



**PHARMACY BEST PRACTICES
AND
COST CONTROL REPORT
2009**

**Office of Vermont Health Access
Vermont Agency of Human Services**

Report Facts and Figures from State Fiscal Year (SFY) 2008

- A total of 2,227,758 pharmacy drug claims were paid for all of Vermont's publicly funded pharmacy programs.
- Gross spending was \$112,406,224.
- The rate of generic dispensing; that is, the use of generics as a percentage of all drugs dispensed, was 65.25%.
- The overall generic substitution rate when a generic equivalent was available was 98.00%.
- Federal rebates totaled \$30,496,900.
- Supplemental rebates collections were \$5,318,443.
- Net of rebates, the program spend was .49% less in SFY 2008 than in SFY 2007.

Overview

Pharmacy is the second highest spending item in OVHA's benefit programs. In SFY 2008, the gross spending of \$112,406,224 was second only to nursing home care, which was \$115,642,835.

Vermont's publicly funded health insurance programs covered an average of 142,526 beneficiaries monthly in SFY 2008.

Some of these programs include full health insurance coverage. All of them included a pharmacy benefit in SFY 2008. These programs are:

- Programs for Adults:
 - Traditional Medicaid
 - Vermont Health Access Plan
 - Employer Sponsored Insurance Assistance (ESIA)
- Programs for Children:
 - Traditional Medicaid
 - Dr. Dynasaur
- Pharmacy Only Benefits:
 - Pharmacy Benefit
 - VHAP-Pharmacy
 - VScript
 - VScript Expanded
 - Medicare Part D Wrap Benefit
 - VPharm
 - Discount Benefit
 - Healthy Vermonters

Critical Issues

The goals of the Vermont Health Access Pharmacy Benefit Management (PBM) Program are:

- To assure the availability of clinically appropriate services and
- To do so at the most reasonable cost possible.

At stake is preserving the benefit that has evolved in Vermont's programs to the greatest extent possible.

Vermont Strategies in Pharmacy Benefits Management

The Vermont pharmacy best practices and cost control program was authorized in 2000 and established in SFY 2002 by Act 127. This program, as the Vermont Health Access Pharmacy Benefits Management (PBM) Program, is administered by the OVHA. Operational strategies include:

- Partnering with a vendor with skills and expertise in pharmacy benefit administration
- Managing and processing claims
- Managing benefit design
- Monitoring and managing utilization
- Procuring supplemental rebates on drugs used
- Managing reimbursement
- Responding to change

Pharmacy Benefit Administration

Pharmacy benefit administration (PBA) services support the program in the following areas:

- Claims operations
- Benefit management
- Utilization review and management
- Rebate management
- Analysis and reporting

The OVHA contracts with MedMetrics Health Partners of Worcester, Massachusetts as the Pharmacy Benefits Administrator (PBA) for Vermont's programs. MedMetrics is a non-profit, full-service pharmacy benefit manager, wholly owned by Public Sector Partners (PSP) and affiliated with the University of Massachusetts Medical School and the University of Massachusetts Memorial Medical Center. MedMetrics was selected as OVHA's PBA contractor through a competitive bid process in 2005. The contract was

for three years with an option to extend for two additional years. OVHA chose that option in 2008. Thus, the PBA contract will be rebid in 2010.

Managing and Processing Claims

Claims processing activities include accepting drug claims according to the rules of coverage under Vermont programs; providing the mechanisms to support the application of the generic and alternative drug requirements authorized by Title 18, Chapter 91 of the Vermont Statutes; transmitting program requirement messages to pharmacies as drugs are dispensed and claims are processed (e.g., eligibility verification, federal/state drug rebate requirements, coverage limitations, prior authorization needs, prospective and retrospective drug utilization review (DUR) issues, etc.); and authorizing payments according to the reimbursement rules. Claims are submitted by pharmacies enrolled to provide benefits in Vermont's programs. As of December 2008, 224 pharmacies were enrolled and processing claims.

The maximum reimbursement is established on a per claim basis at the individual drug level in all cases but VPharm. In SFY 2008 the amount was the lesser of:

- Average wholesale price (AWP) less 11.9% plus a dispensing fee,
- The Centers for Medicaid and Medicare Services established Federal Upper Limit (FUL) plus a dispensing fee,
- The MedMetrics managed Vermont Maximum Allowable Cost (MAC) amount plus a dispensing fee, or
- The pharmacy's usual and customary/submitted fee including a dispensing fee.

The beneficiary pays the rate established with this methodology in the Healthy Vermonters Program. For the programs other than VPharm, Vermont pays the difference between the rate set and any other insurance payment.

VPharm provides a wrap benefit to Medicare Part D coverage for drugs for those beneficiaries who prior to the implementation of Part D received their primary coverage through Medicaid, VHAP-Pharmacy, VScript, and VScript Expanded.

Under VPharm, Medicaid beneficiaries receive Vermont coverage for Medicaid covered drugs in classes excluded from Medicare coverage.

Others beneficiaries are limited to drugs that would be covered under Vermont primary coverage; that is, VPharm1, VPharm2, and VPharm3 beneficiaries receive coverage for the drugs covered in the comparative primary program (VHAP-Pharmacy (VPharm1), VScript (VPharm2), and VScript Expanded (VPharm3)). This coverage is in the form of the Part D Prescription Drug Plan (PDP) cost-sharing including deductibles, coinsurance, copayments, and coverage in the "donut hole", which is the period in a coverage year when there is a lapse in Part D coverage. These VPharm beneficiaries

also are eligible for drugs covered under VHAP-Pharmacy, VScript, and VScript Expanded respectively that are in classes excluded from Medicare coverage. Details are outlined below.

In SFY 2008, a total of 2,227,758 drug claims were paid for all of Vermont's publicly funded pharmacy programs.

Managing Benefit Design

General Design

Benefit management activities occur in all programs for all beneficiaries. Fundamental to understanding the difference in benefits is identifying the individual drug classes covered in the specific programs:

- Medicaid, Dr. Dynasaur, VHAP (including VHAP-ESIA), and VHAP-Pharmacy: All drugs for which a rebate is paid to the federal Medicaid program. Limitations may apply.
- VScript: All maintenance drugs for which a rebate is paid to the federal Medicaid program. Limitations may apply.
- VScript Expanded: All maintenance drugs for which a rebate is paid to the State of Vermont. Limitations may apply.
- Healthy Vermonters Program: All Medicaid covered drugs.
- VPharm:
 - Coverage for Medicaid drugs in classes excluded from Medicare coverage (Medicaid).
 - Cost sharing to Medicare Part D coverage and coverage for drugs in classes excluded from Medicare coverage; both limited to Medicaid covered drugs (VPharm1).
 - Cost sharing to Medicare Part D coverage and coverage for drugs in classes excluded from Medicare coverage; both limited to VScript maintenance drugs (VPharm2).
 - Cost sharing to Medicare Part D coverage and coverage for drugs in classes excluded from Medicare coverage; both limited to VScript Expanded maintenance drugs for which a rebate is paid to the State of Vermont for VScript Expanded (VPharm3).
- Employer Sponsored Insurance Assistance Chronic Care Wrap Program for beneficiaries not eligible for VHAP: Employer sponsored insurance cost sharing for Medicaid covered drugs used to treat the following chronic health conditions: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure (CRF), Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain.

Preferred Drug List (PDL)

When limitations apply for Medicaid, Dr. Dynasaur, VHAP (including VHAP-ESIA), and VHAP-Pharmacy and for VScript maintenance coverage, the OVHA PBM Program utilizes a Preferred Drug List (PDL). The PDL is a key feature in the program. The PDL identifies drugs in which specific clinical criteria has to be met in order for them to be covered. It also identifies drugs that are clinically effective, but less costly. If a drug is not listed as "preferred" in a particular category on the PDL, it requires Prior Authorization in order for the drug to be covered.

The PDL has been developed with the help of the Vermont Medicaid Drug Utilization Review (DUR) Board acting as the Program's Pharmacy and Therapeutics (P&T) Committee. In 2008 the Board membership included six Vermont doctors and four pharmacists.

The PDL features clinically appropriate, low-cost options including:

- OTCs as prescribed by physicians
 - For Medicaid, VHAP and VHAP Pharmacy - without restriction and
 - For VScript, VScript Expanded and VHAP Limited - limited to loratadine (generic Claritin[®] and the like); omeprazole (generic Prilosec OTC[®] and the like); non-steroid anti-inflammatory drugs; and cetirizine (generic Zyrtec[®] and the like). VHAP Limited also covers smoking cessation products.
- generics;
- lower-cost brands;
- brands where manufacturers pay a level of federal Medicaid rebates that makes the net cost of the drug comparative to other products in the drug's therapeutic class; and
- brands where manufacturers pay Vermont rebates supplemental to required federal Medicaid rebates to make their products more affordable.

In March 2002, the first iteration of the PDL was completed with PA required for any drug not identified as "Preferred" in designated PDL classes. Throughout 2002, additional classes were systematically implemented. By 2003, the foundation of the PDL was established. Since that time, the PDL has been modified to reflect changes in clinical approaches, prescribing practices, product availability, and supplemental rebate opportunities. Since January 1, 2006, the PDL has been expanded by almost 60%, from 79 drug classes to over 140 drug classes today. Automated step-therapy protocols and over 100 new product-specific dispensing limits have also been instituted. It is estimated that since January 2006 this has resulted in over \$25 million in cost avoidance.

Management of Mental Health Drugs

In 2002, when the Vermont Health Access Pharmacy Benefit Management Program's PDL was implemented, drugs used to treat severe and persistent mental illness (SPMI) were exempt from management. All other major cost categories of drug treatment were subject to management. In SFY '05, 31.7% of the total drug spending was for mental health drugs. In 2005, Act 71 approved the management of mental health drugs subject to the review of the DUR Board.

In the summer of 2005 the DUR Board agreed that mental health drug classes could be managed through the Preferred Drug List (PDL). The proposed PDL changes identified the most cost-effective clinically appropriate drugs in specified classes. These drugs included generic equivalents and alternatives as well as other low-cost alternatives. More expensive alternatives were made available with prior authorization using criteria developed through literature review of acceptable evidence-based standards, including the Texas Implementation of Medication Algorithms (TIMA), the International Psychopharmacology Algorithm Project (IPAP), class reviews from the Oregon Evidence Based Practice Center, the Veterans' Administration, and the Micromedex[®] Health Series.

At the time, the Board recommended that certain beneficiaries' active treatment be "grandfathered" so as not to risk destabilization. For that it was decided that patients of all ages, using antipsychotics, antidepressants, and/or mood stabilizers would continue to use existing drug therapies. For drugs without generic equivalents, lapses in treatment of four months or longer or changes in treatment would result in the application of the PDL and its clinical criteria. For drugs with generic equivalents, grandfathering would continue for four months to allow prescribers to transition patients to the generic option. The PDL and the criteria would apply to all new patients.

A report on the review and the DUR Board's deliberations was submitted to the Legislature's Health Access Oversight Committee (HAOC) for comment on September 1, 2005. The Committee heard testimony from prescribers and advocates and recommended that Central Nervous System (CNS) Agents used to treat ADHD be included in the "grandfathering" provisions. This recommendation was approved at the DUR Board meeting in September 2005.

A claims processing implementation plan was developed, provided to the DUR Board, and further reviewed with the DUR Board's psychiatrist member and with the Medical Director of the Division of Mental Health at the Department of Health.

Following provider notification, the plan was implemented in January 2006. MedMetrics claims processing system's pharmacy claims history was used wherever possible to determine if the criteria had been met to minimize the impact on prescribers who would otherwise have to request a prior authorization.

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With the implementation of Medicare Part D in January 2006 many beneficiaries transitioned to Part D coverage. With Part D implementation problems, patient care was at risk and provider services were under considerable pressure. As a result, the plan to limit grandfathering on drugs with generic equivalents to four months was not enacted immediately. On August 16, 2006, the OVHA sent a letter to prescribers notifying them that this provision would be effective October 1, 2006.

In 2007 it was reported that the transition to managing the mental health drug classes appeared to cause little disruption to patient care. That situation continued in 2008. Indications are that new patients or patients with a lapse in therapy of four months or more attempt therapy with preferred drugs. Between January 2006 and November 2008, prior authorization requests for non-preferred mental health drugs dropped by 62.45%.

Mental Health Drug Prior Authorization Requests - January 2006, November 2006, November 2007, and November 2008				
	January 2006	November 2006	November 2007	November 2008
Anti-depressants - Novel	231	197	164	128
Anti-depressants - SSRI	300	236	98	85
Anti-depressants - Tricyclics	0	1	0	0
Anti-psychotics - Atypical & Combinations	159	59	54	69
Anti-psychotics - Typical	0	0	0	0
CNS Stimulants	16	34	22	12
Anti-Hyperkinesis - ADHD, ADD, Narcolepsy	86	101	94	65
Sedative Hypnotics - Benzodiazepines	6	0	1	3
Sedative Hypnotics - Non- Benzodiazepines	212	98	25	18
Anti-Anxiety - General	10	28	12	3
Totals	1,020	754	470	383
Cumulative percentage reduction since January 2006		-26.08%	-53.92%	-62.45%
Annual percentage reduction (since previous November)			-37.67%	-18.51%

From a funding perspective, it is clear that continued mental health management is necessary. Drug spending for mental illness treatment continues to be a significant. In SFY'05, the top twenty drug classes in terms of spending included seven specific classes identified for the treatment of SPMI. Those seven classes represented 28.1% of the total drug spending in that year. The percentage of total spending by those same classes was 29.3% in SFY '07 and 29.5% in SFY '08.

In 2008 individuals in the community involved with mental health issues expressed their concerns about the use of mental health drugs, particularly with children. The Department of Mental Health has formed a workgroup of stakeholders to determine the

questions the system of care should be asking about usage patterns and potential policy statements on the use of psychotropic medications for Vermont's children and youth with significant mental health concerns. OVHA representatives are and will continue to be members of this workgroup in its deliberations.

Specialty Pharmacy Services

In 2005, the Administration proposed to allow the PBM Program to require the purchase of selected pharmacy products using mail order options. The intention was to assure that when beneficiaries received drug treatments for complex medical conditions that those treatments were obtained in the most economical way possible and that the patients had the opportunity to obtain the best health outcomes through the availability of disease and case management services to assure optimal results from product use. The Legislature approved this requirement with the addition of V.S.A. 33 §1998a. This allowed the use of the mail order services of specialty pharmacies.

In 2007 the OVHA sought bids from specialty pharmacies to provide this additional tool in chronic care management. This serves as a resource in the treatment of complex conditions which do not require the level of support of those addressed in the OVHA Chronic Care Initiative.

Targeted were services for the treatment of such conditions as hemophilia, growth hormone deficiency, multiple sclerosis, and respiratory syncytial virus (RSV) (a condition that is the leading cause of pneumonia and bronchitis in infants). Additional potential conditions identified included hepatitis, cystic fibrosis, cancer, and deep vein thrombosis. It was stated that additional treatments might be identified over time.

In 2008, two specialty pharmacies were selected to serve Medicaid beneficiaries: Wilcox Medical dba Wilcox Home Infusion and ICORE Healthcare, LLC, partnering with our pharmacy benefits administrator, MedMetrics Health Partners. Wilcox Medical is the specialty pharmacy for respiratory syncytial virus (RSV) and ICORE Healthcare/MedMetrics is the specialty pharmacy for all other conditions. Dispensing of identified specialty medications is limited to these pharmacies for Medicaid beneficiaries where Medicaid is the primary insurer.

Both providers were selected based on a combination of the quality and the value of the services they offered and the price of the products involved. Operating in Rutland, Wilcox Medical represents the pharmacy that served the majority of Medicaid RSV patients in the last two RSV seasons. They came with local clinical recommendations including the physician who has been the primary prescriber for most Medicaid RSV patients. In addition, this physician is the Medical Director of the Neonatal Medical Follow-up Clinic at Fletcher Allen Health Care. MedMetrics Health Partners of Worcester, Massachusetts has been OVHA's pharmacy benefit administrator for the last three years. ICORE is their specialty pharmacy partner and is located in Plantation,

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Florida. ICORE is a wholly owned subsidiary of Magellan Health Services, Inc. and provides specialty pharmacy services for 35 managed care contracts covering 60 million subscribers. The partnership of MedMetrics and ICORE assures the coordination of our pharmacy benefit management initiatives with our specialty pharmacy approach.

As of October 1, 2008 Wilcox Medical began providing services for Synagis[®], the drug used to prevent respiratory syncytial virus (RSV). As of November 3, 2008 ICORE Healthcare, LLC, with MedMetrics Health Partners, began providing services for other select specialty drugs. These include, but are not limited to, hemophilia factors, growth hormones, multiple sclerosis self-injectables, hepatitis C (ribavirin and injectables) treatments, and Elaprase[®] (for Hunter's Syndrome).

The estimated annual gross savings for specialty pharmacy is \$ 328,000 broken down as follows:

- Hemophilia drugs: \$100,000
- Hepatitis drugs: \$110,000
- Multiple sclerosis drugs: \$ 50,000
- Growth Hormones: \$ 35,000
- RSV prevention: \$ 33,000

Diabetic Testing Supplies

Diabetic testing supplies are a specialty need. In 2005, when the Administration proposed managing specialty pharmacy services, they were identified as a target area. However, the use of such supplies generally does not require any specialty disease management services. As a result, the OVHA opted to address this by limiting the product choices available in local pharmacies while seeking rebates from preferred manufacturers, rather than using a specialty pharmacy service.

This initiative began with a partnership between the states of Maine, Utah, North Dakota, and Vermont. Diabetic supply manufacturers were approached in the summer of 2007 and offered preferred status for their products in exchange for rebates against states' utilization in their Medicaid programs.

Abbott and Lifescan were the manufacturer lines chosen by Vermont because all product needs could be met. These products were most commonly used by Vermont program beneficiaries. In addition, there was be no cost to pharmacies, patients, or the Vermont programs for the transition. For patients who had to change to Abbott or Lifescan products, coupons were provided to pay pharmacies for the manufacturer-specific glucometers required in conjunction with the products.

This approach was reviewed and unanimously approved by the DUR Board for an implementation in February 2008.

Rebate amounts received against the first two calendar quarters of 2008 were \$397,669. It is estimated that annualized savings will be greater than \$700,000.

Physician-Administered Drugs

Historically, drugs administered in physician offices have often been billed with other physician services. As such they have not been managed in the same manner as drug dispensed in pharmacies where in the course of claims processing the pharmacy receives messages regarding coverage requirements and conditions. Managing physician-administered drugs promotes consistency in administering the PBM Program's clinical criteria for drug coverage.

In SFY 2007, the OVHA began reviewing physician-administered drugs to identify where and how management techniques should apply. Since then drugs have been identified that are limited to dispensing through pharmacies where prior authorization requirements and utilization review conditions can apply prior to dispensing. Other drugs that must be available in physician offices are subject to prior authorization to assure that established clinical criteria apply. In the process, mechanisms have been established to facilitate the process for the offices. Evaluating physician-administered drugs for clinical management is an ongoing project and will continue in SFY 2009.

Compound Drugs

Compound drugs are produced by a pharmacist combining individual ingredients. Generally insurers cover a compound drug when the prescription is determined to be medically necessary, there is no equivalent manufactured alternative available, and its ingredients meet coverage criteria including program rebate requirements. Prior to 2006, the OVHA's pharmacy claims processing systems were unable to accept the report of individual ingredients. Beginning January 2006 and throughout state fiscal year 2007 the OVHA worked with compounding pharmacists to develop an approach to account and claim reimbursement for compound drugs that assures that they are managed under the PBM Program. The claims processing system now requires that all rebateable ingredients be identified on the claim and only those ingredients that meet coverage criteria are paid. Types of drugs that previously were compounded have since been reviewed by the DUR Board to determine if coverage should require prior authorization. Guidelines for the coverage of compounded products are now described in the Clinical Criteria Manual of the Preferred Drug List.

Formulation/Combination Conditions for Non-Managed Products

Increasingly, products become available as combinations/formulations of products/ingredients that are otherwise readily available in the market. Generally, the resulting item is more costly than its parts and has little, if any, additional value; for

example, the packaging of an ointment or cream with applicators or the combination of ingredients with vitamins. In 2006, the DUR Board approved the establishment of a category in the PDL where products not otherwise in managed classes are identified as requiring prior authorization because the combination/formulation is not the preferred approach, clinically or economically. This category continues to be reviewed routinely.

Dose Consolidation Opportunities

The DUR Board continues to review for opportunities to consolidate dosages to save money when clinically possible. Considerations are the pill burden for patients, the complexity of drug regimens, and the impact on patient adherence to therapy. Reviews occur as classes are reviewed.

Educating Health Care Providers

The Vermont Health Access PBM Program continues to face the challenge of counteracting the influence of manufacturers' national and local marketing and advertising. The Office of the Vermont Attorney General has estimated that \$3.11 million was spent on marketing in Vermont in SFY 2004; another \$2.17 million in SFY 2005; \$2.25 million in SFY 2006; and \$3.13 million in SFY 2007. With a 33% increase in 2007 over 2006, the pressure is clearly significant.

The PBM Program relies on the Drug Utilization Review (DUR) Board for advice on how to best educate providers and address the impact of pharmacy manufacturers advertising, in particular. The DUR Board meets as often as monthly. In calendar year 2008 the Board met eight times. In these meetings counter-detailing opportunities are considered.

In the course of DUR activities, the DUR Board may select certain drugs to target for review in order to ensure that clinical criteria and prescribing patterns are appropriate. Staff makes recommendations for targeted areas and the Board selects those most relevant. When this occurs, OVHA relies on MedMetrics to access clinical researchers from the University of Massachusetts' School of Medicine. Specific providers may be polled regarding the patients affected, and the Board reviews their responses. The Board then determines if follow-up is appropriate either with the identified prescribers or with a clinical advisory to all providers.

In the event a preferred drug is changed to a non-preferred status and specific beneficiaries are affected, prescribers are provided with two tools as recommended by the DUR Board. One is a list of all the patients who were prescribed the specific drug that is being changed. The second is a profile unique to each patient with the drug change listed. This creates a record for use in the patient's file.

To educate providers on general PBM Program coverage activities, various methods are used. Most frequently mailings are prepared around both general and specific changes and they are targeted to prescribers and pharmacies separately. Examples include clinical advisories and alerts. These mailings are also sent electronically to provider affiliates and representatives so that these organizations can use their proprietary methods to distribute the materials. Examples of these organizations include the Vermont Medical Society and the Vermont Pharmacists Association. The OVHA and MedMetrics have also begun to publish a periodic pharmacy bulletin to provide timely updates on claims processing and clinical issues.

Providers may find all general pharmacy benefit management materials posted on the OVHA webpage at ovha.vermont.gov/. These materials include the description of the PBM Program; DUR Board information; the Preferred Drug List and Criteria; prior authorization information and forms; bulletins and mailings; and other information, instructions, and alerts.

Monitoring and Managing Utilization

Generic Utilization

Vermont's alternative drug selection law described at 18 V.S.A chapter 91 requires pharmacies to dispense the lowest priced drug which is chemically and therapeutically equivalent, unless the prescriber expressly requires the brand. The Vermont Health Access PBM Program with the support of the DUR Board heavily promotes the use of generics and low cost alternatives in general and directly through identified classes in the PDL.

Generic dispensing rates can be expressed in a variety of ways. The "generic dispensing rate" is a term used to refer to the number of prescriptions dispensed using generic medications as a percentage of all prescriptions dispensed. Not all drugs have generic equivalents available. The "generic substitution rate" is a term used to refer to the number of prescriptions that are dispensed with a generic medication when an equivalent generic version of the drug is available. Generic versions of medications are only available when a brand (that is, innovator) medication has lost patent protection. In general, generic dispensing reflects the extent to which generics are used in a program, while generic substitution represents both the prescribing instructions of the physicians and other prescribers and the dispensing practices of the pharmacies.

The generic dispensing rate for the covered populations in Vermont's programs has increased with the efforts of both Vermont's programs and Medicare Part D Pharmacy Drug Plans to promote generics and the number of generics that have reached the market.

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For the fourth quarter of calendar year 2005, the last quarter prior to Medicare Part D implementation, the generic dispensing rate on all claims was 61.37%. In the first quarter of calendar year 2006, utilization measurement for Part D and non-Part D beneficiaries was difficult with the Part D problems and Vermont temporarily reinstating Vermont program coverage for Part D eligibles. However, for the quarter ending June 30, 2006, with those with Medicare coverage re-transitioned to Part D, the non-Part D rate was 61.47%. In a study of July and August 2006, a point at which Part D transition was effectively complete, the non-Part D rate was 62.4%

In December 2005, the overall generic substitution rate for all generic claims when a generic equivalent was available was 97.7%. That was exactly the rate for non-Part D beneficiaries as of July and August 2006.

For state fiscal years 2007 and 2008, rates were established for both Part D and non-Part D beneficiaries. The following chart identifies the results:

SFY 2007	Percentage of non-Part D Rx	Percentage of Part D Rx	Percentage of All Rx
Generic use as a percentage of all drugs dispensed	62.54%	65.36%	63.95%
Generic use when generic equivalent available	97.95%	97.18%	97.57%

SFY 2008	Percentage of non-Part	Percentage of Part D Rx	Percentage of All Rx
Generic use as a percentage of all drugs dispensed	62.99%	69.86%	65.25%
Generic use when generic equivalent available	98.39%	97.30%	98.00%

Prior Authorization Requirements

Through prior authorizations prescribers can access any non-preferred drug on the PDL. Under the Vermont Health Access PBM Program, criteria are available for these exceptions. MedMetrics' clinical pharmacists manage the criteria. Criteria have been and continue to be developed as classes are selected for management. They are then reviewed annually. New criteria and proposed changes are reviewed, modified, and approved by the DUR Board acting as the Vermont Health Access PBM Program's Pharmacy and Therapeutics Committee.

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The following chart reports the incidence of prior authorization requests in SFY 2007:

	Number of Prior Authorization Requests	Number of Prior Authorizations Approvals	Number of Prior Authorization Changes	Number of Prior Authorizations Denials
July 2006	1,456	1,128	122	206
August 2006	1,580	1,242	127	211
September 2006	1,649	1,246	140	263
Q1 Totals	4,685	3,616	389	680
October 2006	1,663	1,244	128	291
November 2006	1,683	1,294	91	298
December 2006	1,384	1,100	99	185
Q2 Totals	4,730	3,638	318	774
January 2007	1,635	1,312	119	204
February 2007	1,318	1,024	97	197
March 2007	1,451	1,093	112	246
Q3 Total	4,404	3,429	328	647
April 2007	1386	1066	85	235
May 2007	1504	1169	83	252
June 2007	1411	1130	100	181
Q4 Totals	4301	3365	268	668
Totals for SFY '07	18,120	14,048	1,303	2,769
Percent of Totals	100.00%	77.53%	7.19%	15.28%
Totals for SFY '06	26,859	22,486	3,127	1,236
Percent of Totals (rounded)	100.00%	83.72%	13.91%	4.60%
Difference	-32.54%	-37.53%	-58.33%	124.03%

The decline in prior authorization requests from 2006 to 2007 can be attributed to the following factors:

- When the PDL was implemented, the number of PA requests was significantly higher because of a statutory provision that made it possible for prescribers to override criteria. In 2006, the DUR Board specifically requested a legislative change to require prescribers to provide concrete clinical justification in requesting a criteria override.
- In January 2006, thousands of Medicaid beneficiaries were transitioned to Medicare Part D primary coverage. That meant their drug use no longer subject to the PBM Program's management. Historically beneficiaries who are elderly and disabled were major users of many of the drug classes managed in the Vermont PDL and their use contributed to the volume of prior authorizations.
- In January 2006, the PBA contract with MedMetrics was implemented. Their claims processing system is able to systematically identify areas where certain criteria elements have been met. Examples include age criteria, use of preferred

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drugs, use of preferred drugs for prescribed periods, etc. These step-therapy protocols effectively automate prior approval. This ability has reduced the need for paper/phone requests for authorizations from prescribers.

The following chart reports the incidence of prior authorization requests in SFY 2008:

	Number of Prior Authorization Requests	Number of Prior Authorizations Approvals	Number of Prior Authorization Changes	Number of Prior Authorizations Denials
July 2007	1,391	1,134	73	184
August 2007	1,470	1,193	49	228
September 2007	1,345	1,084	102	159
Q1 Totals	4,206	3,411	224	571
October 2007*	1,713	1,354	142	217
November 2007	1,482	1,193	111	178
December 2007	1,349	1,102	105	142
Q2 Totals	4,544	3,649	358	537
January 2008	1,909	1,552	156	201
February 2008	1,445	1,147	142	156
March 2008	1,647	1,292	146	209
Q3 Total	5,001	3,991	444	566
April 2008	1495	1151	171	173
May 2008	1566	1242	155	169
June 2008	1519	1166	151	202
Q4 Totals	4580	3559	477	544
Totals for SFY '08	18,331	14,610	1,503	2,218
Percent of Totals	100.00%	80%	8.20%	12.10%
Totals for SFY '07	18,120	14,048	1,303	2,769
Percent of Totals (rounded)	100.00%	77.53%	7.19%	15.28%
Difference	1.16%	4.00%	15.35%	-19.90%

By appearance, there would seem to be an increase in prior authorization requests from 2007 to 2008. However, in October 2007 (Q2 SFY 2008) quantity limit prior authorization requests became included in total prior authorization requests. Managing quantities to appropriate clinical guidelines assures appropriate, cost-effective use.

Removing quantity limit PA requests from the above analysis to provide a comparative picture of 2008 to 2007, other prior authorizations have decreased:

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	Number of Prior Authorization Requests	Number of Prior Authorizations Approvals	Number of Prior Authorization Changes	Number of Prior Authorizations Denials
Totals for SFY '08	18,331	14,610	1,503	2,218
Less Quantity Limit PA's	-1,158	-939	-123	-96
Total Less Quantity Limit PA's	17,173	13,671	1,380	2,122
Percent of Totals	100.00%	80%	8.20%	12.10%
Totals for SFY '07	18,120	14,048	1,303	2,769
Percent of Totals (rounded)	100.00%	77.53%	7.19%	15.28%
Difference	-5.23%	-2.68%	5.91%	-23.37%

Utilization Review Events

Pharmacies use computer systems to transmit claims “real time”; that is, as they prepare drugs for dispensing. A claim identifies information about the beneficiary, the prescriber, and the drug. With the ability to electronically submit a claim there is the ability to message the pharmacist on that individual claim. Messaging occurs on specific utilization issues as claims are processed. The issues include drug-drug interactions, early refills, therapeutic duplication, ingredient duplications, drug-disease interactions, drug-age precautions, and others. The drug-drug interactions, early refills, and therapeutic duplication edits require the pharmacist to override or otherwise resolve the potential problem before a prescription may be filled. The other messages alert the pharmacist to potential problems, but do not require intervention to fill the prescription.

The following chart reports the incidence of messages in SFY 2007:

	Q1 SFY '07	Q2 SFY '07	Q3 SFY '07	Q4 SFY '07	Totals	Percent
Drug-Drug Interaction(DD)	79,808	75,739	68,460	66,521	290,528	29%
Early Refill (ER)	10,782	10,216	10,022	10,703	41,723	4%
Drug-Disease (MC)	9,959	9,754	10,337	10,048	40,098	4%
Ingredient Duplication (ID)	20,327	20,473	20,054	20,970	81,824	8%
Drug-Age Precaution (DA)	37	64	65	52	218	0%
Therapeutic Duplication (TD)	121,859	128,665	154,480	153,582	558,586	55%
Totals	242,772	244,911	263,418	261,876	1,012,977	100%

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The following chart reports the incidence of messages in SFY 2008:

	Q1 SFY '08	Q2 SFY '08	Q3 SFY '08	Q4 SFY '08	Totals	Percent
Drug-Drug Interaction(DD)	68,870	73,532	76,090	65,666	286,158	25%
Early Refill (ER)	10,806	11,441	12,271	11,233	45,751	4%
Drug-Disease (MC)	10,197	10,765	9,420	9,209	39,591	4%
Ingredient Duplication (ID)	21,159	25,271	25,920	25,029	97,379	9%
Drug-Age Precaution (DA)	21	50	80	87	238	0%
Therapeutic Duplication (TD)	151,554	164,449	175,306	169,406	660,715	58%
Totals	262,607	285,508	299,087	280,630	1,129,832	100%

Difference SFY '07 to SFY '08:

8% 17% 14% 7% 12%

In SFY 2006, 2,783,171 messages were returned to pharmacy providers. With the implementation of MedMetrics' claims processing system in 2006, steps were taken to minimize the processing burden on pharmacists by limiting messages to interactions categorized in pharmacy claims processing standards as "major" as opposed to "moderate" or "minor" in terms of severity or "absolute" as opposed to "potential" or "precaution". For example, a drug-drug interaction or therapeutic duplication edit applies when it is categorized as major in severity and a drug-age precaution edit applies when it is absolute. From 2007 to 2008, there was a 12% increase in utilization review events. The majority of the increases are ingredient duplications, therapeutic duplications, and early refills. These are critical pharmacy benefit management areas where the issues can be related to both health and safety and appropriate, cost-effective use.

Drug Utilization Review (DUR) Board Activities

A charge of the DUR Board is to select certain drugs and/or prescribing practices to target for review of actual use and/or application. Staff makes recommendations for targeted areas and the Board selects those most relevant.

Examples of the DUR Board's activities in the last year to target certain drugs and prescribing practices included reviews of the following:

- Health and safety:
 - Topical immunomodulators used to treat skin conditions but potentially dangerous in treating young children

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- Acetaminophen used as an analgesic but dangerous in quantities over 4 grams a day
- Botox[®] /Myobloc[®] while not covered by Vermont Medicaid for cosmetic purposes used for limited clinical reasons

- Health and safety/concern for diversion:
 - Carisoprodol used as a skeletal muscle relaxant but abused as a sedative intoxicant
 - Marinol[®] used to treat pain as medical marijuana but abused as a recreational drug

- Treatment management:
 - Asthma Medication Therapy – Pre- and Post-Emergency Room or Inpatient Hospital Admission: Assessment of adherence to maintenance medication therapy

- Cost containment:
 - Quantity limits and dose consolidation:
 - Select mental health medications
 - Step therapy requirements limiting access to certain drugs before the trial of less expensive therapies
 - Advair[®] used to treat asthma and chronic obstructive pulmonary disease
 - Lidoderm[®] used to treat neuropathic pain
 - Angiotensin receptor block therapy used for controlling high blood pressure, treating heart failure, and preventing kidney failure in people with diabetes or high blood pressure
 - Branded drugs more expensive than generic alternatives:
 - Cough and cold medications
 - Skeletal relaxants; promoting generics
 - Acne products

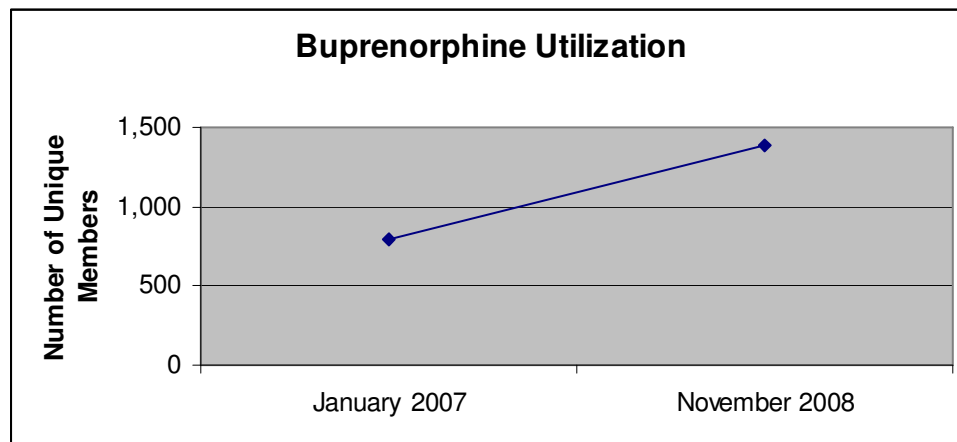
One activity of particular note in 2008 was the DUR Board review of utilization and cost patterns for the buprenorphine products Suboxone[®] and Subutex[®], FDA approved for use in patients with a diagnosis of opiate dependence. Subutex[®] is more costly than Suboxone[®], but more importantly, is more easily diverted and abused by injection or intranasal use as it does not contain the added ingredient naloxone.

In December 2007, management of this drug class began and prior authorization was implemented for all new patients being prescribed either Subutex[®] or Suboxone[®]. Under management coverage was limited to those with a diagnosis of opiate dependency. Requests were to be denied for use for pain control. Prescribers were required to have a DATA 2000 waiver ID number. Additionally, a request for Subutex[®] required the

patient to either be pregnant or have a documented allergy to naloxone which would preclude Suboxone[®] use.

At the time of implementation, all current users of either Subutex[®] or Suboxone[®] were “grandfathered”; that is, they were allowed to continue use of the products without having to demonstrate they met the criteria for coverage. In August 2008 the DUR Board decided to end the grandfathering of Subutex[®] users to ensure the use of that specific preparation only when medically necessary.

While the number of total unique members receiving Subutex[®] or Suboxone[®] on a monthly basis has increased 76% during the time period January 2007 through November 2008 (from 788 to 1387) and monthly expenditures have increased 74% (from \$263,000 to \$458,000), the percentage of members on buprenorphine who are using the Subutex[®] preparation has decreased from 10% in January 2007 to 9% in November 2008 after reaching a high of 15.1% in November 2007.



Supplemental Rebates

Federal law requires that manufacturers pay rebates for drugs to be covered by the Medicaid Program. It also allows states to separately negotiate with manufacturers to secure rebates subject to the approval of the Centers for Medicare and Medicaid Services.

When states develop a preferred drug list they “prefer” clinically appropriate products because they are singularly clinically appropriate. When multiple products are clinically appropriate, products may be preferred because they are inherently cost effective or because the manufacturer has offered to make them cost effective.

Beginning in October 2002 Vermont started securing Vermont-only supplemental rebate agreements. From April 2003 until December 2005, Vermont was a member of the

National Medicaid Pooling Initiative (NMPI) with eight other states under the management of the PBA vendor for all of the states, First Health Services Corporation.

In the fall 2005, Vermont committed to the Sovereign States Drug Consortium (SSDC), the first in the nation state-administered Medicaid pooling initiative for supplemental rebates. Member states were Iowa, Maine, and Vermont. Since membership has grown with Utah in 2007, Wyoming in 2008, and West Virginia as of January 1, 2009. A number of other states are considering the Consortium.

As SSDC members, states pool their collective lives, state staff and pharmacy benefit management contractor resources to negotiate supplemental rebate agreements with drug manufacturers. This approach provides significant administrative efficiency. In addition it provides a greater opportunity for state involvement; state-specific drug coverage customization; multi-state collaboration in publicly funded programs; and creates a pool not dependent upon a single contract vendor or a state's affiliation with a PBM vendor.

In the spring of 2007 on behalf of the SSDC, the OVHA released a Request for Proposal for a vendor to act as the rebate procurement agent to negotiate with drug manufacturers for Medicaid supplemental rebates for the SSDC. A contract was awarded to GHS Data Management of Augusta, Maine for two years with an optional contraction extension of up to two additional years. This contract began in September 2007 and is managed by the OVHA for the SSDC.

Supplemental rebates continue to be a valuable resource in the Vermont Health Access PBM Program. SFY 2006 collections on calendar year 2005 utilization were \$10.4 million. With the transition of 30,000 beneficiaries and their utilization to Medicare Part D in calendar year 2006, the rebate collections for SFY 2007 were anticipated to be \$3.9 million. Actual collections for SFY 2007 against calendar year 2006 utilization were greater than projected at \$4.7 million. SFY 2008 collections against calendar year 2007 utilization were \$5.3 million.

Managing Reimbursement

Nationally, Medicaid programs reimburse individual claims based on the lower of a pharmacy's usual and customary/submitted fee including a dispensing fee, a measure of ingredient costs plus a dispensing fee, the Centers for Medicaid and Medicare Services established Federal Upper Limit (FUL) plus a dispensing fee, or a Maximum Allowable Cost (MAC) amount plus a dispensing fee if the State opts for a MAC list.

As a matter of routine the OVHA monitors reimbursement to pharmacies serving Vermont's programs. The following chart compares Vermont's reimbursement to that of other states in the northeast for the calendar quarter ending December 2008. A note of comparison: AWP minus 11.9% is approximately WAC plus 8.1%.

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State	Ingredient Cost	Dispensing Fee	State MAC List for Multi-source Drugs
Connecticut	Ingredient cost is AWP minus 40% for selected multi-source brands and generics; AWP minus 14 (other brands)	Dispensing fee is \$3.15	Y
Maine	Ingredient cost is AWP minus 15%; AWP minus 17% (on direct supply); AWP minus 20% (mail order)	Dispensing fee is \$3.35; \$1.00 (mail order); \$4.35 and \$5.35 (compounding); \$12.50 (insulin syringe)	Y
Massachusetts	Ingredient cost is WAC plus 5% (all drugs except 340B billed drugs); actual acquisition cost (340B billed drugs)	Dispensing fee is \$3.00 (all drugs except 340B billed drugs) \$10 (340B billed drugs)	Y
New Hampshire	Ingredient cost is AWP minus 16%	Dispensing fee is \$1.75	Y
New York	Ingredient cost is AWP minus 14% (brand); AWP minus 25% (generic); AWP minus 12% (specialized HIV pharmacies)	Dispensing fee is \$3.50 (brand); \$4.50 (generic)	Y
Rhode Island	Ingredient cost is WAC	Dispensing fee is \$3.40 (outpatient), \$2.85 (long-term care)	N
Vermont	Ingredient cost is AWP-11.9%	\$4.75 (in-state); \$3.65 (out-of-state); plus \$15 - compounding	Y
(AWP=average wholesale price, WAC=wholesaler acquisition cost, FUL=federal limit, MAC=maximum allowable cost)			
SOURCE: Centers for Medicaid and Medicare Services Approved State Plans			

Vermont's reimbursement for brand drugs is the highest in the northeast. Vermont pays for many generic drugs based on a competitive MAC price; as a result, Vermont's generic reimbursement is believed to be less than in the other New England states as well as the state of New York. Vermont's dispensing fee for in-state pharmacies is the highest in the region.

Section 107a of Act 215 of the Vermont General Assembly of the 2005-2006 Legislative Session (H.881) authorized a Medicaid generic reimbursement reduction and dispensing fee study. Proposed changes to Medicaid reimbursement on generics effective for calendar year 2007 as contained in the Federal Deficit Reduction Act (DRA)

of 2005 was a driving force for this authorization. The expressed issue was the impact of changes on overall reimbursement.

The federal Deficit Reduction Act of 2005 proposed that, for purposes of Medicaid reimbursement for drugs available from multiple manufacturers, an established pricing standard, the Federal Upper Limit (FUL), be based on Average Manufacturer Price (AMP). Until that time manufacturers' published wholesale prices had been used to establish a ceiling or upper limit for cost reimbursement for multi-source drugs in federal programs when three or more multi-source equivalents were available. The DRA methodology proposed to use AMP to establish the FUL for multi-source drugs when two or more equivalents are available.

To assure a thorough analysis in the study, the OVHA opted to include all possible aspects of drug reimbursement in programs. The study was completed and distributed to the Legislative Health Access Oversight Committee and the Legislative Joint Fiscal Committee in January 2007 and is available on the OVHA's website at <http://ovha.vermont.gov/>.

The findings of that study were:

- The average reported cost of dispensing individual prescriptions in pharmacies serving Vermont Medicaid was \$10.55.
- The full potential impact of the DRA could not be determined as the federal rules proposed in December 2006 were not expected to be finalized until later in 2007.

Section 110g of Act 65 of the Vermont General Assembly of the 2007-2008 Legislative Session (H.537) stated that the OVHA would analyze the impact of the Centers for Medicare and Medicaid Services (CMS) implementation of the final rule revising the federal upper limits (FULs) for prescription drug reimbursement.

Before that analysis was completed, the National Association of Chain Drug Stores (NACDS) and the National Association of Community Pharmacists (NCPA) filed a related lawsuit against CMS and the U.S. Department of Health and Human Services. On November 15, 2007 the NACDS and the NCPA filed a preliminary injunction motion with the United States District Court for the District of Columbia to block its implementation.

On December 14, 2007 a hearing was held and the court issued a preliminary injunction blocking making data on the AMPs available and the implementation of any reimbursement cuts. On December 19, 2007, the order was issued. On December 21, 2007 CMS notified states that the AMPs would not be provided to Medicaid State Agencies and that they would not be used in the calculation of the FUL until further notice.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 was enacted. As a result of this legislation, CMS was prohibited from taking any action prior to October 1, 2009, to impose FULs for multiple source drugs.

As a result of these actions, the analysis proposed in response to Act 65 Section 110g cannot be completed until the necessary information can be made available.

Responding to Change

Medicare Part D

2008 was the third year where Vermont's publicly funded pharmacy benefit programs were the secondary payer for pharmacy benefits after Medicare Part D.

Vermont Coverage for Medicare Eligibles

Traditional Medicaid (Primarily below 100% of the FPL)

- The State's coverage is limited to excluded drug classes (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; cough and cold preparations; drugs when used for anorexia, weight loss, or weight gain) for those who are enrolled in a Part D plan (or Part C with a drug component) or have creditable coverage.
- No State premium is charged.
- The beneficiary pays the Part D co-pays (from \$1.10 to \$6.00) with the exception that pregnant women and children's co-pays are paid by the State.
- All other cost-sharing is covered by a federal benefit referred to as the low-income subsidy (LIS).
- Drugs that are not on the plan's formulary or are denied by the plan as not medically necessary are not covered without specific approval from the OVHA.
- When a Part C or D plan denies a non-formulary drug or a drug the plan indicates is not medically necessary, beneficiaries may apply to the OVHA for coverage of the drug after the plan's appeal process is exhausted (through the Independent Review Entity level) and the denial remains upheld.
- The plans are required to cover all or substantially all of the drugs in the following categories: antidepressant, anticonvulsive, antipsychotic, anticancer, immunosuppressant, and HIV/AIDS.

Vermont's Medicaid Waiver and State Pharmacy Programs: VPharm
(100% to 225% of the FPL)

During 2008, Vermont provided a State wraparound program named VPharm. This program supplemented Medicare coverage to a level that was comparable to state coverage provided prior to the implementation of Part D.

Throughout 2008, beneficiaries eligible for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) programs benefited from a resource test elimination. By virtue of eligibility for these programs, they became eligible for the full federal LIS. Based on historical expenditures the analysis indicated that this change would be (at worst) cost-neutral for the State.

VPharm coverage highlights:

- Beneficiaries must be eligible for Part A or enrolled in Part B.
- Beneficiaries must be enrolled in a Part D plan (or a Part C plan with a drug component, or a Part C plan without a drug component and separately enroll in a Part D plan) and secure the LIS if it appears they might be eligible.
- Beneficiaries pay premiums to the State of \$17, \$23 or \$50.
- The coverage is:
 - Payment of cost-sharing that is not covered by the LIS, including premiums, deductibles, co-payments, coinsurance and the coverage gap (for beneficiaries at the VScript or VScript Expanded coverage level of 150% to 225% FPL, only maintenance drugs are eligible for the cost-sharing coverage); and
 - Coverage of drug classes that are excluded from Part D (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; cough and cold preparations; drugs when used for anorexia, weight loss, or weight gain). Some of these may have requirements or limits attached. For beneficiaries at the VScript or VScript Expanded coverage level (150% to 225% FPL), only maintenance drugs in these classes are included in the benefit.
- Drugs that are not on the plan's formulary or are denied by the plan as not medically necessary are not covered without specific approval from the OVHA.
- When a Part C or D plan denies a non-formulary drug or a drug the plan indicates is not medically necessary, beneficiaries may apply to the OVHA for coverage of the drug after the plan's appeal process is exhausted (through the Independent Review Entity level) and the denial remains upheld.
- The plans are required to cover all or substantially all of the drugs in the following categories: antidepressant, anticonvulsive, antipsychotic, anticancer, immunosuppressant, and HIV/AIDS.

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Healthy Vermonters Program
(Primarily greater than 225% and up to 400% of the FPL)

Healthy Vermonters Program beneficiaries who have Medicare may obtain drugs in the Part D excluded classes (benzodiazepines; barbiturates; over-the counter prescriptions; vitamins or minerals; cough and cold preparations; drugs when used for anorexia, weight loss, or weight gain) at the Medicaid cost.

Phased-Down Contribution

The pharmacy benefit under Medicare is conceptually a federal benefit. However, in the case of full benefit dual eligibles (those Medicare beneficiaries who are also eligible for the health insurance benefit of Medicaid), it is funded in the same way as it is funded under Medicaid, with federal and state funding. What in Medicaid is referred to as the state share is called the phased-down state contribution for Medicare. The Part D design requires that states annually pay a portion of what they would have paid in Medicaid state share in that year for the support of drug coverage of Medicare beneficiaries who are also eligible for Medicaid drug coverage. This is the concept sometimes referred to as “clawback”. Key concepts of the phased-down contribution:

- Based on Medicaid full benefit eligible state expenditures in calendar year (CY) 2003 adjusted for inflation (excluding VHAP-Pharmacy, VScript, and VScript expanded in Vermont since no portion of those expenditures were for Medicaid full benefits eligibles).
- Calculated on expenditures net of drug rebate.
- Premised on states retaining a specified portion in support of providing other coverage to their dual eligibles.

Based on these concepts, for calendar year (CY) 2008, Vermont was expected to pay the phased-down state contribution of 86.67 % of the estimated CY state share of Medicaid/Medicare pharmacy expenditures net of rebate. The contribution in future years will be progressively less:

CY 2009	85.00%
CY 2010	83.33%
CY 2011	81.67%
CY 2012	80.00%
CY 2013	78.33%
CY 2014	76.67%
CY 2015 and thereafter	75.00%

For state fiscal year 2008, the Vermont phased-down contribution \$20,339,254.

PDP Selection

A Medicare-contracted Prescription Drug Plan (PDP) provides the primary pharmacy benefit to Medicare eligibles. Every beneficiary has a choice of at least two PDPs. Beneficiaries choose their plans annually during their annual enrollment period (AEP) which is November 15 through December 31. Dual eligibles may change plans any month in the course of the year. Some beneficiaries have special enrollment periods (SEP) which are the only times they can choose or change plans. As Vermont's State pharmacy program that wraps the Part D benefit, VPharm is designated as a state pharmacy assistance program (SPAP) by the federal government. CMS permits individuals eligible for a SPAP one SEP in addition to their AEP and one SEP in addition if they lose their SPAP eligibility.

PDP Drug Coverage

Each Medicare PDP sets its coverage plan (formulary) according to Medicare guidelines:

- The guidelines require mandatory Medicaid class coverage. Coverage does not include specified optional Medicaid coverage including over-the-counter and selected other products (products for the treatment of weight loss/gain, barbiturates, and benzodiazepines).
- Unlike Medicaid, the formulary can be closed; that is, within the Medicare defined classes, not all drugs need to be covered. The regulations specify at least two drugs to a class must be included.
- The formulary may change monthly. That means that beneficiaries who choose a plan based on specific drugs may not be assured the same coverage throughout the year they are enrolled in the plan.

OVHA PDP Administration

The OVHA remains involved in the administration of wrap coverage. These include providing enrollment and eligibility functionality and data transfers to Medicare; managing the medical coverage for traditional Medicaid eligibles; coordinating any State pharmacy benefits with Medicare pharmacy coverage; and educating/supporting beneficiaries/providers.

OVHA Continuing Support for Beneficiaries

The OVHA continues to take steps to ensure that Vermonters who are having trouble accessing the federal prescription drug benefit have assistance in resolving issues. Since 2006, the OVHA has had a team of employees that acts as a liaison between the beneficiary and the federal prescription program.

Coordination of Benefits with Medicare Part D

On January 1, 2006, when Medicare drug coverage authorized under the Medicare Modernization Act (MMA) of 2003 was implemented. 30,000 Medicaid, VHAP Pharmacy, VScript, and VScript Expanded beneficiaries were transitioned to primary drug coverage under Part D. Almost instantly it was apparent that there were problems and they were not immediately solved.

With the difficulties, the Legislature appropriated state funds to support the reinstatement of Vermont program provisions as they existed on December 31, 2005. The Governor approved and ordered this on January 5, 2006 and the changes were implemented on January 6, 2006. This provided an answer for assuring both beneficiary access and pharmacy reimbursement while Medicare Part D system issues were being resolved.

In March 2006, the OVHA determined that the Medicare Part D Prescription Drug Plans (PDPs) had demonstrated their ability to handle the coverage of their beneficiaries. At that time the OVHA began transitioning people back to Part D coverage. This was completed by July 2006.

Between January and July 2006, Vermont spent an estimated \$11.7 million on drugs as part of Medicare Part D bailout coverage. Vermont participated in the Centers for Medicare and Medicaid Services (CMS) Medicare Section 402 Demonstration Project to receive reimbursement for administrative expenses and claims on select eligibles. Claims ineligible for or denied under the 402 Demonstration Project must be billed to the Medicare Prescription Drug Plans (PDPs). The OVHA's Pharmacy and Coordination of Benefits (COB) Units developed a process to submit the claim billings and its Administrative Services Unit managed the collection of administrative expenses.

Vermont State Auditor of Accounts Report on \$2.2 Million in Questioned Pharmacy Claims

In December 2006 the Office of the Vermont State Auditor released a report that identified a possible \$2.2 million in improper payments associated with pharmacy claims processing by First Health for the period January 1, 2004 through December 31, 2005.

Over \$569 thousand has been recovered thus far. In conjunction with our PBM partner, MedMetrics, claims processing changes have been implemented which will minimize the likelihood of future claims errors associated with quantities and/or dosage forms.

To assure a complete review of all First Health claims identified by the state auditor, the OVHA has amended its contract with MedMetrics to include performing provider recovery services against those claims. This process is well underway. In addition, the OVHA's Program Integrity Unit has contracted with Ingenix to perform a variety of claims audits on an ongoing basis.

Act 80 of the Vermont General Assembly of the 2007-2008 Legislative Session (S.115)

In the spring of 2007 the Legislature enacted Act 80, *An Act Relating to Increasing Transparency of Prescription Drug Pricing and Information*. This Act:

- Implemented a joint pharmaceuticals purchasing consortium.
- Increased transparency of drug pricing information.
- Increased the federal poverty level for eligibility for the Healthy Vermonters program from 300% to 350% for those who are less than age 65 or not eligible for Medicare or Social Security disability benefits.
- Required increased oversight of pharmacy benefit managers (PBMs) and their practices.
- Established an evidence-based education program.
- Established a generic drug voucher pilot project.
- Protected the confidentiality of prescription information.
- Established a fee for drug manufacturers to fund the education program including the voucher pilot project.
- Enhanced consumer protections.

The following outlines the status of each of these items:

- Joint pharmaceuticals purchasing consortium (JPPC): The JPPC provides a vehicle to negotiate rebates on behalf of non-Medicaid programs. Preliminary design discussions have occurred exploring options to pool covered lives with other states to maximize opportunities. Implementation of this will require the authorization and funding of OVHA staff.
- Drug pricing information: This component requires drug manufacturers to report to the OVHA the same pricing information reported to the Centers for Medicare and Medicaid (CMS) for Medicaid drug rebate purposes. A quarter of information was collected in 2008 but the effort proved to be very labor intensive. Full implementation of this will require the authorization and funding of OVHA staff.
- Healthy Vermonters' Program: The Act increased the eligibility income test level from 300% to 350% of the Federal Poverty Level for those who are less than age 65 or not eligible for Medicare or Social Security disability benefits. This change was implemented on July 1, 2007. The Act also proposed securing rebates from manufacturers for this program with the approval of CMS. This latter provision will require the authorization and funding of OVHA staff to implement.
- Pharmacy benefit management regulations, registration, audit and oversight of practices: These aspects are related to regulatory oversight taken on by the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA).
- Establishment an evidence-based education program: This program charges the Vermont Department of Health in collaboration with the Office of the Attorney

General (AG), the University of Vermont Area Health Education Centers (AHEC), and the OVHA with the establishment of an evidence-based prescription drug education program for health care professionals designed to provide information and education on the therapeutic and cost-effective utilization of prescription drugs. Litigation has been filed impacting the funding of these activities. The OVHA's participation in the education program is dependent on the authorization and funding of staff. The AHEC Program's participation is dependent on funding.

- Establishment of a generic drug voucher pilot project: This project is a part of the evidence-based education program. Design meetings have been held. Drug selection and plans for determining where and how the pilot might be implemented are outstanding issues. Claims processing specifications have been developed. Litigation has been filed impacting the funding of this component of the evidence-based education program. Implementation of the project will require funding for the benefit, the authorization and funding of OVHA staff to administer the benefit, and funding for claims processing requirements.
- Prescription information confidentiality: This piece of the Act is subject to litigation.
- Consumer protection enhancements: These entail consumer protections in terms of advertising and insurance marketing. These are provisions that provide improved controls for the AG's office and for BISHCA in their respective roles.
- Establishment of a fee for drug manufacturers: This fee is intended to fund collection and analysis of information on pharmaceutical marketing activities, analysis of prescription drug data needed by the AG's office for enforcement activities, and the education-based drug education program's activities including the drug voucher pilot program and the work of the AHEC Program. On August 13, 2008, the Legislative Committee on Administrative Rules approved OVHA's Bulletin 08-03, Pharmaceutical Manufacturer Fee. This authorizes the fee at 0.5% of the previous calendar year's prescription drug spending by OVHA assessed based on labeler codes in the rebate program. This bases the fee on spending in Vermont's publicly funded pharmacy benefit programs. With these programs covering nearly 25% of the total population, this method is a proxy for manufacturer market share in Vermont and applies a greater portion of the fee to those manufacturers with the greater market share.

Tamper-Resistant Prescription Drug Pads

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007 set requirements regarding the use of tamper-resistant prescription drug pads in Medicaid. This was signed into law on May 25, 2007. Initially the Centers for Medicare and Medicaid Services (CMS) intended to impose this requirement as of October 1, 2007. However with many concerns raised, President Bush signed legislation into law on September 29, 2007 delaying implementation until April 1, 2008.

The following were the conditions for Medicaid program reimbursement as of April 1, 2008:

- All written prescriptions for outpatient covered drugs must be written on tamper-resistant prescription paper.
- To be considered tamper-resistant, prescription paper must contain one of the following three characteristics:
 - one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
 - one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
 - one or more industry-recognized features designed to prevent the use of counterfeit prescription drug forms.

As of October 1, 2008, all of the above-referenced characteristics were required for the prescription paper to be considered tamper-resistant.

With implementation, CMS will be requiring that state Medicaid programs audit pharmacies to assure compliance. Pharmacy documentation will be necessary. If it is determined that a payment was made on a claim for a prescription that was not in compliance with the Medicaid tamper-resistant prescription requirements, payments must be recovered. Provisions allow for federal auditors to audit state audit samples to assure that audits occur.

VITL's Electronic Medication History Service

Late in 2006, Vermont Information Technology Leaders, Inc. (VITL) initiated planning on a pilot project for a service designed to support the Blueprint for Health's Chronic Care Information System.

The service makes insurers' medication history data available electronically to hospital emergency departments. A patient can allow emergency room personnel to quickly review his or her drug utilization using an electronic query transmitted to the claims history databases of participating insurers. Access to this information can lead to faster diagnosis and improved medical treatment for individuals who may not be able to provide a complete medication history, often due to the acute nature of their illness or injury.

The pilot began in the spring of 2007 with two hospitals: Rutland Regional Medical Center in Rutland, Vermont, and Northeastern Regional Vermont Hospital in St. Johnsbury, Vermont. The service utilizes software provided by G.E. Health Care in South Burlington, Vermont.

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Drug history claims data is available from several health insurance claims payers, the largest being the OVHA through its PBA, MedMetrics. Other payers include Blue Cross and Blue Shield of Vermont, MVP Health Care, CIGNA Health Care and some Part D Plans.

The service has now completed its pilot phase and is being offered to additional hospitals in Vermont. Both hospitals involved in the pilot are still participating as is Brattleboro Memorial Hospital in Brattleboro which began using the service at the end of 2008.

Assessment of SFY 2008

In the early years of the Vermont Health Access Pharmacy Benefit Management Program, the major drug classes with regard to expenses were gastric acid reducers, anti-inflammatory drugs, and analgesic pain relievers. It was easy to focus on such classes where utilization was high. Success was measured in terms of millions of dollars in reduced spending as beneficiaries were moved to the least expensive alternatives.

With the maturing of the Program, success in drug class management is not as easily accomplished. The promotion of generics, the management of select utilization, and the acquisition of supplemental state rebates on drugs used in Vermont's programs have contributed the most to expense avoidance.

As indicated before, Vermont programs' generic usage is as follows:

SFY 2007	Percentage of non-Part D Rx	Percentage of Part D Rx	Percentage of All Rx
Generic use as a percentage of all drugs dispensed	62.54%	65.36%	63.95%
Generic use when generic equivalent available	97.95%	97.18%	97.57%

SFY 2008	Percentage of non-Part	Percentage of Part D Rx	Percentage of All Rx
Generic use as a percentage of all drugs dispensed	62.99%	69.86%	65.25%
Generic use when generic equivalent available	98.39%	97.30%	98.00%

The University of Connecticut, School of Pharmacy assisted the OVHA in the production of the Generic Reimbursement Reductions and Dispensing Fee Study in 2006. They procured an independent vendor, Advance Pharmacy Concepts (APC), knowledgeable in pharmacy operations to assist in data analysis. APC reports that the use of generic products has been seen to be the single most valuable cost-saving initiative that can be

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implemented by any insurer. APC indicated that the generic use performance in Vermont programs is excellent compared to commercially administered drug benefits.

Examples of generic savings as a result of drug specific targeting in 2008 include:

	Estimated annual gross savings
Cough and cold medications	\$ 77,256
Skeletal relaxants	\$ 155,654
Acne products	\$ 311,308

Examples of PBM Program utilization management activities that produced program savings include:

	Estimated annual gross savings
Carisoprodol	\$ 13,863
ARB step therapy	\$ 54,766
Topical immunomodulators	\$ 62,684
Lidoderm®	\$ 235,083
Mental health drug dose consolidation	\$ 621,359

As previously described, supplemental rebates continue to be another valuable tool in Vermont. Even with the transition of 30,000 beneficiaries and their utilization to Medicare Part D, collections for SFY 2007 against calendar year 2006 utilization were \$4,746,226; SFY 2008 collections against calendar year 2007 utilization were \$5,318,443.

At this stage the charges of the PBM Program are to maintain the level of success achieved to date and to monitor the benefits vigilantly to identify areas where additional returns may be found.

With the implementation of Medicare Part D and the transition of 30,000 beneficiaries to primary coverage under Part D, it is estimated that 95.9% of elderly beneficiaries and 46.8% of disabled beneficiaries became Part D covered. Historically beneficiaries who are elderly and disabled are major users of Vermont drug programs' coverage, particularly in many of the drug classes managed in the Vermont PDL. Prior to Part D, much of the PBM Program's focus was directed to Medicare eligibles.

The following chart illustrates the impact of the Part D change with paid claims volume attributed by age. The 2005 figures show program activity with all Vermont programs including coverage for those who would become eligible for Part D in 2006. The 2008 figures show beneficiary activity in Vermont programs fully managed by the PBM

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Program; that is, those without Part D coverage. This illustrates that for those ages 65 and older the vast majority of primary claims have now transitioned to Part D coverage. In addition, with those ages 21 to 64, a number of primary claims can also now be attributed to Part D:

Primary Vermont Program Paid Pharmacy Claims				
Ages	Jul-Dec 2005		Jul-Dec 2008	
0-12	102,687	6.3%	100,326	13.7%
13-20	85,055	5.2%	85,476	11.7%
21-40	265,438	16.3%	226,655	30.9%
41-50	240,446	14.7%	149,627	20.4%
51-64	206,637	12.7%	166,562	22.7%
65 and older	731,558	44.8%	4,413	0.6%
Totals	1,631,821		733,059	

As a result, at this point the age focus is first on adults and then on children.

In SFY 2005, prior to the transition of many beneficiaries and their expenditures to Medicare Part D, the top five drug classes with regard to expenditures were:

1. Antipsychotics, atypical, dopamine, & serotonin antagonists
2. Anticonvulsants
3. Lipotropics
4. Gastric acid reducers
5. Selective serotonin reuptake inhibitors (SSRIs)

For the non-Part D beneficiaries, management of antipsychotics, atypical, dopamine, & serotonin antagonists; anticonvulsants; and selective serotonin reuptake inhibitors (SSRIs) began in SFY 2006. In addition, lipotropics and gastric acid reducers were on the PDL and managed to the extent possible to meet clinical needs.

In SFY 2008, the top five drug classes for all beneficiaries with regard to expenditures were:

1. Antipsychotics, atypical, dopamine, & serotonin antagonists
2. Anticonvulsants
3. Analgesic narcotics
4. Gastric acid reducers
5. Drugs for attention deficit – hyperactivity (ADHD)/narcolepsy

Clearly, some areas requiring attention remain the same. Drugs used to treat attention deficit, hyperactivity, and narcolepsy reflects the impact of the change in populations served. Drugs taken by largely an older population (such as lipotropics) have moved from being paid primarily by Medicaid to being paid primarily by Medicare Part D.

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Looking at overall utilization and claims specific spending during each of SFY 2006, SFY 2007, and SFY 2008, with all eligibles including Part D eligibles, the following occurred:

All Paid Pharmacy Claims for All Beneficiaries			
	SFY 2006	SFY 2007	SFY 2008
Claims	2,832,959	2,270,948	2,188,538
Days Supply	73,625,601	58,626,935	57,065,126
Claims Payments	\$167,532,603	\$109,319,875	\$112,298,713
Average Monthly Eligibles	132,240	132,554	135,509
Claims per Eligible per Month	1.8	1.4	1.3
Days Supply per Eligible per Month	46.4	36.9	35.1
Paid per Eligible per Month	\$105.57	\$68.73	\$69.06

From 2006 to 2007 the reduction in paid per eligible per month can be attributed to eligibles moving to Part D coverage and out of primary coverage in Vermont programs.

From 2007 to 2008 there is only a 1.51% increase in the amount paid per eligible per month. This is a credit to all of the 2008 activities of the PBM Program including the commitment of both prescribers and pharmacies that resulted in 3.06% increase in pharmacy spending before rebates and .49% **decrease** in spending after rebates from SFY 2007 to SFY 2008.

Note, though, that eligibles have increased. This is a likely result of the downturn in the economy. Removing Medicare eligibles and looking at only the last six months of each of the last three years produces the following:

All Paid Pharmacy Claims for Beneficiaries Without Medicare Coverage			
	Jul - Dec 2006	Jul - Dec 2007	Jul - Dec 2008
Claims	693,553	689,861	733,400
Days Supply	16,488,946	16,664,689	17,866,703
Claims Payments	\$45,784,079	\$47,159,832	\$52,833,594
Average Monthly Eligibles	104,363	102,486	116,536
Claims per Eligible per Month	0.6	0.6	0.5
Days Supply per Eligible per Month	13.2	13.6	12.8
Paid per Eligible per Month	\$36.56	\$38.35	\$37.78
Percentage Increase Over Previous Year	2.19%	4.89%	-1.48%

While the paid per eligible is less in 2008 than in 2007 the average number of eligibles has increased by 13.7% and the resulting total spending has increased by 12%. Containing costs becomes all the more critical to maintaining pharmacy benefit coverage.

Planned for SFY 2009

Activities planned in the coming year include:

- Addressing changes in pharmacy benefits coverage in Vermont's publicly funded programs in light of dwindling cash resources to support them;
- Reviewing and updating the PDL as needed;
- Managing the cost and utilization in specific therapeutic categories where appropriate;
- Promoting over-the-counter medications when they are less expensive alternatives to prescription medications;
- Continuing to review the dispensing of drugs under medical procedure codes;
- Continuing to establish criteria for appropriate dose consolidation and optimization;
- Continuing to implement the Specialty Pharmacy Initiative to support beneficiaries in managing complex health conditions;
- Coordinating activities with the OVHA's Chronic Care Initiative;
- Coordinating activities with the Office of Alcohol and Drug Abuse Programs on treatment approaches for opiate dependence;
- Coordinating activities with the Department of Health on treatment options for smoking cessation;
- Coordinating activities with the Department of Health in addressing needed vaccines;
- Coordinating activities with the Department of Mental Health on treatment options for mental illness;
- Partnering with the OVHA Program Integrity Unit and other state and law-enforcement agencies to identify areas where program oversight can be improved;
- Working to promote new state membership in the SSDC to expand the Medicaid supplemental rebate pool;
- Working with the University of Vermont Area Health Education Centers (AHEC) on the creation of an evidence-based prescription drug education program to promote the most appropriate therapeutic and cost-effective utilization of prescription drugs; and
- Supporting the expansion of VITL's Electronic Medication History Service to hospitals in Vermont