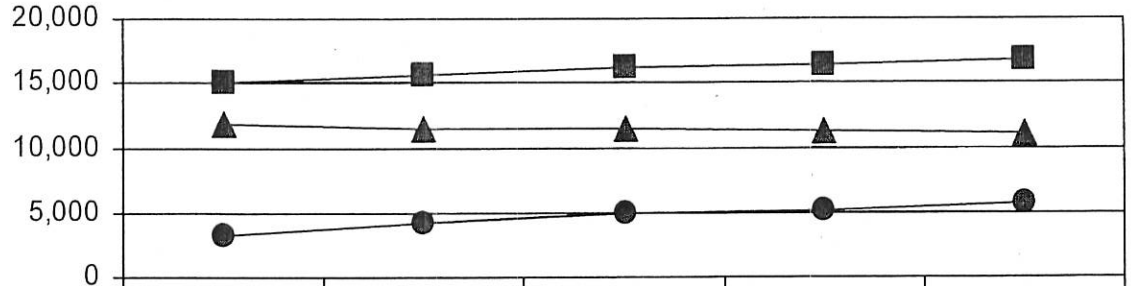
Monthly Medicaid Averages of Customers Served



	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002
Total Average	15,120	15,624	16,271	16,399	16,676
Monthly Ave of NF	11,788	11,340	11,394	11,162	10,979
Monthly Ave of HCBS/FE	3,332	4,284	4,877	5,237	5,697
Total Customer % Yearly Increase		3.33%	4.14%	0.79%	1.69%

- For SFY 2002, the increase in the average monthly number of customers served on the HCBS/FE and Nursing Facility programs was 1.69%, which is slightly less than the population growth of 2.03% for the elder population, aged 80 and over.

- The average age on the HCBS/FE waiver is 79 and the average age for residents in a nursing facility is 84.

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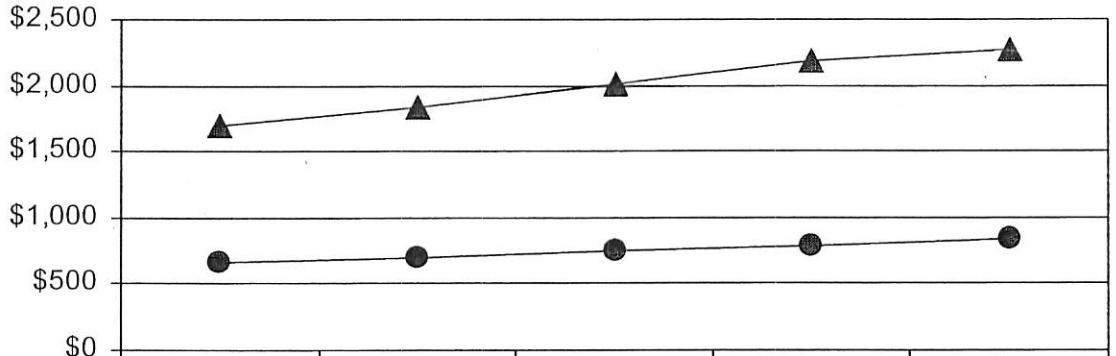
Monthly Average Medicaid Expenditures per Customer

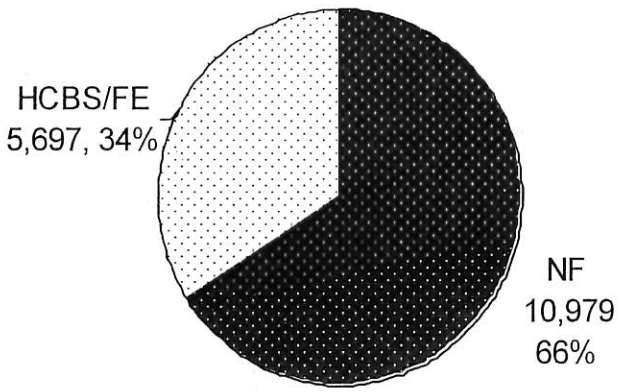


	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002
Monthly Ave NF Cost	$1,694	$1,841	$2,003	$2,184	$2,270
Monthly Ave HCBS/FE Cost	$672	$698	$747	$789	$840

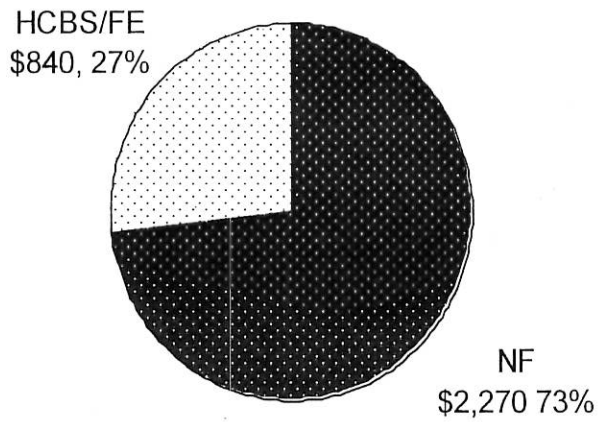
- In addition to the above analysis, the Department of Social and Rehabilitation Services conducted a study to determine the impact of HCBS/FE on nursing facility utilization (see Attachment A). The results from that study support KDOA's finding that HCBS/FE is a cost-effective alternative to nursing facility placement.

Comparison of Nursing Facility and HCBS/FE Customers and Expenditures

Monthly Average Served



Monthly Average Expenditures



Attachment A

Are Home and Community-Based Services Less Costly than Nursing Home Care?

TI Shireman, SK Rigler, KS Braman, RM Day. Univ of Kansas Schools of Pharmacy and Medicine, the Landon Center on Aging, and Kansas Dept of Social & Rehabilitative Services

Background: Kansas Medicaid covers home and community-based services (frail elderly (FE) program) as an alternative for older adults who are eligible for nursing home (NH) care but wish to stay in the community.

Objectives: To describe demographic and health characteristics of Kansas Medicaid enrollees receiving NH or FE services and to compare their relative Medicaid expenditures.

Methods: We compared one-year direct medical costs, from Medicaid's perspective, for a random sample of NH and FE recipients (n=1050 and n=1165, respectively), using mean monthly costs to adjust for enrollment time. We explored the influence of demographic factors and comorbidities on cost differences between the NH and FE groups using multiple linear regression models.

Results: The NH cohort was older than the FE cohort, (83.2 vs 76.9 years), more likely to be white (93.4% vs 82.0%), and more likely to have dementia (34.4% vs 5.6%) or psychoses (28.6% vs 10.4%). The FE cohort had a higher prevalence of major medical diagnoses and died at a higher rate than their NH counterparts. After adjusting for key demographic and clinical features, mean monthly total costs for the FE cohort were $1,147 ($p < 0.001$) lower than for the NH cohort. When we excluded direct NH and FE-specific costs, the FE cohort's mean monthly costs were $243 higher than for NH cohort ($p < 0.001$), reflecting higher use of inpatient and outpatient services.

Conclusions: FE program enrollment was associated with reduced total costs relative to NH care. When considered with a concurrent analysis of nursing home placement rates, results support the notion that these services are a cost-effective care alternative for frail older adults.

Supported by a grant from the Kansas Department of Social and Rehabilitative Services.

5-8

Do Home and Community-Based Services Reduce Nursing Home Placement?

TI Shireman, SK Rigler, KS Braman, RM Day. Pharmacy Practice, Univ of Kansas School of Pharmacy and Medicine, Landon Center on Aging, and Kansas Dept of Social & Rehabilitative Services

Background: Kansas Medicaid covers home and community-based services (frail elderly (FE) program) as an alternative for older adults who are eligible for nursing home (NH) care but wish to stay in the community.

Objectives: To determine whether FE services lowered the rate of subsequent NH admission.

Methods: Retrospectively, we identified a randomly selected cohort of community-dwelling, elderly Medicaid enrollees. Those enrolled in the FE program (n=963) were compared to those who did not receive any FE or NH services during the base year (n=2992). The outcome was any NH use during the subsequent year and modeled using logistic regression accounting for differences in demographic factors and comorbidities.

Results: Persons receiving FE services were more likely to be white (82% vs 78%), female (78% vs 70%), and older (78 yrs vs 75 yrs). The 3 most prevalent comorbidities for both groups were hypertension, arthropathies, and diabetes. Subsequent rates of NH use were 4.4% lower among FE enrollees than for the non-FE community-dwelling cohort. After adjusting for differences in age, race, gender and major comorbidities, non-FE community-dwellers were 1.49 (95% CI 1.16-1.92) times more likely to enter a NH as compared to FE enrollees.

Conclusions: FE program enrollment reduced the likelihood of subsequent NH use among older Medicaid recipients. Combined with cost analyses reported elsewhere, results support the notion that these services are a cost-effective care alternative for frail older adults. Supported by a grant from the Kansas Department of Social and Rehabilitative Services.

5-9

Kansas Department on Aging

President's Task Force on Medicaid Reform
February 13, 2003

Kansas Senior Pharmacy Assistance Program
Janis DeBoer, Acting Secretary

For information contact:
Sheli Sweeney, Legislative Liaison
(785) 296-2199 or michelle@aging.state.ks.us

Doug Farmer Assistant Secretary
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Medicaid Prescriptions for Nursing Facility (NF) and Home and Community Based Services for the Frail Elderly (HCBS/FE) Customers

1-2

- For the NF Program, KDOA covers over-the-counter medications through the nursing facility per diem rate setting methodology.

- For both NF and HCBS/FE customers, prescription drugs are covered by the SRS Medicaid pharmacy program using the medical card provided that the medication is on the formulary.

frail elderly

Kansas Senior Pharmacy Assistance Program

6-3

Eligibility Criteria

- Must be an individual must be 67 years of age or older; and
- Must not be covered by a private prescription reimbursement plan; and
- Must not have voluntarily canceled a local, state, or federal prescription drug program or a private prescription reimbursement plan within six months prior to application of enrollment; and
- Must be enrolled as a Qualified Medicare Beneficiary within 100% of federal poverty level and have resources less than $4,000 for a single individual or $6,000 for a couple; or
- Must be enrolled as a Low-Income Medicare Beneficiary within 135% of federal poverty level and have resources less than $4,000 for a single individual or $6,000 for a couple.

Coverage

- All FDA approved legend drugs with the exception of "lifestyle" drugs
- Diabetic supplies not covered by Medicare.

Benefit

- Reimbursement of 70% of incurred costs up to $1,200 per calendar year

Co-pay

- 30% percent of the cost of the prescription drug

Program funding

- $1.2 million in SFY 2002 and SFY 2003, interest from Senior Trust Fund

Customers Served

- In SFY 2002, assisted 1,511 individuals with an average reimbursement of $528

Kansas Senior Pharmacy Assistance Program
Plans for SFY 2004

- KDOA is working with SRS to apply for a Pharmacy Plus (1115) waiver. This waiver would allow us to draw down federal match to enhance the program and serve more seniors. State share $1.2 million, federal share $1,715,625, with a total budget of $2,915,625.

Eligibility Criteria

- Age would be reduced to 65 years of age or older
- Increase financial eligibility to 200% of federal poverty level

Coverage

- Kansas Medicaid Drug Formulary
- Continue to cover diabetic supplies not covered by Medicare

Benefit

- Maximum retrospective payment of $1,200 per calendar year

Co-pay

- 10% of the cost of the prescription drug on the Medicaid formulary

Tentative Program Enhancements

- Expand the Senior Health Insurance Counseling for Kansas' (SHICK) Prescription Drug Program efforts
- Serve 4,000 customers, assuming $600 average annual payment (60% FFP match)

Summary of Issues Relating to Drugs Paid for by Kansas' Medicaid Program From the Performance Audit, *Reviewing the Medicaid Program's Use of Generic Drugs*

President's Task Force on Medicaid Reform
Barb Hinton, Legislative Post Auditor
February 13, 2003

The Medicaid Program should have a system of policies, procedures, and practices in place that help ensure the State pays for the most cost-effective drug therapies for clients, pays for only the amount of drugs clients need and can use, and doesn't pay more than it needs to. Here are issues our audit identified in these areas:

Controlling the Types of Drugs Prescribed To Help Ensure That the Program Pays for the Most Cost-Effective Drug Therapy for Clients' Medical Conditions

1. Restrict the amount paid for higher cost "name brand" drugs when generic drugs are available

   a. 60% of prescriptions filled for Medicaid clients in FY 1999 had generic versions available, but these accounted for only 25% of the amount spent on prescription drugs that year

Drugs with...	# of prescriptions filled	% of total prescriptions	$ spent on drugs	% of total $
> 1 source	2 million	59%	$28.8 million	24%
only 1 source	1.4 million	41%	$91.8 million	76%

   b. Federal law caps reimbursements when there are 3 or more equivalent versions of a drug; State law caps when there are 2 or more versions (went into effect after the year we reviewed).
   c. Our analysis of computer records for a sample of 55 high-cost and high-use drugs showed
      i. The Program paid for the generic version 82% of the time.
      ii. Using generic drugs saved the Program $2.2 million in FY 1999–about half the savings came from just three drugs.
      iii. If generics had been dispensed for all 55 drugs, the State would have saved another $830,000. More than half that amount related to just one drug—clozapine, which is used to treat psychotic disorders. This drug has 2 sources, but the name brand was prescribed 91% of the time (the State's cap wasn't yet in effect). BUT, there can be reasons why generic drugs aren't dispensed.
      iv. The name brand version **wasn't the most costly option** for 23 of 55 drugs, and was the **least expensive** option for 7 of those drugs (possible savings $234,000)
      v. When rebates were taken into account, 4 other name brand drugs **were less expensive** than their generic equivalents (possible savings $700,000)

2. Provide financial incentives to use the lowest cost drug (for both providers and clients)
3. Don't pay for certain drugs (i.e., cosmetic drugs, fertility drugs, weight-loss drugs, and many OTC drugs)
4. Require prior authorization for drugs that are expensive or subject to abuse
5. Analyze data to assess whether the type of drug prescribed is appropriate for the client's diagnosis.
6. Educate providers as to what's expected of them

7. **Require a client to "fail" on a less expensive drug therapy before receiving a more expensive version** (Iowa does this. Physicians expressed reservations about this approach)
8. **Require the use of the generic drug by statute unless the physician specifies the name brand should be dispensed.** (New Mexico does this.)
9. **Require the pharmacy to get authorization from SRS to dispense a name brand drug based on the client's medical condition.** (CO and PA do this. Would require proof of medical necessity before a client could get a brand name. Adding this "red tape" requires physicians, pharmacists, and clients to work together to provide the information needed for approval.)
10. **Set a lower co-pay for generic drugs and a higher co-pay for the equivalent name brand drug to encourage clients to request the generic version when it's available.** (Colorado does this; Kansas regs set a $2 co-pay for both generic and name brand drugs.)
11. **Pay pharmacists a 50¢ fee to substitute an equivalent generic drug for a name brand drug to encourage them to dispense generic versions.** (Connecticut does this.)
12. **Provide a list of substitutable drugs to pharmacies.** (VA does this.)
13. **Expand coverage of OTC drugs as an alternative to more costly prescription drugs** (VA saved about $460,000 and planned to become even more aggressive)
14. **Expand the use of prior authorization, especially for new, more costly drugs** (increases likelihood those drugs will be dispensed only when needed)—SRS may need more flexibility in restricting access to certain drugs)
15. **Place limits on newer, more costly drugs that research shows are no more effective than older, less expensive drugs.**
16. **Expand educational efforts for physicians on cost-effective alternatives** to common drugs and on name brand drugs that avoid expensive complications
17. **Consider ways to counteract the new direct-to-consumer advertising of certain drugs** (studies have shown a significant increase in the use of several drugs that are the most highly advertised to the public)
18. **Expand review and analysis of data to assess trends in usage and costs** (i.e., what types of drugs are being paid for, which ones are most expensive or most frequently used, whether generic drugs are being used when appropriate, whether drugs may be candidates for prior authorization, etc. Follow through, identify causes, and make appropriate adjustments

Controlling the Amount of Drugs Prescribed To Help Ensure That the Program Pays for Only the Amount of Drugs Clients Need and Can or Should Use

1. Check for proof of medical need for certain drugs
2. Establish prescription and refill limits (so that more drugs aren't prescribed than can, should, or will be used or needed)
3. Analyze data to identify the number and types of drugs clients are using, whether they're all needed, whether they might have adverse reactions, etc., follow-through to determine the causes, and make adjustments to prevent or minimize future unwanted occurrences.

4. **Analyze high-use, high-cost drugs to ensure that cost increases are cost-effectively reducing other costs** (i.e., certain drugs can prevent hospitalization or other expensive care)
5. **Counsel clients with chronic conditions or diseases on how to better manage those conditions** and reduce overall health care costs (VA asthma program showed counseling increased drug costs, but reduced overall medical costs by $3-4 for every $1 spent on counseling)
6. **Limit the supply of new prescriptions to a "starter dose"** (i.e., 7-10 days) to ensure the medicine is working without adverse side effects
7. **Expand review and analysis of data for clients who use over a certain number of prescriptions.** Follow through, identify causes, and make appropriate adjustments

Controlling What the State Pays for Medicaid Prescriptions To Help Ensure That The Program Doesn't Pay More Than It Needs To

1. Pay the lowest reimbursement option for each drug
2. Get the benefit of discounts providers receive on drugs
3. Don't pay for drugs that are covered by another insurance policy (such as Medicare)
4. Receive all the drug rebates the State is entitled to
5. Analyze data to make sure the Program isn't paying for billing errors, double billing, etc.
6. Review cases to identify potential fraud or abuse (i.e., billing for drugs not actually dispensed, for more expensive drugs than actually dispensed, for the partial filling of a prescription, etc.)
7. Place limits on clients who are misusing the Program (i.e., limit their access to one provider)
8. Obtain reimbursements for errors, and prosecute fraud or abuse

9. **Pay pharmacists to split larger dose tablets in two when there's little difference in cost between the larger and smaller dose** (NE estimated savings of $300,000/year by spitting the antidepressant Zoloft, even after paying pharmacies 15¢ a tablet to split tablets, and was exploring splitting other drugs that have a high cost per dose. KS could save about $700,000 a year on Zoloft.)
10. **Expand the analysis of data to assess trends in usage and costs** and more proactively and aggressively identify errors or abuse.

Medical Service Bureau
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msbmedlinks@yahoo.com

Accessing medication is difficult for many. The high cost of medication prevents seniors, and those that are uninsured from living a healthy life. Medical Service Bureau (MSB) has three programs designed to ease the burden of high cost medications.

To qualify for MSB's programs individuals must…

- Live or work in Sedgwick County
- Not have any other prescription insurance or be enrolled in any government program that provides access to medications.
- Meet income guideline (there are different guidelines for different programs).

The three programs provided by MSB are…

- **The Non-Profit Pharmacy Program**

  This program provides a generous formulary of generic medications that cover most chronic and immediate medical needs. These prescriptions are available for $10.00 or $15.00 each depending on the medication. MSB also has a half-price formulary that includes the more expensive generic prescriptions, some brand name prescriptions, and diabetic supplies. This program can be accessed at any time in the month, month after month, as long as client has a prescription. The pharmacy is self-sustaining. All monies paid into the pharmacy go to cover a minimal dispensing fee and the cost of the medication. We buy our medicines in bulk and semi-bulk and the drug cost and dispensing fee are covered by the $10.00 or $15.00 payment. We allow community health agencies, social service agencies, HUD housing programs, area hospitals and emergency rooms to buy medications for their patients at our cost. This is accomplished by relay fax. We are faxed a request for voucher, said fax qualifying the patient, we approve the same and fax to our pharmacy who then bills the payor, who will be the referring agency or the referred client.

- **The Voucher Program**

  This program provides assistance in acquiring prescription medication by paying a limited amount of the medication. This program is available as funds are available. This program also provides access to prescription eyeglasses. This program is usually accessed at the first of the month for prescription medications. Call on the last Monday of the month to schedule an appointment for eyeglasses.

- **The Pharmaceutical Drug Program (PDP)**

  MSB also provides assistance in locating, and enrollment for those companies that provide free or low cost medications through the Pharmaceutical companies. There are certain days that MSB sets appointments for PDP programs. Call to find out which day is best to set up your appointment.

Other services…

- **Referrals**

  MSB provides referrals for low cost eye exams. Call on the last Monday of the month for eye exam referrals. Referrals are also given to clients with specialized needs to access other community agencies.

When you come you must bring…

- **Proof of income for the past 30 days.**
- **Original prescriptions or a printout of prescriptions that include the name, strength and quantity.**

President's Task Force on
Medicaid Reform
February 13, 2003
Attachment 8-1

MEDICAL SERVICE BUREAU
INCOME GUIDELINES

Size of Family	150% Federal Poverty Guidelines Voucher Program	200% Federal Poverty Guidelines PDP Program	250% Federal Poverty Guidelines Non-Profit Pharmacy
1	$1,108	$1,477	$1,846
2	$1,493	$1,990	$2,488
3	$1,878	$2,503	$3,129
4	$2,263	$3,017	$3,771
5	$2,648	$3,530	$4,413
6	$3,033	$4,043	$5,054
7	$3,418	$4,557	$5,696
8	$3,803	$5,070	$6,338
Additional person	$385	$513	$642

*Adjusted monthly income will be gross household income less total cost of prescriptions purchased during the previous month

MEDICAL SERVICE BUREAU
2002 STATISTICS

Via Christi
Regional Medical Center

- In 2002, the agency served 4,402 clients with 25,310 units of service
- We assisted with the purchase of 835 pairs of glasses, 231 pairs for children and 604 for adults at a cost of $32,887
- We referred clients for 756 low cost eye exams, 220 for children and 536 for adults at a cost of $225
- We purchased 7,803 prescriptions, 616 for children and 7,160 for adults for a total cost of $130,620.
- The agency spent a total of $163,731 on direct client services.
- With our Pharmaceutical Drug Program, we enrolled 1,595 clients with Pharmaceutical Companies for a total of 10,561 medications and sustained a savings of $2,688,648 for our clients.
- 63% of the clients were female and 37% were male.
- 8 %of the clients were less than 19 years old, 55% were between 19 and 59 and 37% were 60 and older.
- Non-minorities made up 54% of our clients with 46% being minorities. Less than 1% were American Indian, less than 5% were Asian, 19% were Black, 20% were Hispanic and 1% mixed race.
- 54% of our clients have income less than $10,000 per year, 37% have incomes between $10,000 and $20,000 and less than 9% have incomes over $20,000 per year.
- Of clients in our agency, 93% live inside Wichita city limits, 5% in Sedgwick County and 2% outside Sedgwick.
- In 2002, the agency was forced to turn away 2,666 potential qualified clients due to budget constraints

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Robert (Bob) R. Williams, MS, CAE, Executive Director

TESTIMONY
President's Task Force on Medicaid Reform

February 13, 2003

My name is Bob Williams, Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Task Force on Medicaid reform.

This session there have been several reports presented to various Legislative Committees regarding Medicaid. Jim Verdier with Mathmatica Policy Research Inc. listed the following State Spending Control *Options:*

- Maximizing rebates from drug companies.
- Pharmacy Dispensing Fees
- Generic and therapeutic substitution
- Step Therapy
- Limits on number of prescriptions
- Prior Authorization
- Drug Utilization and Review (DUR)
- Disease Management programs
- Beneficiary cost sharing (co-payments)

Recommendations from Muse and Associates focused primarily on high utilizers of prescription medication particularly in nursing homes and poly-pharmacy.

President's Task Force on
Medicaid Reform
February 13, 2003
Attachment 9-1

For the most part, as a result of legislative action in 2002 many of the recommendations have been implemented.

- Pharmacy reimbursement has been decreased from AWP-10% for brand/generic to AWP-13% for brand and AWP-27% for generics with a $3.40 dispensing fee. Pharmacists report they are having some problems with the reimbursement on generics in that there are "single source" generics which cost pharmacists more than what they receive in reimbursement. SRS policy requires pharmacists to dispense these medications which leaves the pharmacist few options but to take a loss on the medication or drop out of the program. (See attached list.)
- Kansas now has a mandated generic dispensing policy. Generic substitution is permitted in Kansas, therapeutic substitution is not permitted.
- Preferred Drug List (PDL). While this program is not totally up and running, pharmacists indicate the PDL appears to be reasonable. The PDL will require additional effort on the part of physicians and pharmacists regarding prior-authorizations and drug therapy management.
- SRS has implemented a five brand drug limit (unlimited generics) per month for Medicaid beneficiaries. Pharmacists have begun to work with physicians and patients to comply with the new requirement. In some instances, it has been very challenging.
- Co-payment was increased from $2.00 to $3.00, the maximum allowable.
- Prior-authorization, for the most part, is being implemented by SRS to it's fullest extent.
- Step therapy has been consistently rejected by the Kansas legislature as a means to control costs. However, to a certain extent, the increased use of prior-authorization and PDL are forcing the issue.

Disease Management:

A common thread throughout all of the presentations has been "disease management" or "drug therapy management". If one assumes the cost of prescription medication will continue to increase and more

diseases will be treated with prescription medication, the most effective means to control expenditures is to improve outcomes.

The pharmacy profession has been a long standing champion of disease management. Attached is a listing of studies documenting the impact of disease management on outcomes and health expenditures. I have also attached the results of a study conducted in Iowa in which pharmacists and physicians were reimbursed for "pharmaceutical case management". In a 1997 issue of the Archives of Internal Medicine, drug related morbidity and mortality among ambulatory patients cost the U.S. economy $76 billion annually in direct cost alone.

Other Considerations:

Medicaid receives substantial rebates. For the most part, these rebates exceed rebates in the private sector. Kansas does not receive rebates for that portion of the Medicaid drug program which is contracted out to managed care organizations.

The Medicaid drug program is frequently viewed in a vacuum with very little consideration given to outcomes and cost shifting. For example: Psychotropic drugs are expensive, but more cost effective than institutionalizing patients (how many state hospitals have been closed and how much has that saved the state?). Proton pump inhibitors are expensive, but less costly than ulcer surgery.

The "managed care" concept has become part of the problem. It promotes a "one size fits all" health care system and it's emphasis on volume in exchange for reduced reimbursement allows for very little room to "manage" health care.

"Turf" issues prevent qualified health care providers and mid-level practitioners from assisting with disease management.

Better management of drug therapy will make a difference. However, it must be adequately funded and will require a major shift in program parameters.

Thank you.

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NDC #	Generic Name	Compare To Brand Name
00472 0067 08	Phenytoin Susp. 8oz.	Dilantin Susp.
60432 0131 08	Phenytoin Susp. 8oz.	Dilantin Susp.
00781 1830 01	Promethazine 25 mg. Tab 100s	Phenergan
53014 0575 30	Methylphenidate 20 mg. 30s	Metadate CD
00067 0215 14	Nicotine Patch 14mg. Box 30 (problem may apply to all nicotine patches)	Habitrol
00066 0494 25	Clindamycin/Ben. Peroxide 25 gm. 5%/1%	Benzaclin
00066 0494 50	Clindamycin/Ben. Peroxide 50 gm 5%/1%	Benzaclin
65199 1201 01	Methenamine Hipp. 1gm. 100s	Urex
54746 0001 01	----------	Alferon N 5mu/ml
62027 0663 01	Hydrocodone/APAP 7.5/325 mg. 100s	Anexsia
52544 0729 01	Hydrocodone/APAP 7.5/325 mg. 100s	Norco
00781 1766 01	Imiprimine Tab 50mg 100s	Norpramin
65473 0754 01	Vospire 4mg. 100s	Volmax
00074 4332 01	Vancomycin 500mg Inj 10s	Vancocin
00186 1090 05	Metoprolol 50mg 100s	Toprol XL
52544 0847 28	Low Ogestrel	Lo Ovral
00078 0241 15	Cyclosporine 100mg 30s	Sandimmune
00093 0475 73	Cephalexin Susp. 125/5 100s	Keflex
00781 1506 10	Atenolol 50mg 100s	Tenormin
00378 0757 01	Atenolol 100mg 100s	Tenormin
00093 2275 34	Amox./Clavul. 875/125 Tab 20s	Augmentin
00029 6072 12	----------	Augmentin (Chewables-all strengths)
00591 4012 01	Valproic Acid 250mg Cap 100s	Depakene
00145 2371 05	Ben. Peroxide 1%/5% 45gm	Duac Gel
00032 1220 01	----------	Creon 20 Cap 100s
58914 0004 10	----------	Ultrase MT 20 Cap 100s
00713 0526 12	Promethazine 25mg supp. 12s	Phenergan
00574 2021 16	----------	Laclotion 12% Lotion 400 g
00085 0072 04	----------	Tinactin SPR. Powder 100 g
51672 4047 09	Carbamazine Susp. 100mg/5ml,450 ml.	Tegretol
00054 4527 31	Lithium Carbonate 300mg 1000s	Eskalith
00781 2048 01	Amantadine 100 mg Cap 100s	Symmetrel

9-4

The Value of Pharmaceutical Care Services

- Prepared from research by the editorial staff of Pharmacist's Letter and Prescriber's Letter -

By Stephen C. Burson, R.Ph.

This table offers many examples of recent and past studies documenting the impact of pharmaceutical care on outcomes and health expenditures.

Setting or Disease State	Results	Citation
Ambulatory Care Clinic	The clinical pharmacy services of one pharmacist were associated with net annual savings in drug cost of $38,776.	Jones, RA, Lopez LM, Beall DG. Cost-effective implementation of clinical pharmacy services in an ambulatory care clinic. Hosp Pharm 1991;26(9):778-82
Anticoagulation	A pharmacist-run anticoagulation service in a community hospital showed a 57.9% decrease in hospitalization rates (p=0.078) and a 7.1% decrease in total hospital days (p=0.108) after six months compared to the patients' previous six months before enrollment.	Spalek VH, Cong WC. Pharmaceutical care in an integrated health system. J. AM Pharm Assoc 1999; 39:553-7
Anticoagulation	A pharmacist-managed anticoagulation service significantly lowered total hospital costs compared to usual patient care ($1,594 vs. $2,014 in 1997 dollars, p=0.04). These services were also associated with an earlier start of warfarin (p=0.05) and shorter hospital stays (p=0.05).	Mamdani MM, et al. Clinical and economic effectiveness of an inpatient anticoagulation service. Pharmacotherpy 1999; 19(9): 1064-74.
Anticoagulation	A clinical pharmacist-run anticoagulation clinic improved anticoagulation control, reduced bleeding, and saved $162,058 per 100 patients annually in reduced hospitalizations and emergency department visits. Patients had significantly lower rates of warfarin-related hospitalizations (5% vs 19% control group) and emergency department visits (6% vs 22%)	Chiquette E, Amato MG, Bussey HI. Comparison of an anticoagulation clinic with usual medical care: anticoagulation control, patient outcomes, and health care costs. Arch Intern Med 1998;158(15):1641-7.
Asthma	A pharmacist-run asthma management program reduced the number of emergency department visits for asthma attacks from 92 in the previous six months to only six during the six-month study. The study consisted of 25 asthma patients.	Pauley TR, Magee MJ, Cury JD. Pharmacist-Managed, physician-directed asthma management program reduces emergency department visits. Ann Pharmacotherpy 1995;29(1):5-9
Community	Pharmacists' cognitive services generated a mean drug cost savings of $13.05 per intervention that resulted in a change of drug therapy. For the specific payment rate for cognitive services used in this study, paying for cognitive services is estimated to save an additional $10 per 1,000 prescriptions. For interventions when drug therapy was added (9% occurrence), the estimated additional cost is $13 per 1,000 prescriptions. Sensitivity analysis revealed that a higher intervention rate leads to even higher potential savings.	Smith DH, Fassett WE, Christensen DB. Washington State CARE project; downstream cost changes associated with the provision of cognitive services by pharmacists. J AM Pharm Assoc 1999;39:650-7.
Community	Five rural community pharmacists in Nebraska performed 878 interventions with pharmaceutical care services over a two-month period. These included non-prescription-based interventions (29% of total). The estimated cost savings associated with these interventions totaled $752,391 from avoiding hospitalizations due to adverse drug effects, avoiding office visits, and other intervention outcomes.	Miller LG, Scott DM. Documenting indicators of pharmaceutical care in rural community pharmacies. J Man Care Pharm 1996;2(6):659-66.
Community/ Hyperlipidemia	A pharmacist-run lipid management program significantly decreased total and low-density lipoprotein cholesterol values at 12 months compared with either baseline or at six months (p>0.02). Patient surveys showed a significant improvement in quality of life, patient satisfaction, and patient opinions about the role of pharmacists.	Shibley MC, Pugh CB. Implementation of pharmaceutical care services for patients with hyperlipidemias by independent community pharmacy practitioner. Ann Pharmacother 1997;31(6):713-9.
Diabetes	Pharmacist members of interdisciplinary primary care teams impacted glycemic control in type 2 diabetes patients who require insulin. Glycosylated hemoglobin, fasting blood glucose, and random blood glucose concentrations decreased significantly from baseline: 2.2% for HbA1c (p=0.00004), 65 mg/dl for fasting blood glucose (p>0.01), and 82 mg/dl for random blood glucose (p=0.0001).	Coast-Senoir EA, Kroner BA, Kelly CL, Trilli LE. Management of patients with type 2 diabetes by pharmacists in primary care clinics. Ann Pbarmacother 1998;32(6):636-41.
Diabetes	In an outpatient clinic, pharmaceutical care was effective in the reduction of hyperglycemia associated with type 2 diabetes. Over a four-month period, significant improvements occurred in glycosylated hemoglobin, (p=0.003) and fasting plasma glucose (p=0.015). These changes were also found to be significantly different from the control group (p=0.003 and p=0.022, respectively)	Jaber LA, et al. Evaluation of a pharmaceutical care model on diabetes management. Ann Pharmacother 1996;30(3):238-43.

9-5

	Results	Citation
	volving a clinical pharmacist in the follow-up and monitoring of heart failure patients significantly lowered rates of mortality and heart failure events over a six-month period (p=0.005). Patients in the intervention group received higher doses of angiotensin-converting enzyme inhibitors and were closer to their targeted dose. There was also a significant reduction in hospital readmission rates, 29% vs. 42% for control group (p=0.03).	Gattis WA, Hasselblad V, Whellan DJ, O'Connor CM. Reduction in heart failure events by the addition of a clinical pharmacist to the heart failure management team. Arch Intern Med 1999;159:1939-45.
,pital	Over a 30-day period, six pharmacists at a large university hospital reduced drug costs by 41% using pharmaceutical care services (p>0.0010). This was estimated to equal annual savings of $394,000	McMullin ST, et al. A prospective, randomized trial to assess the cost impact of pharmacist-initiated inter-ventions. Arch Intern Med 1999;159:2306-9.
Hospital	Both centrally-based and patient-specific clinical pharmacy services reduced hospital mortality rates. A decrease of up to 40,478 deaths a year was seen in over 1,000 hospitals that had the following clinical pharmacy services: clinical research, drug information, drug admission histories, and participation on a cardiopulmonary resuscitation team.	Bond CA, Raehl CL, Franke T. Clinical pharmacy services and hospital mortality rates. Pharmacotherapy 1999;19(5);4556-64.
Hospital, Children's	Pharmacists' interventions were assessed over a two-week period for impact on patient care and medication costs. Out of the 361 interventions 93% were judged to have a positive effect on patient outcomes, 7% had no effect, and none were considered detrimental. Ninety percent if the interventions resulted in improved quality of care while 8.5% were deemed life-saving. The estimated annual savings for the cost of medication alone was $17,654. These savings did not include decreased adverse drug effects or decreased hospitalization.	Strong DK, Tsang GW. Focus and impact of pharmacists' interventions. Can J Hosp Pharm 1993;46(3):101-8.
Hospital/ Cardiovascular	Pharmaceutical care for acute cardiovascular patients in a community hospital was estimated to save $17,576 in annual patient medication costs. 95% of the pharmacists' recommendations on drug therapy were accepted by the prescriber. 66% of the recommendations were considered significant and 4% were considered extremely significant.	Chisholm MA, Pittman DG, Longley JM, Mullis SR. Implementation of pharmaceutical care in acute medical cardiovascular patients. Hosp Pharm 1995;30(7):572-4,577-8.
Hypertension	Pharmaceutical care for hypertensive patients in a clinic resulted in significant decreases in mean blood pressure compared to the control group after an average follow-up of five months. The decrease in systolic pressure was 12.0 vs 2.7 mm Hg (p=0.05), and the decrease in diastolic was 4.7 vs 2.6 mm Hg (p=0.49).	EricksonSR, Slaughter R, Halapy H. Pharmacists' ability to influence outcomes of hypertension therapy. Pharmacotherapy 1997;17(1):140-7.
Intensive Care Unit	During 13 weeks, one clinical pharmacist in an intensive care unit performed 310 interventions, which saved $79,723 (equal to $318,891 annually). 85.4% of the savings involved the cost of medications.	Chaung LC, Sutton JD, Henderson GT. Impact of a clinical pharmacist on cost savings and cost avoidance in drug therapy in an intensive care unit. Hosp Pharm 1994;29(3):215-8,221.
Intensive Care Unit	Including a pharmacist on rounds, as a member of the patient care team in an intensive care unit was associated with a lower rate of adverse drug events (ADE) caused by prescribing errors. The rate of ADEs was decreased by 66% from 10.4 to 3.5 per 1,000 patient-days (p<0.001). The pharmacist made 366 drug-ordering recommenda-tions, of which 362 (99%) were accepted by the physicians.	Leape LL, et.al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA 1999;282(3):267-70.
Managed Care Facility	A pharmacist-run medication review service at a managed care facility resulted in an annual savings of $644 per patient. Patients also used fewer health services after participating in the program.	Borgsdorf LR, et. al. Pharmacist-managed medication review in a managed care system. AM J Hosp Pharm 1994; 51(6):772-72.
Surgical Ward	Pharmacist involvement on surgery services produced both financial and clinical benefits. Pharmacists' activities saved $33,265.58 over one year. Annual drug expenditure for the surgical ward decreased $59,622 (9%). Pharmacists-directed pharmacokinetic monitoring had a 93.8% success rate for treatment regimes.	Ariano RE, et al. Economic impact and clinical benefits or pharmacist involvement on surgical wards. AM J Hosp Pharm 1995;48(5):284-9.
Ulcers	A pharmacist-run enhanced compliance program (ECP) improved patient compliance with bismuth subsalicylate, metronidazole, and tetracycline hydrochloride (BMT) triple therapy for H. pylori infections. There was a statistical significance in the number of patients taking more than 90% of the medications between the ECP group and the control group (p<0.01). Adequate results for triple therapy require good patient compliance.	Lee M, et al. A randomized controlled trial of an enhanced patient compliance program for Helicobacter pylori therapy. Arch Intern Med 1999 Oct 25;159(19):2312-6.

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Iowa Medicaid Pharmaceutical Case Management Program

Report of the Program Evaluation

December 2002

Submitted by The PCM Evaluation Team from The University of Iowa Colleges of Public Health, Pharmacy, and Medicine:

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Executive Summary

Background

The Iowa Medicaid Pharmaceutical Case Management (PCM) program was designed to benefit a subset of individuals at very high risk to experience adverse effects from their medications. The Iowa PCM program began with funds appropriated during the 2000 Iowa Legislative session. The innovative care delivered through this program is based on a model of care known to improve medication safety in hospital and clinic settings where pharmacists and physician are under the same roof and have ready access to the patient medical record. To deliver this model of care in a *community* setting, Iowa pharmacists and physicians who participated in the PCM program did so without benefit of a shared practice location or common access to a patient medical record. By most measures, they did so successfully.

Pharmaceutical case management provides an opportunity for physicians and pharmacists to closely scrutinize the total drug regimens of their most complex patients. Working together, they can find the best combination of medications and doses for a particular, complex patient with multiple disease states.

Under this initiative, pharmacists and physicians may provide and be reimbursed for one Initial Assessment, up to four Problem Follow-up Assessments per 12 months, up to two New Problem Assessments per 12 months, and up to one Preventive Follow-up Assessment every six months. Eligible patients are those taking at least four medications and with one of 12 disease states. Eligible patients who participate in the program receive an Initial Assessment by the pharmacist who then makes written recommendations to the patient's physician. Recommendations that are accepted or modified by the physician are considered an action plan. Pharmacists make Problem Follow-up Assessments until all problems are resolved, communicating with the physician in each case. Once problems are resolved, Preventive Follow-up Assessments can occur every six months and new problems that arise episodically can trigger a New Problem Assessment and a new action plan.

The primary objectives of the PCM evaluation were to describe the extent and content of PCM services and determine the effect of the PCM program on medication safety. Secondary objectives included describing the health of eligible patients, determining whether there was an impact on healthcare utilization, and compiling the responses of physicians and pharmacists who participated in the program.

Findings

There were four major findings:

1. Those who are eligible for PCM are at very high risk for adverse medication effects:
    - Standardized health status measures found that this population is much less healthy than a typical sample of the US population.
    - Alarmingly, 30% self-reported an adverse drug reaction in the previous year. This is three times the rate observed in a different population of elderly Iowans not on Medicaid.
    - Approximately 35% of PCM-eligible patients had drug-drug interactions. More alarming was the finding that, among those age 60 and over who were taking antihypertensive medications, approximately 75% had a drug-drug interaction.
    - 35% of adults aged 60 and older who received PCM services had been taking at least one medication considered to have a poor risk-benefit balance and to be inappropriate for use among older adults.
2. PCM services were provided to many eligible patients:
    - A total of 117 pharmacies participated in the program from all areas of the state.
    - Of 3,037 patients eligible during the first year of the program, pharmacists had met with 943, sent recommendations to physicians for 500 of these patients, and received replies from the physician for 327 within the first three months of patient eligibility.
    - The mean patient age was 52.5 years, two-thirds were age 45 or older, and 6.4% were children.
    - Pharmacists chose to provide care first to those at highest risk for medication-related problems (patients who received care were older, took more medication, and were taking more high risk medications than those who were eligible for PCM but who did not receive it).
    - Pharmacists detected an average of 2.6 medication-related problems per patient.
    - The most common recommendation made by pharmacists (52% of patients) was to start a new medication. This finding confirms numerous other studies of pharmacist interventions indicating that many patients have untreated conditions. Examples included failure to received life-saving medications like aspirin or beta blockers

following a heart attack. Pharmacists recommended a change in medication 36% of the time indicating a more appropriate therapy might be available. Pharmacists also recommended discontinuation of medications 33% of the time.

3. The PCM program significantly improved medication safety and did not measurably affect Medicaid expenditures.
    - Those who received PCM services had a statistically significant 12.5% improvement in the Medication Appropriateness Index, a detailed, structured measure of ten domains of prescribing quality.
    - Among PCM recipients age 60 or older, the percent using medications considered inappropriate for use among the elderly decreased by 24%, a statistically significant decrease relative to those who did not receive PCM services.
    - Medicaid paid a total of $94,170 for PCM services through May 31, 2002.
    - Even after including the amount paid for PCM services, there was no net increase in healthcare utilization or charges among patients who received PCM relative to those who were eligible but did not receive the services.
    - The data suggested that emergency room and outpatient facility utilization may have decreased for patients of pharmacies who adopted PCM most intensely.
4. The PCM program can be extremely effective if obstacles to success can be miminized:
    - Some pharmacists were more successful in completing all PCM functions and included more patients in the program. It is assumed that these pharmacists overcame challenges and obstacles that daunted other pharmacists. The pharmacists who achieved a higher intensity of PCM service provision yielded the greatest improvement in medication safety (e.g. Medication Appropriateness Index scores).
    - Many patients presented a challenge because they were difficult to contact or schedule, many missed appointments or declined the service.
    - Even though these patients were at extremely high risk for medication-related problems and drug interactions, physicians did not accept half of pharmacists' recommendations, and most of these were ignored rather than actively rejected. Frequently physicians did not respond to repeated requests for information and communication.

- Physicians who responded to a questionnaire about the program exhibited largely positive attitudes toward the collaboration with a pharmacist, but 17% indicated they would not cooperate with pharmacists. Physicians on average reported not having knowledge about what services were reimbursable under the PCM program.
- Pharmacists and physicians who responded to surveys agreed on average that physician-pharmacist discussions led to better quality of care, better health outcomes, and increased continuity of care.
- Unlike physician offices, pharmacies lack support staff to obtain medical records, schedule patients, follow-up when patients miss appointments and keep records. Therefore, participating pharmacists were doing most of this work themselves and found it difficult to incorporate these activities into their other responsibilities.

Recommendations

As it matures, the fledgling PCM program has the potential to achieve greater benefits to more patients eligible for the program. In order for this to happen, the program should be actively nurtured. Action is recommended on the part of the Iowa Department of Human Services (DHS), the state and local professional organizations, and pharmacy colleges:

1. The Iowa DHS, Colleges of Pharmacy and Iowa Pharmacy Association should develop and deliver pharmacist training to address the obstacles identified in this report and to involve more pharmacists in the delivery of these services.
2. The Iowa DHS and professional societies should facilitate development and maturation of pharmacist-physician care teams by actively fostering training and dialogue.
3. Medical societies and the Iowa DHS should develop and implement training programs for physicians about the potential crisis of high-risk medication use among patients eligible for PCM and about specific mechanisms for integrating PCM services in their practices.
4. The Iowa DHS should maintain the eligibility screening process but increase its flexibility so that not only the DHS but also individual physicians and pharmacists may identify patients in need of PCM.
5. The Iowa DHS should notify all PCM-eligible patients about their eligibility and inform them about how to obtain these services.

Conclusion

High-risk medication use among Medicaid patients taking four or more medications is a public health issue of significant import. In a relatively short period of time, the PCM program has achieved numerous successes. It is anticipated that if the program can be maintained and nurtured into maturity, greater collegiality among providers will develop and improvements in longer-term health outcomes will be achieved.

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Testimony
President's Task Force on Medicaid Reform
February 13, 2003

My name is Jonathan Brunswig, President of the Kansas Pharmacists Association. Thank you for your time today.

I would like to tell you a little information about myself. My wife and I graduated from the University of Kansas in 1996 with our bachelors of pharmacy. We moved to Leoti, Kansas located in Wichita County and opened our first retail pharmacy. We took turns returning to KU and obtained our Doctor of Pharmacy Degrees in 1998. In September of 1998 we opened our second pharmacy in Lakin, Kansas located in Kearny County. Prior to us opening our pharmacies these two rural western Kansas communities were without pharmacy services for several years. Since then we have managed to obtain consulting contracts with five rural community hospitals, four long-term care facilities, and one assisted living facility that provides service to eighty mentally and physically handicapped patients. The long term care consulting allows us to review close to 250 patient's charts per month and interact with 20 different prescribers.

I would like to discuss the role of the pharmacist in the long-term care setting. Please see the following sheet.

Pharmacists Role in Providing Pharmacy Services to Long Term Care Patients

- Long Term Care Pharmacists have specialized knowledge in geriatric pharmacotherapy, and the unique medication-related needs of the elderly population.

- Pharmacists work with other health care professionals, and take responsibility for their patient's medication related needs by making sure the medications are appropriate, effective and safe.

- Pharmacists evaluate the disease state of each individual patient. They look for medication related problems that may add to the patient's overall status and make recommendations to the prescriber.

- Consultant pharmacists do the following:

  Make recommendations on important drug-drug interactions
  Make recommendations on drug-food and drug-lab interactions
  Provide intervention with prescribers
  Assure positive outcomes to prescribed therapy
  Gradual dose reduction recommendations if needed
  Review of lab values and drug therapy modifications if needed
  Review of drug regimen for proper diagnosis
  Monitor patient's drug allergy profile
  Monitor the Medication Administration Record for proper dispensing of medications

- Pharmacists review the patients' medication profile for 9 or more medications. KDHE would like the Long Term Care Residents medication profile to be equal to or less than 9 scheduled medications. If the residents profile has more than 9 scheduled medications then the pharmacist will request from the prescriber justification for the medication orders. This is an opportunity for the pharmacist to cut the costs associated with over prescribing by the practitioner.

- Pharmacies that provide medications to Long Term Care patients must adhere to the facilities packaging requirement. Most facilities in Kansas require medications to be delivered in a unit dose system. The pharmacy works hard to provide this service and this allows for dispensed medications to be returned to the pharmacy for credit. Credit for returned medication is issued to private pay patients as well as those getting aid from the Kansas Medicaid System.

- Pharmacists are very aware of the medications that are so expensive such as the anti-depressants, anti-psychotics, Cox-II inhibitors, and proton pump inhibitors. By making recommendations to the prescribers for less expensive alternatives the over all price per patient can be reduced.

All of that said I would like to address the process of providing the medications to these patients. Retail pharmacies do their best to adhere to the packaging requirements of the facility. The cost associated to provide these services are absorbed by the pharmacies. Not only is there an investment in providing the packaging each month many hours go into preparing the unit dose packaging. While pharmacists agree that unit dose packaging does affect the patients overall health in a positive way there are added costs that affect the bottom line.

In closing I would just like to say that long-term care consulting pharmacists are aware of the over use of medications in the elderly population. Many of us have excellent relationships with the physicians and can relate those concerns to them and keep the idea of poly-pharmacy minimized. There is a growing demand for pharmacists input in the disease state management of the elderly population. We are prepared to take on the challenge of protecting the patients' best interest and to cut costs for the Medicaid drug program at the same time.

Thank you

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Statement of Brad Smoot
Legislative Counsel
Blue Cross and Blue Shield of Kansas
President's Task Force on Medicaid Reform
February 13, 2003

Mr. Chairman and Members,

Blue Cross and Blue Shield of Kansas is a mutual insurance company serving about 700,000 Kansans in 103 counties. We are pleased to be invited to share our information and thoughts with you regarding current trends in health care costs.

Two years ago, we estimated health care expenses were 14% of the U.S. gross domestic product (GDP) and estimated growth by 2008 to 16.2% and 25% of GDP by 2030. The latest predictions are only slightly higher (14.1% today and 17% in six years). A recent Wall Street Journal article (citing a Mercer report) observed that the rise in health care costs was greater than expected (about 15% or 7 times the rate of ordinary inflation) and the largest increase since 1990. Already a huge part of the economy, such dramatic increases continue to strain the ability of employers, families and taxpayers to fund services and insurance coverage.

The problem is universal. It affects all states, the group and non-group insurance markets, state and local governments, employers (insured and self-insured), Medicare and Medicaid and those without coverage. Even with recent allotments, cutbacks in services and reduction of provider reimbursements, Kansas is on track to fund a Medicaid budget which has grown from $544 million in 1999 to $919 million in FY 2003 and expected to be more than $1 billion in FY 2004. Workers Compensation coverage, a mandatory employee benefit under Kansas law, now pays more (approximately $214 million in 2001) for hospital and medical costs than it does for lost wages or functional disabilities (58% to 42%). Ultimately, neither government nor employers will shoulder all these increases. Instead, an ever growing share of the cost of care and coverage will be borne by workers and their families. Last year, for example, the state employees health care plan increased co-pays and deductibles, shifting cost to employees, as a way to stay within the state budget. The legislature may be forced this year to make more tough decisions regarding health insurance for 90,000 state employees, retirees and their families. These options may include an even greater employee share of premium, a likely trend for private employers as well.

Where is all this money going? It is going to provide health care services, for which we Americans seem to have a nearly insatiable need. From allergy medicine to infant heart surgery, it all costs money. Note a few examples of our allowed charges:

$ 118,789	–	heart surgery for infant
$ 226,106	–	liver transplant surgery
$ 86,723	–	major brain trauma with surgery
$ 73,669	–	heart bypass surgery
$ 6,130	–	per hospital admission
$ 1,539	–	per hospital room per day
$ 392	–	emergency room services per visit
$ 59	–	per prescription

Normal delivery of a child is one of the most common procedures we experience, with an average allowed charge for hospital and medical care of $4,636.

With only a modest growth in overall inflation and a relative stagnant population in our 103 county service area, provider charges to BCBSKS have doubled in five years from $940 million to $1.86 billion. Like most insurers, BCBSKS works hard to control costs by contracting with doctors and hospitals and limiting the amount we pay for services. We negotiated provider "write offs" in excess of $470 million in 2001, 6.5 times the total cost of our administrative expense. Such cost containment efforts, however, often put real strain on physicians and hospitals who must deal with inflationary trends in medical malpractice insurance, indigent care costs, under reimbursement of government programs, nursing shortages, expensive technologies and other ordinary business expenses.

The total cost of care is a combination of charge increases and increases in use of services, and utilization of services is exploding. To illustrate: BCBSKS paid for 201,000 more physician office visits in 2001 than in 2000. With an average cost of $200 per visit (including lab, radiology, etc.) this is an additional annual cost of $40 million. While BCBSKS granted an allowable charge increase to hospitals of 3.5% in 2001, the actual payout increase from the previous year was 20.6% or $57.7 million. The same is true for physicians and professional health care providers. We gave an aggregate rate increase of 3.2% in 2001, yet, payouts to providers were much larger: Radiology (19.5%); Diagnostic imaging (25.3%); Clinical lab (29.2%); Family and General Practice (26.6%); Anesthesiology (19.9%); Chiropractors (22.7%) and Speech, physical and occupational therapists (26.9%). In short, more Kansans were receiving more services at a much higher total cost, even though the cost per service increased only slightly.

In the aggregate, BCBSKS paid out $862,352,000 for health care services in 2001 and $939,385,000 in 2002. One way to look at this is to consider how much is paid out per covered person per month. The attached chart tracks the increases in allowed charges per member per month since 1997 through 2002. As you can see, hospital and medical claims, which represent the allowed charges, will have increased 51% over this period while pharmacy claims nearly doubled. Combined, claims are expected to be up 63% over this six year period.

There is no single cause for the increases in health care costs and the corresponding insurance premium costs. And while these cost-driving forces are not readily subject to state government control, several are worthy of mention:

Our aging population. Americans are getting older. Kansas' average age increased six years from 1960 to 1990, from 26.9 to 32.9 years. Life expectancy in general has increased seven years from 1960 to 1998, from 69.7 to 76.7. KU's Policy Research Institute projects that the number of Kansans over age 65 will increase by 200,000 in thirty years. With the aches and pains of old age come the increased costs of treating chronic conditions. So while quality and longevity of life have improved, these improvements are, and will remain, very expensive.

Lifestyle choices. It is a fact: It is less expensive to insure a group of 100 who exercise regularly, eat healthy, don't smoke and limit alcohol consumption than to insure a similar group which does not practice good health habits. The Healthy Kansans 2000 initiative estimates that overweight adults in Kansas increased from 26% of the population in 1992 to 32% in 1998. A Boston researcher estimates that Americans could save $24 billion annually if those who don't exercise merely added 30 minutes of moderate exercise to their daily routines.

Prescription drugs. In 2000, Kansas ranked ninth in the per capita use of prescription drugs reporting an average of 10.62 scripts per year. BCBSKS processes millions of claims, paying out more than $96 million per year. New pharmaceuticals extend life and improve life quality. With the new genetic research underway, our reliance on medications for treatment of illnesses, both mental and physical, will only increase. Add to this greater patient awareness, patent issues and the explosion in generic drug costs, and the upward push in pharmacy costs is likely to continue.

Government regulation. New federal privacy legislation, patient protections, health plan liability exposure, administrative simplification requirements and mandated coverages will add billions to the costs of health insurance. While many features of these laws are desirable, the costs are phenomenal. BCBSKS has already spent $15 million to comply with HIPAA. Nationally, carriers and providers will spend billions over the next few years. Obviously, these costs will be passed on to consumers in the form of higher provider charges and insurer administrative costs.

Cost-shifting and the uninsured. An estimated 43 million Americans lack health insurance. In Kansas, a recent comprehensive survey suggests 10.5% of the under 65 population is uninsured. Yet, the uninsured do receive health care, the costs of which are absorbed by doctors and hospitals and passed along as higher costs to those who can pay the bills. Kansas hospital experts estimate the mark-ups to be 20 to 25%.

Many of you have taken a special interest in the issue of the uninsured and are working to stimulate greater insurance coverage. We commend you for the effort. And

to give you an idea of the magnitude of the problem, we have made some rough calculations on what it might cost to insure Kansas' uninsureds. At a premium of $292 per member per month (similar to the state employees health care plan), it would take $858 million dollars annually to cover the estimated 244,880 Kansans who lack coverage today.

While lack of insurance is a huge problem, under-reimbursements by government programs also cause costs to be shifted to the private sector. Medicare and Medicaid generally pay much less for services than private insurers or private pay patients. Attached, please find a graph prepared by the Minnesota Hospital Association showing how under reimbursement by government programs and the uninsured transfer costs to the private insurance market, which includes state and local government health programs.

Expansion of services. When hospitals and clinics compete for patients, they often feel compelled to acquire new and expensive facilities, equipment and the staff to operate them. Unfortunately, this competition does not translate into cheaper care, but more care and more expense. "Hospital spending was the key driver of overall cost growth, accounting for more than half of the total increases." Stunk, B.C., Ginsburg, P.B., and Gabel, J.R., Tracking Health Care Costs: Growth Accelerates Again in 2001, *Health Affairs*, January 24, 2003. The costs associated with excess capacity (the number of hospital beds in Kansas is 45% higher than the national average) and inefficiencies are passed along to patients and insurers.

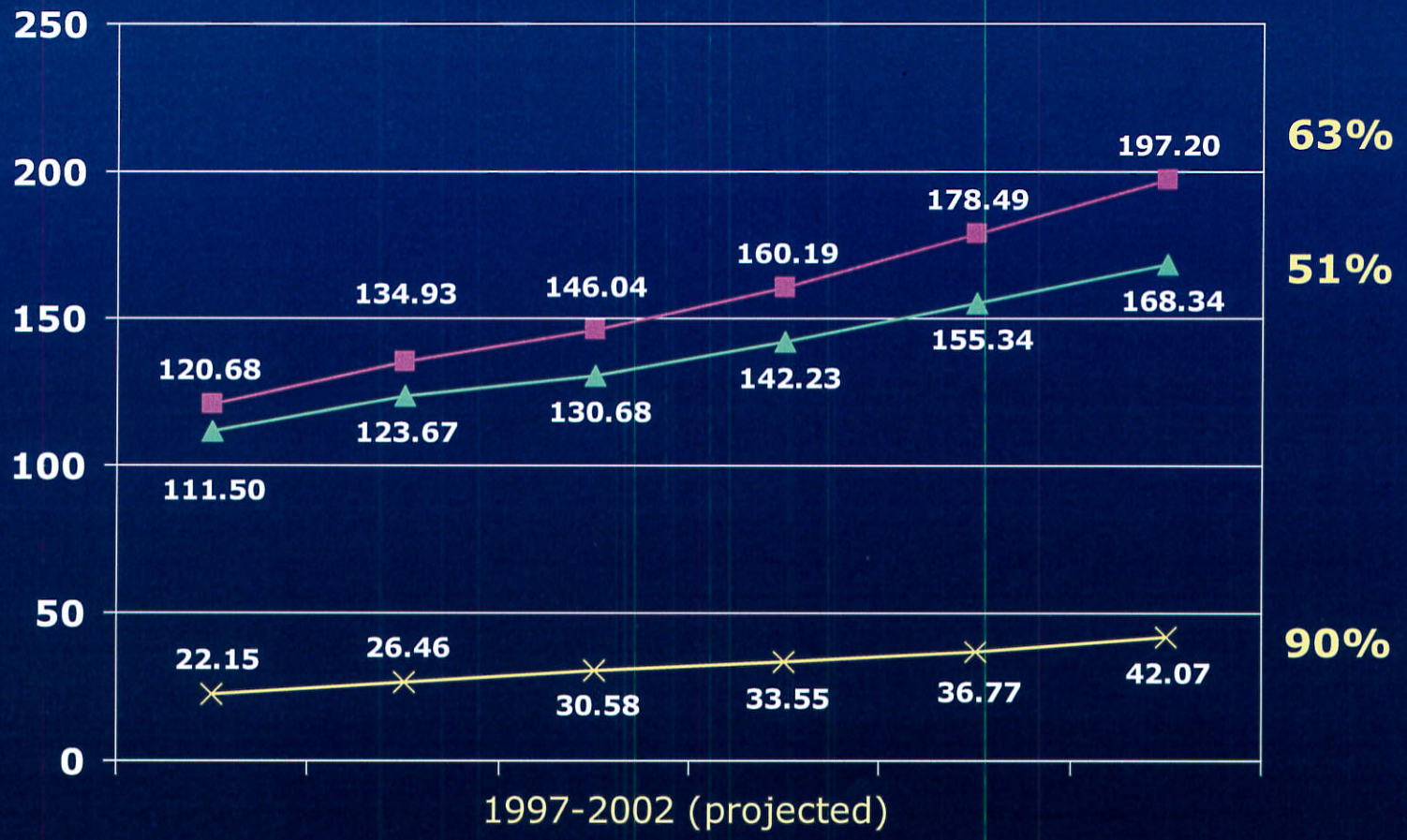
Use of new medical technologies. Like new and life sustaining drugs, non-medicinal devices and procedures have revolutionized health care delivery. Disease state management will reduce hospitalizations and emergency room visits but it requires up front costs for physician visits, monitoring, drugs, etc. An insulin pump may save a diabetic's life or improve life quality. It costs $7,500. A portable implantable defibrillator, like the Vice President's, costs $10,000. And the biggest cost driver of all may be the technological advances in the area of disease diagnosis. CAT (computed axial tomography), MRI (magnetic resonance imaging), PET (positron emission tomography) and other devices are widely available and are rapidly becoming standards of care or demanded by patients. See attached map showing location of this equipment in Kansas. Generally, our allowed charge for CAT scans is $600; for MRI's $700 and PET imaging is $2000. In Kansas, we may have too much technology at our finger tips. The national average for MRI's is 7.6 per million population. By this standard Kansas should have 19. We have 47.

Undoubtedly, there are other causes of health care cost inflation, including federal tax policy, the restraint and decline of managed care or the lack of personal financial responsibility in a third party payment system. However, the above highlighted factors are the ones we see most clearly from our claims data. As you can easily surmise, none of these issues lend themselves to quick, obvious or local solutions.

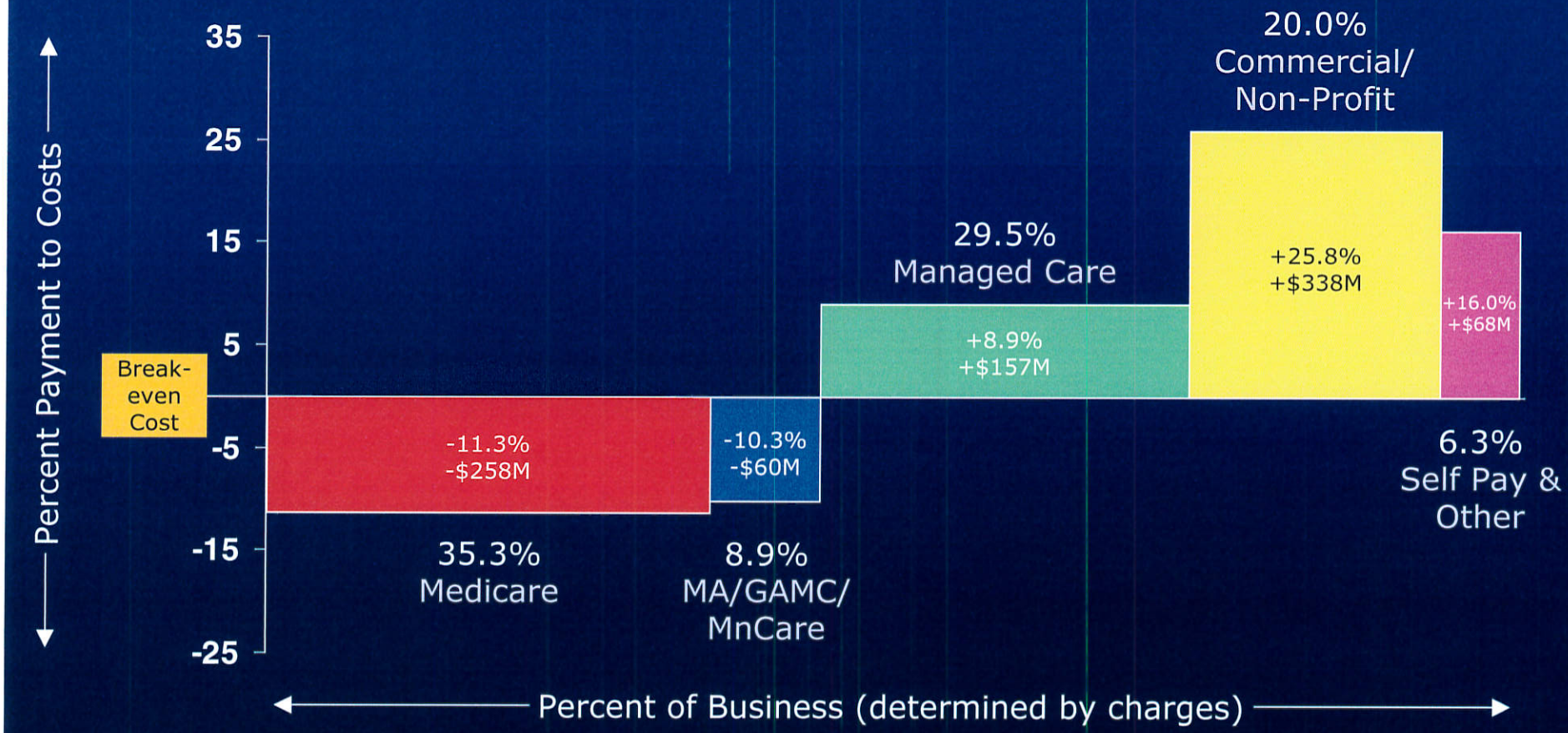
In summary, the economic strains of health care are now fully evident in Kansas. Some health insurers are no longer in business. All but two of the municipal multi-employer pools have failed. The non-group market is even more fragile. Five insurers have withdrawn from the Kansas market and two others have suspended marketing. Businesses, local governments and individuals are groaning under the weight of double digit inflation. And we at BCBSKS are growing more and more concerned about the ability of Kansans to continue to afford health insurance. In 1975, BCBSKS had 910,000 insureds. We now have less than 700,000. In October 2002 alone, we lost 200 contracts and 2000 lives, indicating that families are taking the employer-paid individual coverage and dropping dependent family coverage. As you consider various proposals affecting health care and insurance, we hope you will find the above information helpful.

Thank you for inviting our comments.

Blue Cross and Blue Shield of Kansas, Inc.
Allowed Charge Per Member Per Month (under 65)

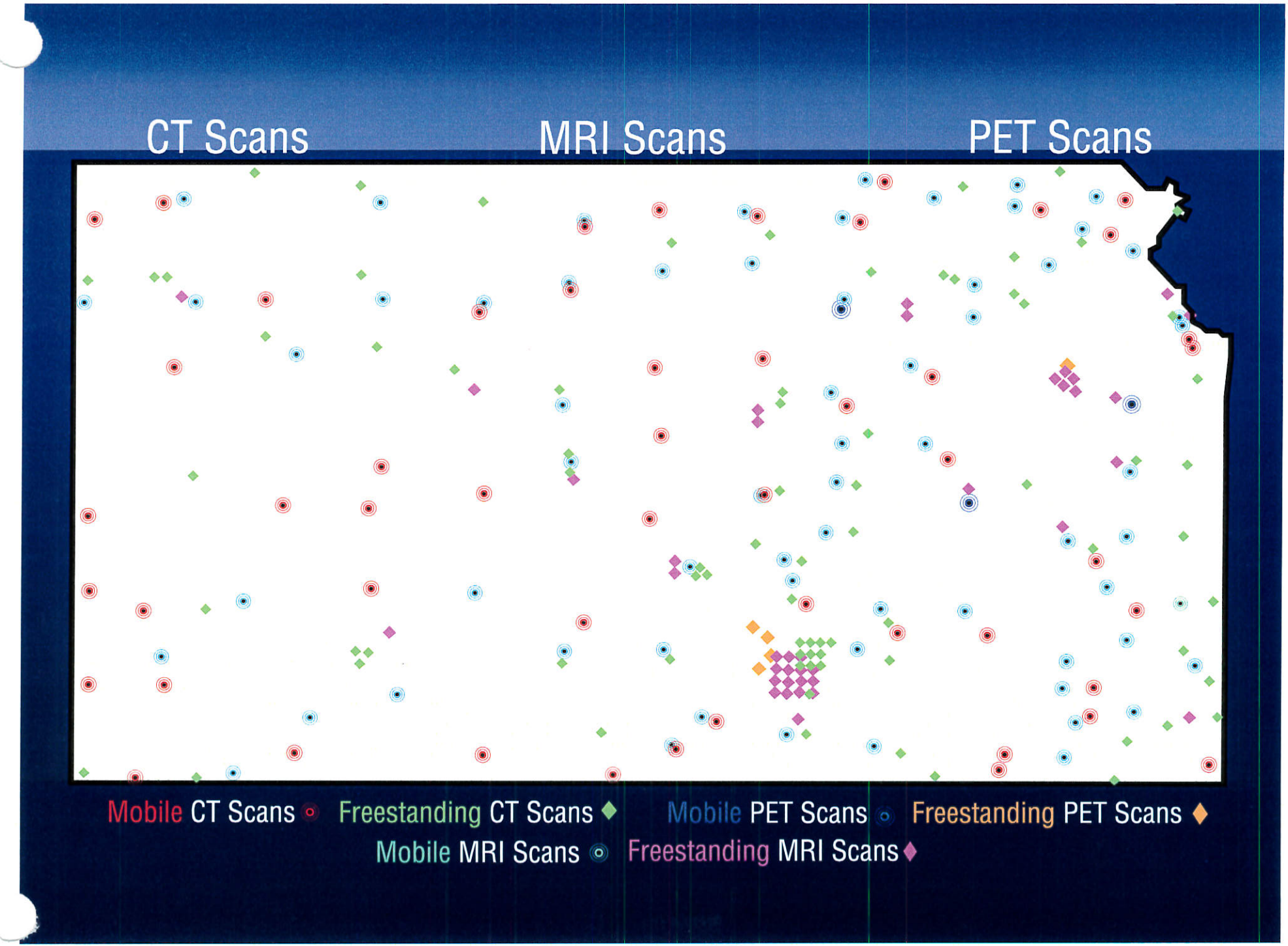


Government Underfunding of Hospitals Shifts Costs to Other Patients Preliminary 2001



Source: MHHP's HIRM Database, 2001 Revenue includes only patient services.

Prepared by the Minnesota Hospital Association


CT Scans
MRI Scans
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Mobile CT Scans
Freestanding CT Scans
Mobile PET Scans
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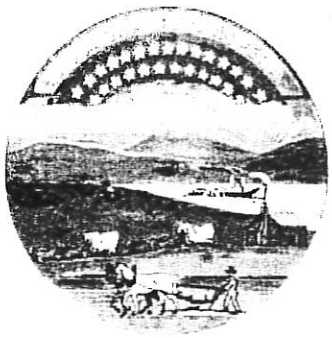
Mobile MRI Scans
Freestanding MRI Scans

Kansas Medicaid Drug Coverage List



Therapeutic Drug Class	Coverage Code
Proton Pump Inhibitors	
Lansoprazole (Prevacid®)	X
Pantoprazole (Protonix®)	X
Omeprazole (Prilosec®)	PA
Esomeprazole (Nexium®)	PA
Rabeprazole (Aciphex®)	PA

Therapeutic Drug Class	Coverage Code
H_2 Antagonists	
Ranitidine (Zantac®)	X
Famotidine (Pepcid®)	X
Nizatidine (Axid®)	PA
Cimetidine (Tagamet®)	NP

Therapeutic Drug Class	Coverage Code
HMG - CoA Reductase Inhibitors	
Atorvastatin (Lipitor®)	X
Simvastatin (Zocor®)	X
Pravastatin (Pravachol®)	PA
Fluvastatin (Lescol®)	NP
Lovastatin (Mevacor®)	NP

Therapeutic Drug Class	Coverage Code
Non-Sedating Antihistamines	
Cetirizine (Zyrtec®)	X
Fexofenadine (Allegra®)	PA
Desloratadine (Clarinex®)	PA
Loratadine (Claritin®)	PA
Generic OTC Antihistamines	NP

Key:
X - Preferred drug covered
NP - Non-preferred drug, but PA not required
PA - Prior authorization required

President's Task Force on
Medicaid Reform
February 13, 2003
Attachment 12-1

A	B	C	D	E	F	G	H	I	J	K	L	M
DRUG	TOTAL DOSES	MEDICAID DOSES	% MEDIC.	# OF Rx's	AWP	AWP - 13% PLUS $3.40 (-) COPAY $3.	MAC	MAC (+) $3.40 (-) $3 COPAY	ACQ	ACQ (+) $10 (-) $5 COPAY	ACQ (+) $15 NO COPAY	Maint. Generic 60 I ACQ plus $15 NO COPAY
'2 & Proton Pump	1-1-95 TO 12-31-0	1-1-95 TO 12-31-01										
ZANTAC 150 MG	27536	8912	32.36%	148.5	$2.06	$16,031.49			1.67	$15,625.54		
RANITIDINE 150 MG	24849	4018	16.16%	67	$1.56		0.34	$1,396.94	0.06		$1,225.99	$773.49
PRILOSEC 20MG	11107	2436	21.93%	81.2	$4.61	$9,811.02			3.75	$9,533.69		
PREVACID 30MG	14811	3933	26.55%	131.1	$4.63	$15,895.08			3.76	$15,443.58		
PREVACID 15MG	2547	1215	47.70%	40.51	$4.54	$4,817.32			3.69	$4,683.42		
NEXIUM 40MG	739	225	30.44%	7.5	$4.42	$868.22			3.59	$845.22		
PROTONIX 40MG	36	0	0%		$3.51				2.85			
	TOTAL DOSES	MEDICAID DOSES										
	1-1-02 TO 2-9-03	1-1-02 TO 2-9-03										
RANITIDINE 150 MG	9866	474	4.80%	7.9	$1.56		0.34	$164.84	0.06		$144.57	$85.32
PRILOSEC 20 MG	1595	610	38.24%	20.33	$4.61	$2,692.65			3.75	$2,383.05		
PREVACID 30MG	3863	1156	29.92%	38.53	$4.63	$4,671.89			3.76	$4,539.21		
PREVACID 15 MG	955	885	92.67%	29.5	$4.54	$3,508.91			3.69	$3,411.38		
NEXIUM 40MG	2660	510	19.17%	17	$4.42	$1,967.95			3.59	$1,915.90		
PROTONIX 40 MG	525	285	54.29%	9.5	$3.51	$874.15			2.85	$859.75		
ANTIHISTAMINES	1-1-95 TO 12-31-0	1-1-95 TO 12-31-01										
CLARITIN 10 MG	9559	1655	17.31%	55.2	$3.23	$4,672.80			2.55	$4,496.25		
ZYRTEC 10MG	6238	554	8.88%	18.5	$2.11	$1,024.38			1.67	$1,017.68		
CHLORPHEN. ER 12M	5321	100	1.88%	2	$0.11	$10.37			0.04		$34.00	
	1-1-02 TO 2-9-03	1-1-02 TO 2-9-03										
CLARITIN 10MG	865	150	17.34%	5	$3.23	$423.51			2.55	$407.50		
ZYRTEC 10 MG	3134	615	19.62%	20.5	$2.11	$1,137.16			1.67	$1,129.55		
CHLOPHEN. ER 12MG	4586	0	0%	0	$0.11				0.04			
CHLORPHEN ER 12 MG PROJECTED		6148	100%	102.47	$0.11	$629.35			0.04		$1,782.97	$1,014.45
	1-1-95 TO 12-31-0	1-1-95 TO 12-31-01										
RISPERDAL 4MG	330	0	0%		$8.48				6.89			
RISPERDAL 1MG	2452	1318	54%	43.97	$3.30	$3,802			2.68	$3,751.89		
RISPERDAL 2MG	578	373	64.53%	12.43	$5.32	$1,731.36			4.23	$1,639.94		
RISPERDAL 3MG	1760	1760	100%	58.67	$6.43	$9,869.09			5.23	$9,498.15		
	1-1-02 TO 2-9-03	1-1-02 TO 2-9-03										
RISPERDAL 4 MG	12	12	100%	1	$8.48	$88.93			6.89	$87.68		
RISPERDAL 1 MG	2277	1319	57.93%	43.97	$3.30	$3,804.44			2.68	$3,754.77		
RISPERDAL 2 MG	430	183	42.56%	6.1	$5.32	$849.44			4.23	$804.59		
RISPERDAL 3 MG	60	60	100%	2	$6.43	$336.45			5.23	$323.80		

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EXPLANATION OF DATA

Column A: Name and Strength of drug dispensed.

Column B: Total individual doses of Drug dispensed during two time periods 1st 7 year period from Jan 1, 1995 through Dec 31, 2001. 2nd, the most recent 13 month period from Jan 1, 2002 through Feb 9, 2003..

Column C: Total number of individual doses dispensed to medicaid patients for the same two time periods as above.

Column D: Percentage of medicaid doses to overall doses dispensed.

Column E: Number of individual medicaid Rx's based upon a 30 day supply.

Column F: AWP --- Average Wholesale Price for individual dose, as listed by my wholesaler Amerisource Bergen, St. Joseph Mo. The wholesale price was calculated from the package size we normally purchase, 500's, 100's, 60's, etc.

Column G: Price currently paid by Medicaid to this pharmacy. Calculated as follows: (total medicaid doses {Col.C.}) X AWP [Col.F] minus 13% plus[$3.40 fee minus $3.00 copay X total # Rx's disp. Col E] ===Total price paid to this pharmacy by Medicaid.

Column H: MAC , Maximum Allowable Cost allowed on certain generics by Medicaid obtained from my computer Rx dispensing program Scriptwriter, prices updated biweekly.

Column I: MAC pricing from medicaid calculated as follows.
MAC individual dose price [Col. H] X total Medicaid doses {Col. C) plus [$3.40 fee minus $3.00 copay X total # Rx's disp. Col E] ===Total price paid to this pharmacy by Medicaid.

Column J: ACQ The individual dose price, my actual acquisition price, I pay Amerisource Bergen for the drug.

Column K: What I propose you would pay this pharmacy for Brand Name, single source drugs, calculated as follows. (total medicaid doses {Col.C.}) X ACQ [Col. J] plus [$10.00 fee minus $5.00 patient copay X total # Rx's disp. Col. E] equals total price to be paid to this pharmacy by Medicaid.

Column L: What I propose you would pay this pharmacy for Generic, multi source drugs, calculated as follows. (total medicaid doses {Col.C.}) X ACQ [Col. J] plus [$15.00 fee {no patient copay} X total # Rx's disp. Col. E] equals total price to be paid to this pharmacy by Medicaid.

Column M: Allow the dispensing of a 60 day supply, instead of the current 30 day restriction, of generic multisource maintenance drugs. Calculated in the same manner as Column L.

CLELAND DRUG STORE
221 MAIN STREET, WAKEENEY KS 67672
(785) 743-2200

PATIENT :
DOCTOR :
DRUG NAME: RISPERDAL 1MG TABLET

Rx #:
DATE: 02/12/2003

RISPERIDONE - ORAL

USES: This medication is used in the treatment of psychotic or mental conditions.

HOW TO USE: Take this medication exactly as prescribed. During the first few days your doctor may gradually increase your dose to allow your body to adjust to the medication.

Do not take this more often or increase your dose without consulting your doctor. Your condition will not improve any faster but the risk of serious side effects will be increased. Do not stop taking this drug without your doctor's approval.

SIDE EFFECTS: Dizziness, drowsiness, nausea, increased dreaming, nervousness, loss of appetite, dry mouth or fatigue may occur the first several days as your body adjusts to the medication. Weight gain, vision changes, decreased sexual desire and insomnia have also been reported. If any of these effects continue or become bothersome, inform your doctor.

Notify your doctor if you develop: rapid/pounding/irregular heartbeat, skin rash, itching, difficulty moving, muscle stiffness, muscle spasms or twitching, sweating, involuntary movements (especially about the face or tongue), drooling, tremors, trouble swallowing, mental confusion, seizures.

If you notice other effects not listed above, contact your doctor or pharmacist.

PRECAUTIONS: Tell your doctor your medical history, especially of: kidney disease, liver disease, heart disease, seizures, blood disorders, breast cancer, swallowing difficulty, allergies (especially drug allergies).

Because this medication may cause drowsiness or dizziness, use caution operating machinery or engaging in activities requiring alertness such as driving.

Dizziness on standing may occur. To avoid dizziness or lightheadedness when rising from a seated or lying position, get up slowly.

This medication may make you more sensitive to the sun. Avoid prolonged sun exposure. Wear protective clothing and use a sunscreen when outdoors.

Caution is advised when using this drug in the elderly because they may be more sensitive to the effects of the drug.

This medication should be used only if clearly needed during pregnancy. Discuss the risks and benefits with your doctor.

It is not known if this drug excreted into breast milk. Consult your doctor before breast-feeding.

DRUG INTERACTIONS: Tell your doctor of any over-the-counter or prescription medication you may take, especially of: sedatives, narcotic pain relievers (e.g., codeine), anti-anxiety agents, antidepressants, muscle relaxers, medication for seizures.

It is recommended you avoid consuming alcohol while taking this medication.

Do not start or stop any medicine without doctor or pharmacist approval.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include unusual drowsiness; rapid pulse; fainting; unusual muscle movement or rigidity of the face, neck, or limbs; tremor; seizures; and loss of consciousness.

NOTES: Laboratory tests may be done periodically while taking this medication to monitor the effects. See your doctor regularly.

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