**Schedule 13**

**Change Request for FY 2009-10 Budget Request Cycle**

| | | | | |
|---|---|---|---|---|
| **Decision Item FY 2009-10** | | **Base Reduction Item FY 2009-10** ☑ | **Supplemental FY 2008-09** | **Budget Amendment FY 2009-10** |
| **Request Title:** | Pharmacy Technical and Pricing Efficiencies | | | |
| **Department:** | Health Care Policy and Financing | **Dept. Approval by:** | John Bartholomew | **Date:** October 31, 2008 |
| **Priority Number:** | BRI - 1 | **OSPB Approval:** | | **Date:** 10-23-08 |

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Fund | Prior-Year Actual FY 2007-08 | Appropriation FY 2008-09 | Supplemental Request FY 2008-09 | Total Revised Request FY 2008-09 | Base Request FY 2009-10 | Decision/ Base Reduction FY 2009-10 | November 1 Request FY 2009-10 | Budget Amendment FY 2009-10 | Total Revised Request FY 2009-10 | Change from Base (Column 5) FY 2010-11 |
| **Total of All Line Items** | **Total** | 2,237,284,805 | 2,348,635,330 | 0 | 2,346,191,746 | 2,368,896,905 | (31,507) | 2,368,865,398 | 0 | 2,368,865,398 | (1,083,886) |
| | **FTE** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | **GF** | 714,806,487 | 709,820,850 | 0 | 708,721,558 | 710,263,658 | (207,348) | 710,056,310 | 0 | 710,056,310 | (729,443) |
| | **GFE** | 327,500,000 | 369,000,000 | 0 | 369,000,000 | 369,000,000 | 0 | 369,000,000 | 0 | 369,000,000 | 0 |
| | **CF** | 0 | 87,225,727 | 0 | 87,163,227 | 97,051,082 | 0 | 97,051,082 | 0 | 97,051,082 | 0 |
| | **CFE/RF** | 72,252,413 | 2,868,326 | 0 | 2,868,326 | 2,868,326 | 0 | 2,868,326 | 0 | 2,868,326 | 0 |
| | **FF** | 1,122,725,905 | 1,179,720,427 | 0 | 1,178,438,635 | 1,189,713,839 | 175,841 | 1,189,889,680 | 0 | 1,189,889,680 | (354,443) |
| **(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects** | **Total** | 0 | 2,443,584 | 0 | 2,443,584 | 1,625,334 | 975,000 | 2,600,334 | 0 | 2,600,334 | 1,050,000 |
| | **FTE** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | **GF** | 0 | 1,099,292 | 0 | 1,099,292 | 752,667 | 300,000 | 1,052,667 | 0 | 1,052,667 | 337,500 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 62,500 | 0 | 62,500 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CFE/RF** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **FF** | 0 | 1,281,792 | 0 | 1,281,792 | 872,667 | 675,000 | 1,547,667 | 0 | 1,547,667 | 712,500 |
| **(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts*** | **Total** | 0 | 24,094,147 | 0 | 24,094,147 | 23,489,449 | 16,380 | 23,505,829 | 0 | 23,505,829 | 0 |
| | **FTE** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | **GF** | 0 | 5,499,078 | 0 | 5,499,078 | 5,382,396 | 4,095 | 5,386,491 | 0 | 5,386,491 | 0 |
| | **GFE** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **CF** | 0 | 1,881,903 | 0 | 1,881,903 | 1,833,613 | 0 | 1,833,613 | 0 | 1,833,613 | 0 |
| | **CFE/RF** | 0 | 100,328 | 0 | 100,328 | 100,328 | 0 | 100,328 | 0 | 100,328 | 0 |
| | **FF** | 0 | 16,612,838 | 0 | 16,612,838 | 16,173,112 | 12,285 | 16,185,397 | 0 | 16,185,397 | 0 |

**Schedule 13**

**Change Request for FY 2009-10 Budget Request Cycle**

| | | | | |
|---|---|---|---|---|
| **Decision Item FY 2009-10** ☐ | | **Base Reduction Item FY 2009-10** ☑ | **Supplemental FY 2008-09** ☐ | **Budget Amendment FY 2009-10** ☐ |
| **Request Title:** | Pharmacy Technical and Pricing Efficiencies | | | |
| **Department:** | Health Care Policy and Financing | **Dept. Approval by:** | John Bartholomew | **Date:** October 31, 2008 |
| **Priority Number:** | BRI - 1 | **OSPB Approval:** | | **Date:** |

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Fund | Prior-Year Actual FY 2007-08 | Appropriation FY 2008-09 | Supplemental Request FY 2008-09 | Total Revised Request FY 2008-09 | Base Request FY 2009-10 | Decision/ Base Reduction FY 2009-10 | November 1 Request FY 2009-10 | Budget Amendment FY 2009-10 | Total Revised Request FY 2009-10 | Change from Base (Column 5) FY 2010-11 |
| **(2) Medical Services Premiums** | **Total** | 2,237,284,805 | 2,322,097,599 | 0 | 2,322,097,599 | 2,343,782,122 | (1,022,887) | 2,342,759,235 | 0 | 2,342,759,235 | (2,133,886) |
| | **FTE** | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | **GF** | 714,806,487 | 703,222,480 | 0 | 703,222,480 | 704,128,595 | (511,443) | 703,617,152 | 0 | 703,617,152 | (1,066,943) |
| | **GFE** | 327,500,000 | 369,000,000 | 0 | 369,000,000 | 369,000,000 | 0 | 369,000,000 | 0 | 369,000,000 | 0 |
| | **CF** | 0 | 85,281,324 | 0 | 85,281,324 | 95,217,469 | 0 | 95,217,469 | 0 | 95,217,469 | 0 |
| | **CFE/RF** | 72,252,413 | 2,767,998 | 0 | 2,767,998 | 2,767,998 | 0 | 2,767,998 | 0 | 2,767,998 | 0 |
| | **FF** | 1,122,725,905 | 1,161,825,797 | 0 | 1,161,825,797 | 1,172,668,060 | (511,444) | 1,172,156,616 | 0 | 1,172,156,616 | (1,066,943) |

*The (1) Executive Director's Office, (C) Information Technology Contracts and Projects, Information Technology Contracts was previously reported as (1) Executive Director's Office, Medicaid Management Information System Contract and Health Information Portability and Accountability Act of 2006 (HIPAA) Web Portal Maintenance.

| | | | |
|---|---|---|---|
| **Non-Line Item Request:** | None | | |
| **Letternote Revised Text:** | None | | |
| **Cash or Federal Fund Name and COFRS Fund Number:** | FF: Title XIX | | |
| **Reappropriated Funds Source, by Department and Line Item Name:** | N/A | | |
| **Approval by OIT?** | **Yes:** ☐ | **No:** ☐ | **N/A:** ☑ |
| **Schedule 13s from Affected Departments:** | N/A | | |

# CHANGE REQUEST for FY 2009-10 BUDGET REQUEST CYCLE

| | |
|---|---|
| Department: | Health Care Policy and Financing |
| Priority Number: | BRI-1 |
| Change Request Title: | Pharmacy Technical and Pricing Efficiencies |

**SELECT ONE (click on box):**

☐ Decision Item FY 2009-10
☒ Base Reduction Item FY 2009-10
☐ Supplemental Request FY 2008-09
☐ Budget Request Amendment FY 2009-10

**SELECT ONE (click on box):**

Supplemental or Budget Request Amendment Criterion:
☒ Not a Supplemental or Budget Request Amendment
☐ An emergency
☐ A technical error which has a substantial effect on the operation of the program
☐ New data resulting in substantial changes in funding needs
☐ Unforeseen contingency such as a significant workload change

Short Summary of Request: This request is for a reduction in total funds of $31,507 in FY 2009-10 and $1,083,886 in FY 2010-11. These adjustments include a General Fund reduction of $207,348 and $729,443 in FY 2009-10 and FY 2010-11, respectively. The adjustments requested are the net result of the implementation of an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure.

Background and Appropriation History: The Department is committed to ensuring that clients are healthier when they leave the Medicaid and Children's Basic Health Plan programs than when they entered. To that end, the Department is proposing a set of enhancements to administrative and program functions and interventions designed to maximize the health, functioning and self-sufficiency of Medicaid clients and providers. The primary goals of all four proposals in the Department's Budget Request for FY 2009-10 are to (1) provide a model that delivers seamless, integrated care to clients between different delivery systems, (2) maximize client health and satisfaction, and (3) achieve greater cost-effective care. The common thread underlying all of the proposals is making the health care delivery system, and

access to programs, more outcomes-focused and client-centered. These enhancements and programmatic changes will lead to a more coordinated system based on shared responsibility; where payers, providers, and clients each take appropriate responsibility for improving the health and health care for Colorado residents.

The Department's set of proposals are divided into four Change Requests:

- DI-5 Improved Eligibility and Enrollment Processing;
- DI-6 Medicaid Value-Based Care Coordination Initiative;
- BRI-1 Pharmacy Technical and Pricing Efficiencies; and,
- BRI-2 Medicaid Program Efficiencies.

The request in DI-5 would improve eligibility and enrollment processing by creating a single state-level entity to enhance and complement the current multiple county-level processes. This entity would streamline the navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, create expedited eligibility and improve outreach and enrollment in both programs. In addition, the entity would modernize the current eligibility determination process by implementing an automated customer contact center and create an electronic document and workflow management system. This would provide a central repository for Medicaid and Children's Basic Health Plan applications and related documents. These changes would ensure easier, more reliable and timely eligibility and enrollment processes, making the program more efficient and effective and delivering important benefits to clients, providers and enrollment staff.

The request in DI-6 for a Medicaid Value-Based Care Coordination Initiative would enable the Department to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. To achieve this, the Department will undertake a statewide competitive procurement process for physical health services that emphasizes the importance of increasing the availability and services of medical homes for all clients. The Department intends to regionally procure services from Accountable Care Organizations that would operate as Administrative Services Organizations (ASOs) providing enhanced Primary Care Case Management services. The ASOs would be primarily responsible for establishing a coordinated care delivery system for all clients.

The Department anticipates that payments to primary care physicians would be supplemented with care coordination fees as well as outcomes-based performance incentives.

In addition to strengthening primary care services, the ASO would administer a comprehensive network of care coordination services. Care coordinators would be based in the community and help reinforce treatment plans, coordinate care between different providers, assist in care transitions between hospitals and community care, and importantly serve as a client advocate in navigating between physical health, behavioral health, waiver services, and long term care services as appropriate. The ASO would also deploy evidence-based medical management tools designed to promote patient safety and reduce unwarranted variation in care practices. The ASO contract would also be performance based with guarantees established around health outcomes, functional improvements, and self-sufficiency attainment. The Department anticipates that ASOs will incorporate an electronic health exchange that will greatly facilitate effective communication between clients, providers, and government agencies. Through such efforts, errors and duplication can be reduced. Clinical decision support tools as well as electronic registries will help improve outcomes at the point of care. This initiative aims to create a comprehensive, coordinated, outcomes focused care delivery system that optimizes the well being of Medicaid clients.

The Department's BRI-1, Pharmacy Technical and Pricing Efficiencies, requests a reduction in funds as a result of implementing an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure. Automating prior authorizations would increase efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process would make it easier for providers to submit requests, it would be easier and faster for clients to obtain drugs with prior authorization restrictions, and provide savings within Medical Services Premiums.

The request in BRI-2, Medicaid Program efficiencies, would improve quality of service for clients through six initiatives:

- Medicaid Benefit Package Reform;

- Health Outcomes Measurement Initiative;
- Fluoride Varnish;
- Hospital Back Up Program Enhancements;
- Oxygen Durable Medical Equipment Administrator; and,
- Serious Reportable Events.

Through the Health Outcomes Measurement Initiative, the Department would directly survey Medicaid clients on a monthly basis regarding their health and functional status to measure effectiveness of the Medicaid program and find areas for improvement. In addition, the Department could analyze geographic indicators to identify and address health disparities between urban and rural areas; and analyze and compare the health and functional status of clients in different groups. Through the Hospital Back Up program, the Department would achieve cost savings and improvements to care by moving clients out of hospitals into more appropriate care settings. Potential cost savings would also be generated through the initiative for 1.0 FTE Oxygen Durable Medical Equipment Administrator. This FTE would help the Department contain oxygen related expenditures, which are the highest expenditure category within durable medical equipment, implement process improvements and introduce more technologically efficient oxygen delivery systems.

This package builds upon many recommendations from the Blue Ribbon Commission for Health Care Reform (commonly referred to as the 208 Commission). It draws upon successful Medicaid reform efforts in North Carolina, Indiana, Oklahoma, Arkansas, and New Hampshire. By awarding health care service contracts regionally, the Department anticipates community organizations coming together to serve their own community and be accountable for their performance. The regional model allows for a rough overlap with behavioral health organization regions allowing for more effective coordination of services between physical and behavioral health. Also, alignment with Children's Basic Health Plan regions will help create seamless care for children traversing between programs. A key goal of these initiatives is seamless care to the client between different delivery systems. The initiatives call for a holistic and systems approach to care delivery. The Department recognizes the varying needs of different populations served within

Medicaid and expects to set outcome measures that differ between TANF, SSI, waiver, and dual eligible populations. A key component of the model is comprehensively defining the Medicaid benefit so coverage, duration, amount, and scope are clearly articulated.

General Description of Request:

This request is for a reduction in total funds of $31,507 in FY 2009-10 and $1,083,886 in FY 2010-11. These adjustments include a General Fund reduction of $207,348 and $729,443 in FY 2009-10 and FY20010-11, respectively. The adjustments requested are the net result of the implementation of an automated prior authorization system and changes to the reimbursement rates of drugs using a state maximum allowable cost structure.

**Automated Prior Authorizations**

The Medicaid Management Information System processes automated claims, capitation payments and provides summary reporting. In Colorado, the Medicaid Management Information System processes or adjudicates claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions.

Beginning March 1, 2004, a portion of the Medicaid Management Information System contract was converted to a fixed price contract. The move toward a fixed price contract was the result of three managed care organizations leaving the Medicaid market in FY 2002-03 and the subsequent increase in claims processing for moving these clients into a fee-for-service environment. By moving to a fixed price contract, the Department was able to contain costs related to claims processing, prior authorization reviews and some administrative functions. Remaining functions provided by the contractor, such as pharmacy prior authorization reviews, development costs, and postage that were more difficult to predict, were excluded from the fixed price contract and paid on actual expenditures instead.

In FY 2007-08, drug prior authorizations became part of the fixed price contract and as a result, the contractor, Affiliated Computer Systems (ACS), is obligated to handle all prior authorizations up to the cap set by the contract.

***Preferred Drug List***

In January 2007, Executive Order D 004 07 established a preferred drug list for Colorado's Medicaid program. The purpose of this program is to provide needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. This Executive Order gave the Department the authority to implement a preferred drug list after evaluating various methods of implementation and determining the best option for Colorado.

In FY 2007-08, the Department was appropriated $340,880 in funds for Medicaid Management Information System changes, (Figure Setting, March 8, 2007, page 105). Of this, $290,000 was included to account for the anticipated increase in prior authorizations and $50,880 was included for ongoing maintenance costs. Prior authorizations are necessary for all clients requiring non-preferred drugs within a drug class. Significant increases in prior authorizations will cause the non-preferred drug list prior authorizations to exceed the cap on the fixed price contract. Until the fixed price contract can be renegotiated, the Department will be required to pay a per-unit cost of $12.69. As a result, the Department expects to spend the entire $290,000 appropriated for this purpose.

As of November 3, 2008 the Department has implemented 7 drug classes on the preferred drug list including: proton pump inhibitors, sedative-hypnotics, statins, antihistamines, antihypertensives, opioids and attention deficit hyperactivity disorder drugs. As a result, 60 drugs have been added to the list requiring prior authorizations. In addition, the Department is currently reviewing triptans and antiemetics for implementation January 1, 2009. As the Department continues to add drug classes to the preferred drug list the number of drugs requiring prior authorization will also increase.

***Prior Authorization Process***

The Department currently publishes all therapeutic categories that require a prior authorization with detail identifying all required information specific to the therapeutic category. Effective April 1, 2008 all pharmacy prior authorization requests must be submitted using a universal form; the Pharmacy Prior Authorization Request Form. Prior to this date providers were required to fill out different prior authorization forms depending on the drug being prescribed. In addition, while some prior authorizations are coded electronically, Atypical Antipsychotics and Fentanyl must be made by fax. Pharmacists from long-term-care pharmacies and infusion pharmacies must obtain a signature from someone who is authorized to prescribe drugs before they submit prior authorization forms.

Once the prior authorizations are submitted to the Department's contractor, Affiliated Computer Services, a help desk ticket is created and each prior authorization is individually reviewed for approval. Prior Authorization criterion for approval is based on Food and Drug Administration approved indications, Centers for Medicare and Medicaid Services (CMS) approved compendia and peer-reviewed medical literature. The fixed price contract is based on a maximum number of help desk tickets that can be processed without additional cost. Any help desk tickets above the cap require the Department to pay a per-unit cost of $12.69. Currently the screening and approval process can take up to 24 hours.

***Benefits of Automated Prior Authorizations***

Automating prior authorizations would increase efficiency in managing current prior authorizations and would allow the Department to implement new prior authorization criteria under the current fixed price contract. This would improve the prior authorization process making it easier for providers to submit requests, easier and faster for clients to obtain drugs with prior authorization restrictions and would provide savings within Medical Services Premiums.

Currently, providers are required to submit paperwork on every prior authorization requested either electronically, through the mail or through fax. Automating the prior authorization system would remove a large majority of this administrative burden. Although there would still be paperwork required for a few requests, most prior authorizations would be determined at the point of sale.

Under the current system, clients can only receive an emergency supply of their prescription while a decision was made on the prior authorization request. If the prior authorization is approved, the client is required to go back to the pharmacy to obtain their full prescription. Converting to an automated prior authorization system would minimize the burden of multiple pharmacy visits.

Converting to an automated prior authorization system would allow the Department to better manage the fixed price contract currently in place. Automating the system would significantly decrease the number of manual prior authorization determinations made through a help desk ticket. This would allow the Department to include new prior authorization criteria without hitting the cap on the fixed price contract. As a result, the current fixed price contract would not need to be adjusted.

Further, automating prior authorizations would provide cost savings in Medical Services Premiums. Adding additional prior authorization criteria within and outside the preferred drug list would allow the Department to better monitor and control drug utilization. Based on diagnosis codes and other factors, the system would determine whether the drug prescribed is appropriate for the client based on federally identified standards. This would help ensure that clients are getting a high quality care with medications appropriate to their diagnosis and ensure that the Department does not pay for high cost drugs that are not appropriate.

***Automated Prior Authorization Contractor***

The Department would hire a contractor to provide automated prior authorization services. An automated prior authorization system screens pharmacy claims against

client information from the medical and pharmacy database and determines if a client meets the prior authorization approval criteria within a few seconds through the point of sale system. The automated prior authorization would also improve provider and client satisfaction by minimizing time for approval. Any prior authorizations approved through this process would not require a help desk ticket and would not count against the cap set in the Medicaid Management Information System fixed-price contract.

While an automated system will greatly reduce the amount of fax and phone requests, certain prior authorization requests that require pain evaluations or other attachments would still be required to be submitted by fax. The prior authorization help desk was set up with the expectation of processing a predetermined quantity of requests. Funding an automated prior authorization system would increase savings since the Department could increase the number of medications on prior authorization and implement the preferred drug list while still decreasing the burden to providers.

The Department would require $375,000 total funds in FY 2009-10 for one-time costs related to the implementation of automated prior authorization. The ongoing maintenance cost associated with this contract would be $62,500 monthly or $750,000 annually. For FY 2009-10 maintenance costs would be $375,000 for 6 months of operation. The total cost for FY 2009-10 would be $750,000. See Table 2 Contractor Costs.

***Automated Prior Authorization System and the Impact to the Preferred Drug List***

The implementation of the preferred drug list is currently, and will continue increasing the number of prior authorization requests. The preferred drug list works by targeting specific drug classes and determining which drugs are the preferred drugs for Medicaid clients. Any drug within the drug class that is not included on the preferred drug list requires a prior authorization. Preferred drugs are determined using clinical data provided by the Drug Effectiveness Review Project (DERP). This data is reviewed and recommendations are made by the Pharmacy and Therapeutics Committee, a body comprised of independent medical and pharmacy professionals. Savings result from

price negotiations with drug manufacturers based on the anticipated increases in utilization for the preferred drugs.

An automated prior authorization system complements the preferred drug list and allows the Department to include additional drug classes and prior authorization requirements without going over the Medicaid Management Information System fixed-price cap. As a result, the Department assumes that 6 more drug classes would be added to the preferred drug list for an additional savings of $56,833 in FY 2009-10 and $125,032 in FY 2010-11. See Appendix 6 Estimated Savings. The returns for these classes are significantly lower than earlier drug classes and are not cost effective without changes to the prior authorization system.

***Automated Prior Authorization Drug Class Savings***

Additional savings can be realized using automated prior authorization for drugs that are not appropriate for inclusion on the preferred drug list. These drug classes would be limited to appropriate clinical use through a prior authorization system. For these drug classes, all drugs would require a prior authorization. Based on diagnosis codes and other factors, the system would determine whether the drug prescribed is appropriate for the client based on federally identified standards. Under the current prior authorization process these requirements would add significant time to prescription fill time as the process is a manual, paper-based system. With an automated prior authorization system, new prior authorization requirements can be added to the system without any burden to providers. All determinations would be completed at the point of sale and would not add any time or burden to clients filling their prescriptions.

The Department assumes that there are 5 initial drug classes that are appropriate for prior authorizations but not for inclusion on the preferred drug list. These classes would be reviewed and final recommendations would be made by the Drug Utilization Review Committee.

In addition, the Department can include minimum prior authorization criteria for all drugs to help ensure proper utilization practices for a drug. These prior authorizations would be automatically determined at the point of sale. Any addition of prior authorization criteria would have a positive impact to the number of help desk tickets that would be required but the impact would be minimal with the automated prior authorization system. These edits would require a prior authorization to set controls in place for:

- Dose optimization: changes multiple dose medications to a single daily dose where appropriate;
- Drugs not covered: identifies and disallows drug ingredients that are not covered;
- High dose: requires medications to be within defined parameters;
- Refill too soon, prescriptions cannot be refilled before a set level of use such as 75%, and;
- Therapeutic duplication: newly prescribed drug may not have the same therapeutic effects of another drug already prescribed for an individual patient.

Calculations are included in Appendix 1.

These options also improve client safety. The total savings associated with new prior authorization criteria is $680,931 in FY 2009-10 and $1,498,048 in FY 2010-11. See Appendix 5: Estimated Savings.

**State Maximum Allowable Costs**

***Pharmacy Benefits Program***

The Department's Pharmacy Benefits Program incurs a substantial portion of the Department's expenditures through the Acute Care service category in Medical Services Premiums. In FY 2007-08 the Department reimbursed providers $216,864,136 for the provision of prescription drugs, though manufacturer rebates brought the net expenditure on prescription drugs to $161,399,048. This latter amount accounted for just over 12% of total Acute Care expenditures, and over 7% of total expenditures incurred through the Department's Medicaid program, (FY 2009-10 Executive Budget Request, Change

Requests, August 1, 2008: pg. EN-1). There have been recent substantive changes in the Department's pharmacy reimbursements program that affected expenditures through the Department's Medical Services Premiums line. On January 1, 2006, the federal Centers for Medicare and Medicaid Services assumed responsibility for the Part D prescription drug benefit replacing the Medicaid prescription drug coverage for dual eligible clients. In lieu of the states' obligation to cover prescription drugs for this population, the federal Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred.

Title XIX of the Social Security Act detailed provisions regulating the reimbursement of covered outpatient drugs by state Medicaid agencies. For a state to allow payment for these drugs, the manufacturer of a given drug must have a rebate agreement in effect with states whereby a portion of a state's reimbursement is given back to the state by the manufacturers. In the Colorado Pharmacy Benefits program rebates received by the State were almost 26% of the costs incurred in the reimbursement of pharmacies in FY 2007-08 (FY 2009-10 Executive Budget Request, Change Requests, August 1, 2008: pg. EN-1). In addition to manufacturing costs and consumer demand a significant determinant of costs incurred through this program is the reimbursement methodology used. The Department currently determines reimbursement rates based on the lowest rate as determined by four methodologies. This allows the Department to maximize the cost-effectiveness of the program while maintaining client access to prescription drugs. The four methodologies used are the Federal Upper Limit, Average Wholesale Price, Direct Price, and Usual and Customary Charge. In FY 2006-07, the Department reimbursed approximately 36% of all pharmacy claims using the Federal Upper Limit. The Department reimbursed 23% of the claims using the Usual and Customary Pharmacy Charge. The Average Wholesale Price was used for approximately 33% of all claims submitted in FY 2006-07. Direct Price is the least-used of all reimbursement rates, used to pay approximately 8% of the claims in FY 2006-07.

***Federal Upper Limit***

In 1987 the Centers for Medicare and Medicaid Services implemented regulations limiting the amount state Medicaid agencies could reimburse pharmacies that dispensed prescription drugs to Medicaid clients. Known as the Federal Upper Limit, the regulations were designed to incorporate market prices into Medicaid pharmaceutical reimbursement rates. This would also ensure that the federal government acts as a prudent payer by making use of current market prices for multiple-source drugs. Prior to the passage of the Deficit Reduction Act of 2005, the Federal Upper Limit was calculated as 150% of the Average Wholesale Price of the least costly therapeutic equivalent in the multiple-source drug group, (42 CFR 447.514 (2006)).

This information is published every 6 months by the Centers for Medicare and Medicaid Services. Prior to the passage of the Deficit Reduction Act of 2005, to be included on this list of drugs, a drug must have at least three therapeutically and pharmaceutically equivalent substitutes. This criterion allows the federal government to minimize the federal portion of pharmacy reimbursement costs where the presence of generic drugs lowered the Average Wholesale Price used in the calculation of the Federal Upper Limit. By setting a Federal Upper Limit only for drugs for which three generic equivalents are available, and by calculating this limit as 150% of the lowest Average Wholesale Price among the group of three equivalents, the federal government had intended to lower overall federal financial participation in state Medicaid programs. The Federal Upper Limit is instrumental in the determination of overall pharmacy reimbursements made by the Department, as it determines the overall maximum amount in which federal financial participation will be made available.

The three other methodologies currently used by the Department to determine reimbursements are Average Wholesale Price, Direct Price, and Usual and Customary Charge. Usual and Customary Charge is defined as the prevailing price charged by a pharmacy to final consumers of a drug. The Average Wholesale Price is calculated on a national basis as the average price at which wholesalers of prescription drugs sell to pharmacies, and is adjusted downward before use by the Department by 13.5% for brand

name drugs and 35% for generic drugs to arrive at a final amount. For rural pharmacies with typically higher than average operating and acquisition costs, the Department calculates the Average Wholesale Price minus 12% for all drugs. Direct Price represents a manufacturer's published catalog or list price for a drug product to non-wholesalers.

***Deficit Reduction Act***

In February 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law; it contained provisions for the reduction of overall federal financial participation in State Medicaid programs. The most relevant provision of the Deficit Reduction Act will change the way in which the Federal Upper Limit is calculated, causing it to be defined as 250% of the Average Manufacturer's Price. The Average Manufacturer's Price is distinct from the Average Wholesale Price in that the Average Manufacturer's Price is calculated as the average price paid to manufacturers by wholesalers, while the Average Wholesale Price is the average price at which wholesalers of prescription drugs sell to pharmacies. As each step in the transaction chain from production to consumption adds value to the good in question, the Federal Upper Limit is expected to decrease in the aggregate by movement towards the point of production, explaining the reduction in overall federal financial participation. Though disputes have arisen challenging the constitutionality of the Deficit Reduction Act of 2005 and delayed the provisions related to the Federal Upper Limit indefinitely, full implementation could have several negative consequences for both pharmacies and the State.

One provision of the Deficit Reduction Act of 2005 would require that the Federal Upper Limit be calculated for drugs that have at least two generic equivalents, where previously three were required. This is expected to increase the number of drugs that fall under a Federal Upper Limit by between 1,100 and 2,100 groups. The Department does not currently have a mechanism to control for fluctuations in reimbursement to pharmacies, but implementation of a State Maximum Allowable Cost reimbursement method is intended to remedy this. It is hoped that uncertainty of reimbursement by pharmacy providers will be reduced where Federal Upper Limit reimbursement currently may not match the cost paid by the pharmacies for these drugs. Though the frequent updates in

the Federal Upper Limit were designed to mimic changing pharmacy acquisition costs, they may not have the intended effect. Gathering the data necessary to publish the Federal Upper Limit on a national level is considerably time-consuming. The Centers for Medicare and Medicaid Services set forth a schedule whereby there would be a three month lag between collecting the information and publishing the new Federal Upper Limits. By the time Colorado has access to this information, pharmacy acquisition costs may have changed substantially above or below the lagging Federal Upper Limit. This caused concern among the pharmacy community that they may at times be reimbursed below acquisition cost.

***Benefits of State Maximum Allowable Cost Reimbursement***

Adding the State Maximum Allowable Cost reimbursement methodology would increase the options available for the reimbursement of pharmacy claims. The average pharmacy acquisition costs would be determined in conjunction with the contractor but would be based on the costs of participating pharmacy providers and the currently available prescription drug ingredient costs. The final State Maximum Allowable Cost would then be determined as the average acquisition cost plus 18%, per State rules at 10 CCR 2505-10-8.800 detailing guidelines for this reimbursement method. The markup would serve to both ensure that pharmacies are not reimbursed below acquisition cost and to create incentives for greater pharmacy participation. Once the State Maximum Allowable Cost was implemented, the Department would choose the lowest of the five methodologies, (Federal Upper Limit, Average Wholesale Price, Direct Price, Usual and Customary Charge and the State Maximum Allowable Cost) to determine a final pharmacy reimbursement rate. However, in the case where the selected reimbursement falls short of a pharmacy's acquisition cost, the State Maximum Allowable Cost rate will instead be used to avoid underpayment to pharmacies. Any change to the determination of the State Maximum Allowable Cost must take into account the following considerations:

- Multiple manufacturers;
- Broad wholesale price span;
- Availability of drugs to retailers at the selected cost;
- High volume of Medicaid recipient utilization, and;

- Bioequivalence or interchangeability (of potential generic substitutes for brand name drugs).

These considerations are designed to ensure the incorporation of data from numerous manufacturers over a broad span of time into the calculation of the State Maximum Allowable Cost rate. Additionally, the third and fourth considerations also account for client utilization and provide a way for pharmacies to report to the Department through a help line to be set up by the contractor in the event that reimbursement is found to be below acquisition cost. The last item, "Bioequivalence or interchangeability", refers to the requirement that for a given drug, any potential substitutes must be equivalent in effect and usage in order to be incorporated into the calculation of the maximum allowable ingredient cost that is the basis for the State Maximum Allowable Cost.

A State Maximum Allowable Cost program would allow for more flexibility in the determination of reimbursements for prescription drugs. This methodology could be used to decrease the likelihood of payment below acquisition cost and could serve as a reimbursement ceiling to prevent overpayment in certain cases. The latter is possible as the State Maximum Allowable Cost rate remains closer to pharmacy acquisition cost, and can be used in situations where all other reimbursement rates would result in payment well above acquisition cost. In addition, the Department would have much greater control over the determination of reimbursement under the State Maximum Allowable Cost than is achievable with the use of the Federal Upper Limit or Average Wholesale Price. This is pertinent given the often rapid changes in market prices for pharmaceuticals and the closely related total prescription drug expenditure by the Department. This highlights the need for flexibility in the setting of reimbursement rates as fluctuations in prescription drug expenditures can change rapidly. For example, between FY 2002-03 and FY 2003-04, prescription drug expenditures by the Department rose from $201,539,466 to $265,797,673, an increase of 31.88% (FY 2009-10 Executive Budget Request, Change Requests, August 1, 2008: pg. EN-1).

Use of a State Maximum Allowable Cost reimbursement rate would give the Department the ability to adjust rates in a more timely manner than is possible under the current

Federal Upper Limit, which being based on the Average Wholesale Price was available only once every six months. Currently, due to the injunction pursuant to the Deficit Reduction Act of 2005 lawsuit, the Centers for Medicare and Medicaid Services have announced that they will not be publishing any new Federal Upper Limits under the old or new methodologies. The Department must continue to use the Federal Upper Limit rates that were set months ago until further notice.

By more closely reflecting the market conditions unique to Colorado, a State Maximum Allowable Cost reimbursement methodology would allow the Department to adjust reimbursements between drugs where variations from acquisition cost and the chosen reimbursement rate cause overpayments or underpayments to providers. Whereas the Average Wholesale Price and Federal Upper Limit are calculated on a national basis, a State Maximum Allowable Cost would take into account statewide data only. The Department would direct the contractor to gather data from as many pharmacy providers as possible, and in this way would determine an average acquisition cost specifically applicable to Colorado. This would be done in contrast to using acquisition costs based on a national Average Wholesale Price minus a percentage, another method available for the determination of acquisition costs.

This request would allow the Department to mitigate the negative impacts on pharmacies of existing Federal Upper Limit rates, as the State Maximum Allowable Cost would more closely follow drug purchase prices in the determination of pharmacy reimbursement. It would also decrease the likelihood of payments to pharmacies below acquisition cost, in addition to ensuring cost-effective provision of prescription drugs for Medicaid recipients.

According to the National Pharmaceutical Council, 30 states had implemented versions of a State Maximum Allowable Cost program in 2001, though other states have introduced such programs since then. For example, Indiana Health Coverage Programs reports saving approximately $24,000,000 annually, and maintaining access for its Medicaid clients by ensuring a reimbursement based on acquisition cost plus a markup reflective of that used by fully-private pharmacies. However, the Indiana Health

Coverage Programs had 1,176 drugs subject to their State Maximum Allowable Cost rate in FY 2006-07, whereas the Department estimates that only 97 drugs would be included in Colorado.

***State Maximum Allowable Cost Contractor***

The funding requested would be used to obtain the services of a contractor to implement a State Maximum Allowable Cost program. Specifically, the contractor would be responsible for gathering acquisition costs monthly from a statistically determined number of pharmacies and establishing a methodology to compare, weigh, and confirm the acquisition costs collected. These acquisition costs would be multiplied by an allowable profit margin to determine the final State Maximum Allowable Cost reimbursement rate by drug. The contractor would be responsible for providing to the Department the monthly updated rates that would be loaded into the Medicaid Management Information System via the Department's fiscal agent, Affiliated Computer Services, Inc. The contractor would provide recommendations on which drugs and classes would most advance the goals of the Pharmacy Benefits section by inclusion on the State Maximum Allowable Cost list. In addition, the contractor would be responsible for updating the Department on developments in the pharmaceuticals industry as they relate to the composition of drugs that are likely candidates for inclusion in the State Maximum Allowable Cost reimbursement rate. Finally, the contractor would field calls from pharmacies, creating a forum for pharmacies to voice their concerns relating to reimbursement rates or the composition of the drug list subject to the State Maximum Allowable Cost.

While the implementation and administration of this program could be performed by additional Department FTE, it is believed that a contractor with similar experience in other states could provide a more comprehensive program. For this reason no FTE are being requested in this request. The Department explored the use of additional FTE and found that, in addition to temporary FTE, a contractor would still have been required to gather and analyze pharmacy acquisition costs and track changes in the Federal Upper Limit. Further, using a contractor would decrease the implementation time; the necessary

systems and expertise would be available immediately. This would accelerate the realization of savings and other benefits associated with the implementation of the State Maximum Allowable Cost rates.

***State Maximum Allowable Cost Savings***

Use of a State Maximum Allowable Cost would allow the Department to set rates for drugs that have not been given a Federal Upper Limit by the Centers for Medicare and Medicaid Services, and would allow the adjustment of rates based on the not entirely reliable and infrequently published Average Wholesale Price. The Department estimates a savings of $285,123 in FY 2009-10 and $510,806 in FY 2010-11. This savings estimate is based on implementing 97 drug rate calculations for the first two years of operation. See Appendix 3.1 for further assumptions and calculations.

Consequences if Not Funded:

The Department would not be able to provide the efficiencies necessary to obtain savings of $737,764 in FY 2009-10 and $1,623,080 in FY 2010-11 resulting from implementation of the automated prior authorization system. The Department would also not be able to provide the efficiencies necessary to obtain savings of $285,123 in FY 2009-10 and $510,806 in FY 2010-11 resulting from conversion to a maximum allowable cost methodology.

Additionally, providers would have to continue submitting prior authorizations manually, currently a highly labor intensive process. The Department would also need to re-negotiate the Medicaid Management Information System fixed-price contract.

Finally, if this request is not funded, the Department will not be able to address issues with the Average Wholesale Price, such as its infrequent publication and the likelihood of underpayments and overpayments to pharmacies that often result, depending on the impact of its lagging publication. The Department would not be able to adequately address issues with the current Federal Upper Limit rates, which were set months ago and are not going to be changed until further notice. If the Deficit Reduction Act is fully implemented, the Department will be unable to mitigate the negative impacts of the

frequently changing Federal Upper Limit based on the anticipated Average Manufacturer Price, adversely affecting pharmacies where reimbursement rates fall below pharmacy acquisition costs. By preventing the expansion of methods available to the Department in pharmacy reimbursement, disapproval of a State Maximum Allowable Cost program would prevent the Department from achieving the most cost-effective use of State resources through a balancing of client access and provider satisfaction.

Calculations for Request:

**Table 1: Summary of Request**

| Summary of Request FY 2009-10 | Total Funds | General Fund | Federal Funds |
|---|---|---|---|
| **Total Request** | **($31,507)** | **($207,348)** | **$175,841** |
| **(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects** | **$975,000** | **$300,000** | **$675,000** |
| Automated Prior Authorization Contractor | $750,000 | $187,500 | $562,500 |
| State Maximum Allowable Cost Contractor | $225,000 | $112,500 | $112,500 |
| **(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts** | **$16,380** | **$4,095** | **$12,285** |
| **(2) Medical Services Premiums** | **($1,022,887)** | **($511,443)** | **($511,444)** |
| Automated Prior Authorization Savings | ($737,764) | ($368,882) | ($368,882) |
| State Maximum Allowable Cost Savings | ($285,123) | ($142,561) | ($142,562) |

| Summary of Request FY 2010-11 | Total Funds | General Fund | Federal Funds |
|---|---|---|---|
| **Total Request** | **($1,083,886)** | **($729,443)** | **($354,443)** |
| **(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects** | **$1,050,000** | **$337,500** | **$712,500** |
| Automated Prior Authorization Contractor | $750,000 | $187,500 | $562,500 |
| State Maximum Allowable Cost Contractor | $300,000 | $150,000 | $150,000 |
| **(2) Medical Services Premiums** | **($2,133,886)** | **($1,066,943)** | **($1,066,943)** |
| Automated Prior Authorization Savings | ($1,623,080) | ($811,540) | ($811,540) |
| State Maximum Allowable Cost Savings | ($510,806) | ($255,403) | ($255,403) |

**Table 2: Contractor Costs**

| Row | Item | FY 2009-10 | FY 2010-11 | Description |
|---|---|---|---|---|
| **Automated Prior Authorization Contractor** | | | | |
| A | One-time Systems Costs | $375,000 | $0 | Estimates from the Department's Medicaid Management Information System contractor. |
| B | Monthly Management Costs | $62,500 | $62,500 | |
| C | Months in Fiscal Year | 6 | 12 | See implementation plan. |
| D | Total Annual Systems Cost | $375,000 | $750,000 | Row C * Row D. |
| **E** | **Total Automated Prior Authorization Costs** | **$750,000** | **$750,000** | **Row A + Row D.** |
| **State Maximum Allowable Costs Contractor** | | | | |
| F | Monthly Contract Amount | $25,000 | $25,000 | Estimate provided by the Indiana Medicaid Agency. |
| G | Months of Service Required | 9 | 12 | Partial year of operation in FY 2009-10. |
| **H** | **Total State Maximum Allowable Cost Amount** | **$225,000** | **$300,000** | **Row F * Row G.** |
| **I** | **Total Contractor Costs for Pharmacy Initiatives** | **$975,000** | **$1,050,000** | **Row E + Row H.** |

**Table 2.1: Information and Technology Costs**

| Row | Item | FY 2009-10 | Description |
|---|---|---|---|
| A | Hours Required for Changes to the Medicaid Management Information System | 130 | Estimates from the Department's Information Technology Division. |
| B | Months in Fiscal Year | $126 | |
| **C** | **Total Automated Prior Authorization Amount** | **$16,380** | **Row A * Row B.** |

**Table 3: Summary of Savings and Rebates**

| Row | Item | FY 2009-10 | FY 2010-11 | Description |
|---|---|---|---|---|
| **Automated Prior Authorization Savings** | | | | |
| A | Savings from Drug Classes Implemented February 1, 2010 | ($680,931) | ($1,498,048) | See Appendix 6, Row C and E. |
| B | Savings from Preferred Drug List Classes Implemented February 1, 2010 | ($56,833) | ($125,032) | See Appendix 6, Row C and E. |
| **C** | **Total Estimated Prior Authorization Savings** | **($737,764)** | **($1,623,080)** | **Row A + Row B.** |
| **State Maximum Allowable Costs** | | | | |
| **D** | **Total Estimated State Maximum Allowable Cost Savings** | **($285,123)** | **($510,806)** | **See Appendix 3.1, Row D.** |
| **Physician and Hospital Drug Rebates** | | | | |
| F | Physician Multiple Source Drug Rebates | ($150,969) | ($150,969) | See Appendix 4, Row F. |
| G | Hospital Multiple and Single Source Drug Rebates | ($1,856,576) | ($1,856,576) | See Appendix 4, Row L. |
| **H** | **Total Estimated Savings for Physician and Hospital Drug Rebates** | **($2,007,545)** | **($2,007,545)** | **Row F + Row G.** |

Cash Funds Projections: Not Applicable.

Assumptions for Calculations:

**Table 1: Summary of Request**

Under current federal regulation the Department would receive a 75% match rate for edits or additions within the Medicaid Management Information System contract but only a 50% match rate for contractor services provided outside of the system.

**Table 2: Contractor Costs.**

These costs are based on estimates provided by the Department's current Medicaid Management Information System vendor. The total General Fund cost was consistent with quotes from other contractors providing similar services.

**Table 2.1: Information and Technology Costs**

The Department is planning on contracting the automation of the State Maximum Allowable Cost program into the Medicaid Management Information System through the Department's fiscal agent, Affiliated Computer Services, Inc. The Department assumes that implementation of the State Maximum Allowable Cost into the Medicaid Management Information System will require 130 contractor hours at $126.00 per hour. This assumption is based on an estimate provided by the Department's fiscal agent, Associated Computer Services, Inc. The Department assumes that it will cost no more than $300,000 per year to hire a contractor to gather pharmacy data and develop the State Maximum Allowable Cost rates, research the inclusion of other drugs in the State Maximum Allowable Cost program, update the Department on relevant developments in the pharmaceutical industry, and set up the pharmacy contact line. It is further assumed that the contract will be in effect for nine months of FY 2009-10 given the time required to complete the Request for Proposal process and award the contract, (Please see the Implementation Timeline for further details). This estimate is based on the cost to Indiana of hiring a contractor to perform similar work.

**Table 3: Summary of Savings and Rebates**

Calculations for this table are provided in greater detail in the attached appendices. The Department allocated rebate estimates between single source and multiple source drugs using the presence of generic availability as a proxy. As a result, 35.00% of expenditures are estimated to come from multiple source drugs. In addition, the Department assumes that physicians and hospitals have similar drug utilization profiles. This means that on average, these two types of providers prescribe the same medications in the same relative frequency.

The Department estimates the total savings from putting 12 drug classes on prior authorization based on a review of several potential drug classes identified in the Medicaid Management Information System on June 26, 2008. The classes identified are representative of the types of classes and savings that the Department would consider during the implementation of the automated prior authorization process. Drug classes were identified based on inclusion by other states participating in an automated prior authorization system.

With respect to state maximum allowable cost savings estimates, the Department assumes that it is sufficient to compare allowed ingredient costs to define savings. Specifically this means that introducing a State Maximum Allowable Cost rate structure will have no effect on co-pays, dispensing fees, or third-party paid amounts. In addition, the Department assumes that, for initial implementation, Colorado's State Maximum Allowable Cost rates would be identical to those used in Indiana. The Department plans to implement all drug classes incorporated into the savings estimates at once during initial stages of implementation. The savings estimates are based on the 97 drugs the Department plans to implement if this request is approved, though only 54 of the drugs for which the State Maximum Allowable Cost will be implemented contributed to the anticipated savings in the analysis performed. This is due to the fact that for the other 43 drugs that will have a State Maximum Allowable Cost rate in FY 2009-10, the Average Wholesale Price was below the State Maximum Allowable Cost and thus no savings were derived from those drugs having a State Maximum Allowable Cost calculated.

It is possible that ingredient costs between the two methodologies may diverge where they are currently equal, causing savings to be generated for drugs that currently do not contribute to the total savings. The magnitude of this change is unknown at this time. The savings estimates are expected to materialize at a uniform rate over the course of the first year of implementation, as payments to pharmacies are made weekly throughout the year. It is further assumed that the number of drugs to be subject to the State Maximum Allowable Cost rate in FY 2010-11 will be the same as in FY 2009-10. For FY 2010-11, an estimated rate of inflation was used to adjust the differences in ingredient costs between the two most prevalent reimbursement rates, (Average Wholesale Price and the State Maximum Allowable Cost). This rate is expected to be 4.5% between FY 2009-10 and FY 2010-11, and is expected to increase savings between the two years as ingredient costs diverge by approximately $21,996.

Impact on Other Government Agencies: Not Applicable.

Cost Benefit Analysis:

| FY 2009-10 | Costs | Benefits |
|---|---|---|
| **Request** | The cost of the request includes $750,000 total funds to hire an automated prior authorization contractor, $225,000 to hire a state maximum allowable cost contractor and $16,380 to make Medicaid Management Information System changes in FY 2009-10. | This request provides greater efficiency in managing current prior authorizations under the fixed price contract and would allow the Department to include additional prior authorization criteria. This would significantly improve the process for client and providers, allowing the majority of the prior authorizations to be made at the point of sale without paperwork. Benefits to implementing the state maximum allowable cost rates include the ability to protect pharmacies from receiving reimbursement below their acquisition costs. In addition, the Department will gain the flexibility to set rates in a more timely fashion. Potential consequences if the Deficit Reduction Act is ever implemented would be mitigated as well. The Department would realize total estimated cost savings in FY 2009-10 of $737,764 from automated prior authorizations and $285,123 from implementing state maximum allowable cost rates. |
| **Consequences if not Funded** | The cost of not funding the automated prior authorization system would be the unrealized savings associated with this process, which in FY 2009-10 would be $737,764 from automated prior authorizations and $285,123 from implementing state maximum allowable cost rates. In addition, providers would have to continue to request prior authorizations for their patients through a labor intensive, manual process. Additional consequences include infrequent adjustment of reimbursement rates and overpayment to pharmacies at certain times and underpayment at other times. | There are no benefits. |

Implementation Schedule:

| **Automated Prior Authorizations** | | | |
|---|---|---|---|
| **Task** | **Start** | **Complete** | **Description** |
| RFP Written and Distributed | 5/1/2009 | 6/1/2009 | Assumes that the Department would begin writing the as soon as possible and that it would require 1 month. |
| Provide Public Notice of Proposed State Plan Amendment | 5/1/2009 | 6/1/2009 | Assumes 1 month to provide public notice of proposed changes to the State Plan. |
| State Plan Amendment – Written and Submitted | 5/1/2009 | 6/1/2009 | Assumes 1 month to write a state plan amendment. |
| Medical Services Board Rules - Written | 5/1/2009 | 7/1/2009 | Assumes 2 months to write Medical Service Board rules. |
| Present the Drug Management Prior Authorizations to the Drug Utilization Review Board | 5/1/2009 | 7/1/2009 | Assumes that the criteria for the drug management prior authorizations would require 2 months for approval. |
| Contract Awarded and Signed | 6/1/2009 | 9/1/2009 | Assumes 3 months to award a contract. |
| Medical Services Board Rules - Approved | 7/1/2009 | 10/1/2009 | Assumes 3 months including 2 months to provide notice of readings and 1 month to take effect. |
| 2 Classes to the Drug Utilization Review Board, prior authorizations for drug management to the Drug Utilization Review Board and 3 Classes to the Pharmacy and Therapeutics Committee | 7/1/2009 | 10/1/2009 | Assumes that the criteria for the first series of prior authorizations would require 3 months. |
| 3 Classes to the Drug Utilization Review Board and additional 3 Classes to the Pharmacy and Therapeutics Committee | 10/1/2009 | 1/1/2010 | Assumes that the criteria for the first series of prior authorizations would require 3 months. |
| System Implemented Including 11 Drug Classes and Drug Management Criteria | 9/1/2009 | 2/1/2010 | Assumes that it would take 6 months to implement the automated prior authorization system. 11 drug classes include a total of 5 prior authorization drug classes and 6 preferred drug list drug classes. |

| **State Maximum Allowable Costs** | | | |
|---|---|---|---|
| **Task** | **Start** | **Complete** | **Description** |
| Internal Research and Planning Period | 8/1/2008 | 4/1/2009 | The Department plans on making full use of the period prior to the signing of the Long Bill to plan and prepare for implementation of the program. |
| Request for Proposal Written and Distributed | 5/15/2009 | 7/1/2009 | Assumes that the Department would begin drafting the RFP as soon as possible and that six weeks would be required to complete it. |
| Contract Awarded and Signed | 7/1/2009 | 10/1/2009 | Assumes 3 months will be needed to review proposals received and select a contractor. |
| Automation of State Maximum Allowable Cost Rate in the Medicaid Management Information System | 7/1/2009 | 9/1/2009 | Assumes that the automation process can begin prior to the Department receiving the first data report from the contractor. Though the time required to complete this has been quoted at two months, additional time has been allowed to account for the heavy workload ACS will be experiencing at this time due to implementation of other requests. |
| Initial Data-Gathering Period for Contractor | 10/1/2009 | 11/1/2009 | One month will be required for the contractor to gather, analyze, and prepare for submittal to the Department the first data report. |
| Transmittal of Drug Data into MMIS | 11/1/2009 | 11/15/2009 | ACS has quoted the Department five business days to complete a transmittal; an additional five days has been allowed for contingencies related to a new process. |
| State Maximum Allowable Cost Rates go into Effect | 12/1/2009 | -- | As the Department makes pharmacy payments on a weekly basis, the first and second payments after the completion of the transmittal will include savings due to the State Maximum Allowable Cost rate. |

Statutory and Federal Authority:

**Automated Prior Authorizations**

42 U.S.C. 1396u-8(d)(5)

*(5) Requirements of prior authorization programs. A State plan under this subchapter may require, as a condition of coverage or payment for a covered outpatient drug for which federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (k)(6) of this section) only if the system providing for such approval.*

*(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and (B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72- hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).*

**State Maximum Allowable Costs**

25.5-4-401, C.R.S. (2008) *(2) As to all payments made pursuant to this article and articles 5 and 6 of this title, the state department rules for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.*

42 CFR 447.205 *Public notice of changes in statewide methods and standards for setting payment rates. (a) Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates and services.*

*(b) When notice is not required. Notice is not required if -- (3) The change is based on changes in wholesalers' or manufacturers' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.*

42 CFR 447.514 *Upper Limits for Multiple Source Drugs. (a) Establishment and issuance of a listing. (1) CMS will establish and issue listings that identify and set upper limits for multiple source drugs that meet the following requirements:*

*(i) The FDA has rated two or more drug products as therapeutically and pharmaceutically equivalent in its most current edition of "Approved Drug Products with Therapeutic Equivalence Evaluations" (including supplements or in successor publications), regardless of whether all such formulations are rated as such and only such formulations shall be used when determining any such upper limit.*

*(ii) At least two suppliers meet the criteria in paragraph (a)(1)(i) of this section.*

*(2) CMS publishes the list of multiple source drugs for which upper limits have been established and any revisions to the list in Medicaid Program issuances.*

*(b) Specific upper limits. The agency's payments for multiple source drugs identified and listed periodically by CMS in Medicaid Program issuances must not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee established by the State agency plus an amount established by CMS that is equal to 250 percent of the AMP (as computed without regard to customary prompt pay discounts extended to wholesalers) for the least costly therapeutic equivalent.*

Performance Measures:

This request will assist the Department in meeting its performance measure to "improve access to health care, increase health outcomes and provide more cost effective services using information technology." The Department believes that the automated prior authorizations and State Maximum Allowable Cost program will help maintain client access to prescription drugs through pharmacies while improving the cost-effectiveness of the Pharmacy Benefits program. Additionally, the use of Information Technology is crucial to the successful operation of this request, and would be utilized by the Department to create more efficient administration.

| **Appendix 1: Drug Management Savings** | | | | |
|---|---|---|---|---|
| **Row** | **Item** | **Montana** | **Colorado** | **Description** |
| A | Ratio of Pharmacy Expenditures, Colorado to Montana | 3.30 | N/A | Ratio based on estimated pharmacy annual expenditures for Colorado and Montana as reported on the 5/15/2008 submittal to the Centers for Medicare and Medicaid Services 37 report. |
| B | Dose Optimization Savings | ($22,408) | ($73,946) | Montana annual Savings estimates are reported in the "Mountain-Pacific Quality Health Monthly Drug PA Cost Savings Report" for the reporting period of 3/1/2008 thru 3/31/2008. Colorado is calculated as Row A * (Row B thru Row G). |
| C | Drug Not Covered Savings | ($19,361) | ($63,891) | |
| D | High Dose Savings | ($1,016) | ($3,353) | |
| E | Refill too Soon Savings | ($80,708) | ($266,336) | |
| F | Therapeutic Duplication Savings | ($4,600) | ($15,180) | |
| **G** | **Potential Savings Estimate FY 09-10 for Drug Management** | **($128,093)** | **($422,706)** | **Row B + Row C + Row D + Row E + Row F.** |

| **Appendix 2: Summary of Potential Savings** | | | |
|---|---|---|---|
| **Row** | **Item** | **Total** | **Description** |
| A | Estimated Potential Savings for New Prior Authorization Restrictions for 5 Drug Classes | ($1,211,528) | This total is based on review of several potential drug classes identified in the Medicaid Management Information System on 6/26/2008. The classes identified are representative of the types of classes and savings that the Department would consider during the implementation of the automated prior authorization process. Drug classes were identified based on inclusion by other states participating in an automated prior authorization system. |
| B | Estimated Potential Savings for Drug Management | ($422,706) | See Appendix 1, Row G. |
| **C** | **Potential Savings Estimate FY 09-10** | **($1,634,234)** | **Row A + Row B.** |

| **Appendix 3: Additional Preferred Drug List Drug Classes** | | | |
|---|---|---|---|
| **Row** | **Item** | **Total** | **Description** |
| A | Contractor Savings Estimate for Insulin | ($22,733) | Information reported in a savings estimate provided by Health Information Designs. Insulin was used as a proxy for additional preferred drug list savings due to the difference in magnitude between the original drug classes included and later drug savings. These are marginal savings that would not be attained without the efficiencies gained through an automated prior authorization system. |
| B | Number of Additional Drug Classes Implemented as a Result of Automating Prior Authorizations | 6 | Assumption based on the current number of drug classes to be added to the preferred drug list. |
| **C** | **Total Estimated Savings for Additional Preferred Drug List Drug Classes** | **($136,398)** | **Row A * Row B.** |

| **Appendix 3.1: State Maximum Allowable Cost Savings** | | | | |
|---|---|---|---|---|
| **Row** | **Item** | **FY 2009-10** | **FY 2010-11** | **Description** |
| A | Number of Drugs Subject to State Maximum Allowable Cost Rate in FY 2009-10 | 97 | 97 | Quantity of drugs to be given a State Maximum Allowable Cost rate. |
| B | Average Difference Between Ingredient Costs Calculated for State Maximum Allowable Cost and Average Wholesale Price | $5,039.28 | $5,266.04 | Sum of differences between ingredient costs based on different methodologies divided by total number of drugs for which the State Maximum Allowable Cost rate will be implemented. This is based on a profit margin of 18% in the implementation of the state maximum allowable cost rate methodology. The figures are trended using an estimated FY 2009-10 aggregated inflation rate of 4.5% taken from the Moore Inflation Predictor. |
| C | Proportion of Year State Maximum Allowable Cost Program Expected to be Operable | 58.33% | 100.00% | Assumes that savings will materialize relatively uniformly over the course of the year, as pharmacy payments are made weekly. Note: there are 7 months of savings in FY 2009-10. |
| **D** | **Total Estimated State Maximum Allowable Cost Savings** | **($285,123)** | **($510,806)** | **Row A * Row B * Row C *( -1).** |

| **Appendix 4: FY 2009-10 Baseline** | | | | |
|---|---|---|---|---|
| **Row** | **Item** | **New Drug Classes for Prior Authorizations** | **New Drug Classes for Preferred Drug List** | **Description** |
| A | Maximum Potential Savings (FY 2007-08) | ($1,634,234) | ($136,398) | Appendix 2 and 3, Row C. |
| B | Savings Per Drug Class | ($136,186.17) | ($11,366.50) | Row A / 12, rounded to 2 decimal places. |
| C | Number of Drug Classes Implemented | 6 | 6 | |
| D | Savings Per Drug Class Per Month | ($22,697.70) | ($1,894.42) | Row B / C, rounded to 2 decimal places. |

| **Appendix 5: Estimated Savings for Drug Classes Implemented February 1, 2010** | | | | |
|---|---|---|---|---|
| **Row** | **Item** | **New Drug Classes for Prior Authorizations** | **New Drug Classes for Preferred Drug List** | **Description** |
| A | Number of Drug Classes Implemented | 6 | 6 | Preferred Drug List Implementation Plan (6 drug classes and 1 drug management). |
| B | Effective Number of Months in Fiscal Year | 5 | 5 | Preferred Drug List Implementation Plan. |
| **C** | **Total Savings FY 2009-10** | **($680,931)** | **($56,833)** | **Row A * Row B * Row D (Appendix 4).** |
| D | Effective Number of Months in Fiscal Year | 11 | 11 | Preferred Drug List Implementation Plan. |
| **E** | **Total Savings FY 2010-11** | **($1,498,048)** | **($125,032)** | **Row A * Row D * Row D (Appendix 4).** |