

**Report on Medicaid Reform Activities**  
Prepared by Jeffery W. Santema, Legal Counsel  
Health and Human Services Committee  
**August 2005**

**Implementation Activities**

The Medicaid reform designees continue to solicit input and receive unsolicited feedback regarding Medicaid reform from various sources. The internal HHS working groups established by Mr. Nelson continue to conduct research and develop draft recommendations for consideration.

The Nebraska Legislature has established a web page for information regarding Medicaid reform planning at [www.unicam.state.ne.us/committees/mrac.htm](http://www.unicam.state.ne.us/committees/mrac.htm).

Public meeting(s) in each congressional district are tentatively being planned for the two-week period beginning Monday, October 24, through Friday, November 4, 2005.

A second meeting is being planned between the Medicaid reform designees, Nebraska HHS staff, and the federal Centers for Medicare and Medicaid Services (CMS).

The first meeting of the Medicaid Reform Advisory Council was held on Wednesday, July 27, 2005. A second meeting is being held on August 23, 2005. Future meeting dates and locations will be posted at [www.nebraska.gov/calendar/index.cgi](http://www.nebraska.gov/calendar/index.cgi).

Questions regarding the council and its activities may be directed to Senator Jensen's office at (402) 471-2622 or to Senator Don Pederson, chair of the council, at (402) 471-2729. Agendas, meeting dates and locations, and minutes of council meetings will be posted at [www.unicam.state.ne.us/committees/mrac.htm](http://www.unicam.state.ne.us/committees/mrac.htm).

**Guidelines for Reform**

The Nebraska Legislature established several guidelines for Medicaid reform in LB 709 (2005).

Neb. Rev. Stat. §68-1090 calls for reform of the Medicaid program and a substantive recodification of Medicaid statutes, "including, but not limited to, the enactment of policies to

- (1) moderate the growth of medicaid spending;
- (2) ensure future sustainability of the medical assistance program for Nebraska residents;
- (3) establish priorities and ensure flexibility in the allocation of medical assistance benefits; and
- (4) provide alternatives to medicaid eligibility for Nebraska residents."<sup>1</sup>

Neb. Rev. Stat. §68-1091(1) calls for the development of a Medicaid reform plan. Subsection (2) requires that the plan "consider and address

- (a) the needs of low-income, disabled, and aged persons currently receiving medicaid services;

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<sup>1</sup> Neb. Rev. Stat. §68-1090; Laws 2005, LB 709, §4.

- (b) avoiding the shifting of the primary costs of health care services to providers of care;
- (c) the appropriate role of county government in providing health care services;
- (d) the availability and affordability of private health care insurance and long-term care insurance;
- (e) the personal responsibility of persons, who are able, to select and provide for all or a portion of the payment for their health care services;
- (f) the fiscal sustainability of such plan; and
- (g) alternatives to increase federal funding for services in order to reduce dependence on General Funds and maintain or increase the total amount of funding for such services, and the possible utilization of national consultants to assist in the consideration of such alternatives.”<sup>2</sup>

The following guidelines are offered to help evaluate and ensure successful implementation of LB 709 and fulfillment of the foregoing legislative objectives.

1. Conduct a thorough review and critique of current statutes.

LB 709 (2005) calls for fundamental reform of the medical assistance program in Nebraska and a substantive recodification of Nebraska Medicaid statutes.<sup>3</sup>

On July 30, 1965, President Lyndon B. Johnson signed H.R. 6675<sup>4</sup> to create Title XVIII (Medicare)<sup>5</sup> and Title XIX (Medicaid)<sup>6</sup> of the federal Social Security Act. Legislation to establish a medical assistance (Medicaid) program in Nebraska was enacted in 1965.<sup>7</sup> The Nebraska program became effective on July 1, 1966.<sup>8</sup>

Since their original adoption, Nebraska Medicaid statutes<sup>9</sup> have been amended at least forty-six times in twenty-six different legislative sessions.<sup>10</sup> Several other sections of Nebraska state law also refer to the Medicaid program.<sup>11</sup>

<sup>2</sup> Neb. Rev. Stat. §§68-1091; Laws 2005, LB 709, §5.

<sup>3</sup> Neb. Rev. Stat. §§68-1090; Laws 2005, LB 709, §§2, 4.

<sup>4</sup> The Social Security Amendments of 1965, Public Law 89-97.

<sup>5</sup> 42 U.S.C. §§1395 – 1395ccc.

<sup>6</sup> 42 U.S.C. §§1396 – 1396v.

<sup>7</sup> Laws 1965, c. 397, §3, p. 1277 et seq. (LB 937).

<sup>8</sup> Laws 1965, c. 397, §11, p. 1279 (LB 937).

<sup>9</sup> Neb. Rev. Stat. §§68-1018 et seq.

<sup>10</sup> Laws 1967: LB 318, c. 413, §§1-2; LB 621, c. 410, §2; Laws 1969: LB 883, c. 542, § 1; Laws 1979: LB 138; Laws 1981: LB 39; Laws 1982: LB 522; 1983: LB 604; Laws 1984: LB 723, LB 904, LB 1127; Laws 1986: LB 1253, LB 1254; Laws 1988: LB 229, LB 352, LB 419; Laws 1989: LB 362; Laws 1990: LB 1136; Laws 1991: LB 224, LB 830; Laws 1993: LB 798, LB 804, LB 808, LB 816; Laws 1994: LB 1224; Laws 1995: LB 455; Laws 1996: LB 1044, LB 1155; Laws 1997: LB 307; Laws 1998: LB 1063, LB 1073; Laws 1999: LB 548, LB 559, LB 594; Laws 2000: LB 819, LB 892, LB 950, LB 1115; Laws 2001: LB 257, LB 677; Laws 2002: LB 21, LB 1278; Laws 2002 (Second Special Session): LB 8; Laws 2003: LB 411; Laws 2004, LB 1084; Laws 2005: LB 301, LB 709.

<sup>11</sup> Ninety-seven sections of the Nebraska Revised Statutes currently reference “medical assistance” or “medicaid,” in addition to references in Chapter 68, Article 10 generally, and §§ 68-1018 et seq. specifically. Altogether, “medical assistance” or “medicaid” is referenced in 173 separate sections of the Nebraska Revised Statutes.

LB 709 contemplates the introduction of Medicaid reform legislation in 2006.<sup>12</sup> The scope of proposed legislation must yet be determined, an outline prepared, and draft legislation developed for review.

2. Consider the impact of reforms on current eligibles and providers of care.

Many Nebraskans currently receive medical assistance benefits, and many individuals currently provide needed health care services to Medicaid recipients. The uncertainty created by the prospect of Medicaid reform may be of concern to those directly impacted by the program. Real people with real needs will be affected by Medicaid reform, and their needs and concerns must be carefully considered and addressed in any proposed reforms.

3. Formulate a clear and reasonable articulation of public policy, priorities, and the role of government in the provision of publicly funded medical assistance.

Medicaid reform must include the development of a clear and reasonable articulation of Medicaid public policy. To date, the Nebraska Medicaid program has arguably been built upon a series of ad hoc public policy decisions, and not upon a thoughtful and deliberative public policy foundation. Such foundation is necessary to ensure the program's long-term stability and predictability.

4. Establish a clear roadmap to guide future Medicaid decisions.

The Medicaid reform plan required by LB 709 must provide a clear roadmap for future Medicaid decisions that can be reviewed by Nebraskans and fully and fairly debated by members of the Nebraska Legislature, based on a sound and clearly articulated public policy, specific Medicaid-related recommendations, and a coherent recodification of Medicaid statutes.

5. Consider the non-Medicaid health care environment and avoid the isolation of Medicaid.

The Medicaid program involves a balancing of needs and resources. This fact arguably leads to the conclusion that the Medicaid program, or any publicly funded program of medical assistance, cannot, by itself, meet the health care needs of all citizens.

Medicaid reform should also consider the goal, as with welfare reform, of encouraging personal responsibility and the transition from dependence on publicly funded medical assistance benefits, if possible.

Medicaid reform, therefore, should consider and be more closely integrated with

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<sup>12</sup> Neb. Rev. Stat. §68-1094; Laws 2005, LB 709, §8.

the state's non-Medicaid health care environment and the broader spectrum of health care provision in Nebraska. This includes, among other things, the private health care sector generally, private health and long-term care insurance, employer-sponsored insurance, and the role of "safety-net" providers who serve non-Medicaid-eligible and uninsured Nebraskans. LB 709 requires a consideration of alternatives to the receipt of medical assistance benefits,<sup>13</sup> to assist in ensuring access to adequate and affordable health care for all Nebraskans, whether provided through the Medicaid program or not.

#### 6. Challenge past assumptions and practices and demand needed changes.

The passage of LB 709 (2005) has made Medicaid reform a high priority. The interest in Medicaid reform is based on four realities: (a) Human realities (i.e. many people need health care services and can't afford to pay for them); (2) Demographic realities (i.e. more people will need more assistance and require more services in the future); (c) Fiscal realities (i.e. an increased demand for services will have a significant impact on the state budget and the ability of taxpayers to support the provision of such assistance); and (d) Program realities (i.e. the Medicaid program can serve Nebraskans better and still meet necessary budget constraints).

The legislative and executive branches of state government, in LB 709, have said that the status quo is inadequate and unsustainable. Change is required, and must go beyond the traditional and short-sighted approaches of cutting eligibility, cutting services, and cutting reimbursement in order to be successful.

#### 7. Avoid extremes.

Medicaid reform involves a balance between two, arguably unacceptable, extremes: the provision of publicly-funded health care coverage for all citizens on the one hand, or a complete abdication of government's responsibility to provide a program of medical assistance for its citizens on the other. Medicaid reform must be reasonable, balanced, and effective, and should avoid the imposition of "extreme solutions" that could further compromise the program's long-term viability and effectiveness.

#### 8. Address key issues.

The Medicaid program is a complicated interaction of four key elements: (1) Eligibility (who receives medical assistance); (2) Benefits (the nature and scope of assistance received); (3) Reimbursement (the amount paid for providing that assistance); and (4) Administration (the administrative structures and controls in place to implement and monitor the program).

Reform of the Medicaid program and any substantive recodification of Medicaid statutes must consider and address each of these essential components

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<sup>13</sup> Neb. Rev. Stat. §68-1091; Laws 2005, LB 709, §5.

9. Work closely with the federal Centers for Medicare and Medicaid Services (CMS) to implement desired reforms.

Medicaid reform recognizes the essential dependence of the states upon the federal government for approval of desired Medicaid reforms. The importance of this partnership cannot be overstated. All necessary and appropriate steps must be taken to work closely with CMS to ensure the ultimate success of Medicaid reform. The recognition of this dependence also means that Medicaid reform will be an incremental process that requires progressive implementation over time.

**Report on Medicaid Reform Activities**  
Prepared by Richard P. Nelson, Director  
Health and Human Services Finance & Support  
**August 2005**

**Major Components of the Nebraska Medicaid Program**

**Introduction**

This is the second monthly report I have submitted to the Governor and the Health and Human Services Committee as required by LB 709. The July report was entitled The Framework for Nebraska Medicaid Reform.

In this report, I will provide you an update on my activities, and provide you more information regarding two of the major components of the Nebraska Medicaid Program: Long-term care services for the aged and pharmacy services. In the September report, I intend to provide additional information on the following major components of the Nebraska Medicaid Program: services for persons with disabilities, services for children, and services for adults.

**Update of Activities**

The eight subject matter work teams identified in my July report continue meeting, most of them on a weekly basis. We continue to research the components of Nebraska's Medicaid program, including persons served, services provided, and cost of services. We continue researching Medicaid reform ideas in other states and developing potential strategies that may fit Nebraska's particular populations.

We continue soliciting comments and reform proposals from interested persons and organizations. Since the last report, we have made presentations to the Nebraska Association of Behavioral Health Organizations and the Nebraska Health Care Association. We are actively soliciting recommendations from interested persons representing a wide spectrum of views.

The HHSS Medicaid Reform Website has been revised and expanded. It can now be found at [www.hhss.ne.gov/med/reform](http://www.hhss.ne.gov/med/reform). A number of earlier documents have been updated with 2005 information. It also contains a "comments" link that allows people to submit e-mail comments to us. Those comments are referred to our work groups for review and consideration.

Our emphasis continues to be on developing data that can guide policymaking. We also continue considering what data is relevant and how it can best be used. An example of how this can become an issue is found in a recent guest editorial in the Lincoln Journal Star. The author criticized the data prepared by the Governor's budget office that calculated the increases in Medicaid spending over the last 20 years and then projected those increases into the future. The author suggested that this data was "alarming" and

was intended to inspire fear. We agree that the data is alarming, but the purpose was to inform, not frighten. The fact is that the Nebraska's ability to sustain the growth of the Medicaid program is a real issue.

Using a 20-year history is valid, and it does inform. It compares the growth of the Medicaid spending with the growth of state revenues over a long period of time. During that time, there were years of high health care inflation and low health care inflation. There were periods where Nebraska intentionally expanded Medicaid and a time when it intentionally cut Medicaid. It includes periods of economic boom and periods of recession. It includes years of rapidly increasing state general fund revenues and years when revenues actually declined or remained static. No one claims that economic and political history is guaranteed to repeat itself, but history is one of the few tools we have to predict the future.

We can always use longer or shorter time period of experience to predict the future. Each approach has its own strengths and weakness. For example, in the past five years, according to figures from the Governor's Budget Office, Medicaid costs grew at an annual rate of approximately 7%. That is much less than the 20-year growth rate. But during the same 5 fiscal years, state revenues grew at a 3.3% average. Medicaid growth doubled the growth of state revenues. This 5 year period included the first ever 10%+ reduction in Medicaid eligibles, as a result of LB 8. It also included the first ever, short-term boost in federal financial participation to aid the states, which were in economic crisis. So even in the most recent 5-year period, the continued growth of General Fund spending for Medicaid is alarming.

### **Major Components of the Nebraska Medicaid Program**

My previous report contained a great deal of data. The data needs to be understood and analyzed in context. This report and the September report will provide context for an understanding and discussion of several of the major components of the state's Medicaid program.

#### **Long-Term Care Expenditures For the Medicaid Aged Population**

In general, Nebraska's population is older, more rural, poorer, and relies more heavily on nursing facility care, when compared with the nation as a whole. Population demographics, along with the historically greater availability of nursing facility beds compared with home and community-based services, have been factors influencing the pattern of Medicaid spending for long-term care services for the aged population. (Note that the Medicaid "aged" category encompasses all individuals 65 and over, including some individuals who have chronic physical, mental, or developmental disabilities in addition to care needs resulting from the aging process.)

The elderly population of 18,291 average monthly eligibles accounted for 9.2% of the Medicaid caseload and 26.1% of Medicaid expenditures in Fiscal Year 2005. The number of aged

individuals covered by Medicaid has remained relatively flat in recent years [Attachment 1] but this demographic is expected to change dramatically over the next several decades as the Baby Boomer cohort ages. Between 2005 and 2030, Medicaid rolls will be impacted by the projected 75% increase in Nebraska's age 65 and over population. [Attachment 2]

Of the \$365 million in Medicaid expenditures for the aged population in FY 2005, 71% of the dollars were expended for long-term care services – care provided in nursing facilities (NF) and intermediate care facilities for the mentally retarded (ICF/MR) and through alternative “waiver” services provided in home and community-based settings. [Attachment 3] Waiver services are non-medical services that states may be permitted to provide in lieu of traditional medical care to recipients who would otherwise need nursing facility care. Examples are adult day care, chore services, home delivered meals, and care in assisted living facilities. Because waiver services are designed to be a cost-effective alternative to institutionalization, recipients of these services must demonstrate a need for the level of care provided in nursing facilities. Waiver services are not available to Medicaid eligible persons with lesser care needs, even though such persons might benefit. Because home health care is classified as a medical service, it is available to Medicaid eligible persons in their homes even though they do not require the level of care provided in nursing homes.

Nursing facility care has been and continues to be the most typical setting for long-term care but waiver services have been expanded considerably in recent years. In comparison with other states, Nebraska has a proportionately high number of nursing facility beds and nursing facility residents. According to AARP data from 2003, Nebraska ranked sixth among the states in the number of nursing facility beds per 1,000 persons age 65 and over (71 beds per 1,000 elderly persons in Nebraska compared with 49 beds nationally). We also ranked sixth in the number of nursing facility residents as a percentage of the elderly population (5.9 % in Nebraska vs. 4.0% nationally). It is significant that Nebraska's neighboring states also rank high on these measures; nursing facilities have been widely utilized for long-term care service delivery in the Plains State Region.

Because nursing facility care is costly and because many individuals prefer to live as independently as possible, Nebraska undertook efforts in 1997 to develop and utilize alternative types of care in non-institutional settings as a way to slow the growth in Medicaid expenditures and to serve people in less restrictive settings – and significant progress can be documented. About the same time, a change in state law was enacted to require the screening of Medicaid-eligible individuals seeking entry to nursing facilities or nursing facility residents becoming Medicaid-eligible to divert such persons to less-expensive, less-restrictive types of care where appropriate. The Legislature also authorized the expenditure of \$54 million to support the conversion of excess nursing facility space to assisted living accommodations (969 units created), respite care units (14), and adult day care centers (27). Payments for the two lowest acuity levels of nursing facility care were harmonized with the rates paid for assisted living to incentivize the care of lower needs clients in non-institutional settings. HCB waiver slots were expanded to provide broader access to alternative care. [Attachments 4 and 5]

As demonstrated by the following statistics, a shift in Medicaid expenditures for long-term care has occurred. Nursing facilities still represent the majority of long-term care expenditures, but

assisted living and in-home waiver services consume a growing share of dollars. In FY 2000, institutional care in NFs and ICFs/MR consumed 71% of Medicaid spending for elderly clients and waiver services for the same population accounted for 5%; by FY 2005, corresponding figures were 61% for institutional care and 10% for waiver services. Long-term care expenditures in the aggregate declined from 76% to 71% of total dollars during this time period due, in part, to the cost effectiveness of waiver services. [Attachment 6]

Any discussion of Nebraska nursing facilities needs to acknowledge their significance to the rural economy and the state's health care network. [Attachment 7] In many communities, the nursing facility is one of the largest employers and one of the few or the only one employing RNs, LPNs, and trained assistants such as nurse aides and medication aides. In part because of the shift toward HCB services for long-term care, and in part because of the redistribution of the state's population to larger towns and cities, there has been a declining occupancy in many rural facilities. It is difficult to reduce fixed costs in a nursing facility. Fixed cost, the minimum staffing requirements necessary for safety and welfare of the residents, and the declining census result both in some increased per resident cost for the state and in very tight operating margins for the operators. The state grant program described above allowed some facilities to diversify their operations and others diversified independently, but cost pressures on the state and operating pressures on the facilities continue to grow. Additional strategies will need to be devised if the state desires to maintain a statewide network of long-term care services in the rural areas.

## **Medicaid Pharmacy Program Overview**

### Enabling Statutes and Regulations

Coverage of prescribed drugs by Medicaid is optional under Title XIX of the Social Security Act. Enabling regulations are under Title 42 of the Code of Federal Regulations. The Omnibus Budget Reconciliation Act (OBRA) of 1990 was major legislation that created the rebate program and established mandated Drug Use Review (DUR) for states. The state is required to establish a plan approved by the Centers for Medicare and Medicaid Services (CMS) in order to gain federal financial participation (FFP). State regulations for the Pharmacy Program are found under Title 471 of the Nebraska Administrative Code.

### Administration

The program is administered by State staff consisting of two pharmacists and two support staff. Claims from pharmacies for prescribed drugs are processed under contract by Affiliated Computer Services (ACS) using prospective drug use review criteria, established by the State. Adjudicated claims data is provided electronically to HHSS, which pays pharmacies on a weekly basis, the same as other medical providers.

The Nebraska Pharmacist's Association performs retrospective Drug Use Review under contract. Nebraska Medicaid established retrospective DUR in 1983, before it was federally required, and was among the first three states in the nation to do so.

#### Expenditures, People Served, Rebates

Between State Fiscal Year 2000 and 2005, gross expenditures increased from \$128 million to \$241 million. [Attachment 8] The average number of persons served per month increased from 69,233 to 83,916. [Attachment 9] Rebates from manufacturers increased from \$20.1 million to \$57.1 million. [Attachment 10].

### **Program Management**

#### Drug Use Review

Prospective, point-of-sale, drug use review is a key component of program management, providing real time, instant feedback to dispensing pharmacists about client eligibility, drug coverage and other information related to edits established to assure compliance with program requirements.

Retrospective DUR and drug class reviews for prior authorization criteria are performed by the Nebraska Pharmacists Association. DUR reviews drug use by drug class, prescriber or dispenser to detect patterns targeted for intervention. Public meetings are held by the DUR Board to receive input into the establishment of criteria for prior authorization of certain drug classes. The recommended criteria are provided to the Department, which then adopts and implements them.

#### Prior Authorization

Prior authorization is a primary tool Nebraska uses to control and manage drug use of certain classes of drugs. Targeted classes of drugs are those with potential for abuse or overuse, high expenditure or high growth. Some states have made significant investments with organizations that are reviewing classes of drugs, such as the proton pump inhibitors (e.g. Nexium) or lower sedating anti-histamines to find which is the best drug within the class. Those studies are consistently finding NO significant difference within the classes studied. Prior authorization of all drugs within these classes can safely control cost and utilization until a drug within the class becomes available as a generic or over-the-counter at a much lower price.

The most dramatic impact of Nebraska's prior authorization may be demonstrated by that on the antihistamine and gastrointestinal drugs [Attachment 11]. In 2002, these two classes of drugs were rapidly escalating in growth and cost. After implementation of prior authorization, growth was not only slowed but costs have actually declined significantly. This success is due to availability of other similarly effective drugs at lower cost and the market availability of generic or over-the-counter versions of the

original “bench mark” drugs in each class (loratadine or Claritin® for the antihistamine group and Prilosec OTC® for the gastrointestinal drugs).

Human growth hormone and Synagis® are examples of two very high cost drugs which have potential for inappropriate use or overuse and are managed under prior authorization. Treatment with either drug can easily approach \$10,000/patient/year. Because the prior authorization requirement for these drugs has been in place for several years, providers are familiar with the coverage guidelines. We believe that results in fewer requests, but with a higher likelihood of approval. This is sometimes called the “sentinel effect”. This effect makes savings calculations difficult.

### Generic Drugs

Other cost control initiatives include an aggressive generic drugs program called the State Maximum Allowable Cost or SMAC. The SMAC program requires that the generic version of over 1,000 products be dispensed rather than the brand name drug, unless the prescriber determines that the brand name is medically necessary. The prescriber certifies that medical necessity by signing a form [Attachment 12]. These 1,000 products represent over 88,000 individual products and package sizes and an average discount off average wholesale price of nearly 60%. The average price of a brand name prescription covered by Medicaid in August of 2004 was \$98.32; the average price of a covered generic prescription was \$15.90.

Prescribers and pharmacies have been very cooperative with this program. The requirement that the prescriber sign the MC-6 attesting to the medical necessity has resulted in limited, but medically necessary overrides for most drugs. The Department has departed from this policy for only one class of drugs—the Cox-I non-steroidal anti-inflammatory drugs—and changed to specific prior authorization criteria. That change was primarily in response to marketing tactics for one product, by one manufacturer.

Savings from the SMAC program are in the 6.5 to 13% of the prescription program total cost. That range of savings is based on the difference between what is actually paid for these drugs and what would have been paid, based on the other 3 ways of determining those allowables. Those other 3 ways are the pharmacy’s usual and customary charge, the pharmacy’s submitted charge and the department’s pricing formula of average wholesale price minus 11%. Using the most conservative figure of 6.5% shows a savings in FY 2005 of over \$13 million.

### Pricing

The formula for calculating the drug cost portion of Medicaid allowables was changed to average wholesale price (AWP) minus 11% from minus 10% during 2002. AWP is determined by each manufacturer. First Data Bank, in San Bruno, California is one or two national companies that receives this pricing information from all manufacturers and provides it, under contract to ACS, our claims processor, who uses that information to do drug cost calculation.

Patient copays were also increased from \$1.00 to \$2.00 per prescription during that same year.

Each of those changes was projected to lower expenditures by about \$1 million/year.

In addition to the cost of the drug, Medicaid has established a dispensing fee for each Pharmacy that participates. Those fees range for \$3.25 to \$5.05 per \_\_\_\_?. We intend to conduct a survey of all participating pharmacies in the near future to determine whether these dispensing fees continue to be appropriate.

Medicaid uses the drug pricing (the lower of awp-11% or SMAC) plus the assigned dispensing fee to calculate the upper limit that could be paid for a prescription. The Pharmacy is also required to submit their usual and customary charge as well as a submitted charge for each prescription. Medicaid payment is determined to be the lowest of the calculated amount, the usual and customary charge or the submitted charge.

#### Third Party Liability/Cost Avoidance

Pharmacies are now required to bill other insurers providing drug coverage prior to billing Medicaid. This change was implemented in 2003. Prior to that Medicaid paid the prescription claim and billed the insurer.

From November of 2003 through August 2004 this resulted in cost-avoidance averaging \$775,000/month with additional recoveries, from pay-and-chase of \$175,000/month for a total of \$950,000/month. Prior to implementing cost-avoidance, recoveries averaged \$435,000/month.

#### Tablet Splitting

Tablet splitting of certain products that are priced virtually the same for more than one strength and for which studies have been conducted by Stanford University or other independent researchers to assure quality, was implemented in 2002.

As an example, Zoloft 50mg and 100mg tablets were priced at about \$2/tablet when this program was implemented. By requiring that the prescriptions for the 50mg dose be filled with 100mg tablets and by having the pharmacist (or patient) split the tablets, first year savings exceeded \$400,000. Those savings were after paying additional dispensing fees to the Pharmacy when their staff split the tablets for the patient.

Since then, several other products have been added to the list with projected net savings of well over \$1 million/year. Because of the careful selection of products and the cooperation from prescribers and the pharmacies, quality of care has been maintained and there have been no complaints.

#### Medicare Prescription Drug Benefit

The Medicare Prescription Drug benefit, or Medicare Part D, will require that all persons eligible for Medicare and Medicaid (dual eligibles) now receiving their drug benefits through Medicaid must receive their drug benefit from a Medicare Part D Plan effective January 1, 2006.

This will result in about a 50% drop in the number of claims processed and the Medicaid expenditures for drugs [Attachment 13]. It will also change the mix of drugs provided by Medicaid. [Attachments 14 and 15]

At the same time Nebraska, and all other states, will be required to pay into the Medicare trust fund an amount called the “clawback” or MMA phase down on each dual eligible, based on calendar year 2003 expenditures. It is estimated to take five years before Nebraska will realize net savings from this change.

Medicaid will continue to provide coverage of drugs excluded from the Medicare benefit that are currently covered for dual and other Medicaid eligibles after January 1, 2006. Examples of these excluded drugs are benzodiazepines (e.g., Xanax), barbiturates (e.g., phenobarbital), over-the-counter drugs (e.g. acetaminophen) and cough and cold preparations.

#### Formularies, Preferred Drug Lists and Prior Authorization

There are three ways of controlling drug costs that are widely used: a formulary, a preferred drug list (PDL), and prior authorization. Medicaid may use any of the three. A Medicaid formulary or PDL, however, must provide an exception process so a patient may obtain any medically necessary drug by prior authorization.

A formulary is a list of covered drugs. Many private insurance plans have formularies in place, as do many hospitals, so the use of formularies is familiar to medical professionals. Formularies are used to allow the payor to select the drugs it will cover based on the price it can negotiate from manufacturers, including rebates.

A preferred drug list (PDL) may be best described as a refinement of a formulary in that it not only lists the covered drugs, but also lists which drugs are those that are “preferred”. The preference may be based on lower cost sharing by the patient, such as a lower or no co-payment. Preferred drugs are generally granted that status by the payor, based on the payment of rebates from the manufacturer. Some drugs may be in a preferred status because of a better side effect profile or enhanced therapeutic effectiveness.

Prior authorization is a process used to manage drug utilization by requiring that certain conditions be met before payment will be made for the drug. Nebraska Medicaid uses targeted prior authorization.

Use of formularies and PDL's must be approached cautiously. The early reports of savings from Kansas and other states were very small from their Preferred Drug List operations. Information published by Michigan indicated that they were saving 3% of their drug budget by use of the Preferred Drug list. Our numbers, just from prior approval of the three or four main classes, are more in the \$16 million range or 6-10% of budget.

Patients, prescribers, and pharmacies are significantly impacted by formularies because of their restricted choices. Nebraska's system of targeted prior authorization is less restrictive and has worked well, with a minimum of inconveniences.

There also is concern that formularies and PDL's are more susceptible to influence from pharmaceutical manufacturers' highly funded advertising campaigns. Drugs placed on the formulary or PDL because of pricing and rebates may more easily be overused. Prior authorization, based on clear criteria, may control utilization more effectively.

#### Average Sales Price Proposal

Most states, including Nebraska, pay for brand name drugs based on a percentage off of Average Wholesale Price (AWP). The use of AWP has been soundly criticized and most observers agree that AWP is not a reliable measure. The challenge is to find another method to replace it.

Currently Congress is considering a proposal to base pricing on Average Sale Price (ASP) + 6%. This method was recently introduced on a limited basis as the method Medicare uses to pay for drugs dispensed in physician offices. The details of how ASP would be calculated for the full range of drugs paid for by Medicaid has not been disclosed publicly. Therefore, it is impossible to evaluate the appropriateness of the proposal at this time. Rural states, particularly, where all Medicaid recipients do not have access to chain pharmacies that can purchase at large volume prices, are concerned about the impact on the pharmacy network that now relies on many smaller, independent pharmacies. The issue of how dispensing fees for rural pharmacies will be determined and reimbursed becomes even more important under an ASP formula.

We do not know whether, or when, Congress may change the payment methodology to ASP. We are continuing to monitor those developments. When the details become known, we can reevaluate the effectiveness of formularies, PDL's, prior authorization, and SMAC, in controlling costs and serving Medicaid eligible persons.