MERCER

OKLAHOMA HEALTH CARE AUTHORITY

INDEPENDENT REVIEW OF THE SOONERCARE PHARMACY BENEFIT AND MANAGEMENT

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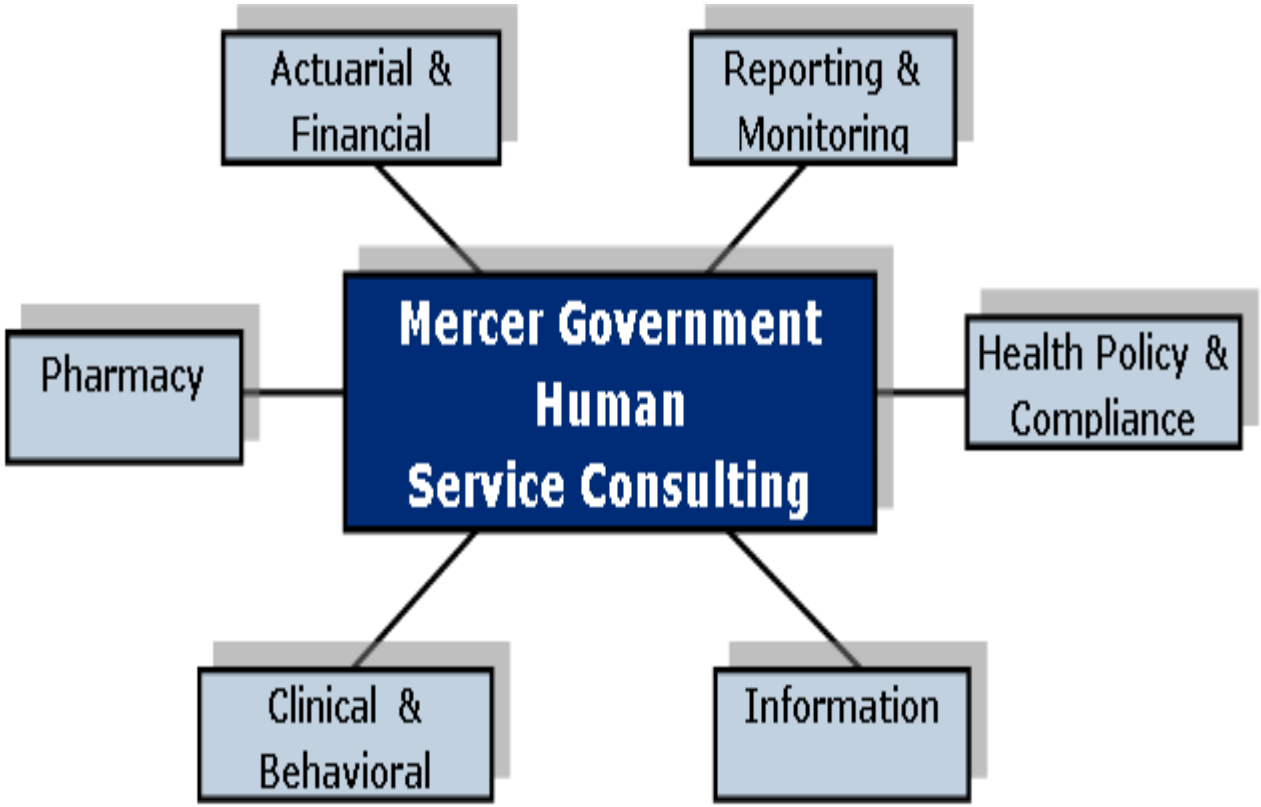
PROJECT OVERVIEW

Project Overview
Introduction – Mercer GHSC

- Medicaid is the core business of Mercer's Government Human Services Consulting (GHSC) practice.
  - Worked with more than 30 states and currently hold active contracts with more than 20 states.



Project Overview
Introduction – Mercer GHSC Pharmacy Practice

- **18** Staff across two offices
- **3** Former state Medicaid pharmacy directors
- **3** Licensed pharmacists
- **9** State licenses including Oklahoma
- **8** Distinct practice settings
- **83** Years of collective pharmacist experience
- **3** Certified pharmacy technicians (CPhT)
- **6** Staff with advanced degrees (Master's level)
- **5** Staff with Pharmacy Benefit Manager (PBM) experience
- **1** Administrative professional with over 25 years experience

Project Overview
Requested Scope of Work

OHCA contracted with Mercer GHSC to evaluate the effectiveness of the SoonerCare Pharmacy benefit management strategies and formulate recommendations for improvement addressing the following components:

- Pharmacy Benefit Program
  - Analyze current program structure and design.
  - Identify opportunities to achieve further cost containment, without compromising the quality of care to SoonerCare members.
- CMS Notice of Proposed Rulemaking (NPRM) titled “Covered Outpatient Drugs” (CMS-2345-P)
  - Analyze and provide planning/implementation recommendations for compliance.
- Cost Benefit Analysis
  - Assess services provided by the University of Oklahoma, College of Pharmacy’s Pharmacy Management Consultants (PMC).

Section #1
PHARMACY PROGRAM REVIEW

Pharmacy Program Review
SoonerCare Pharmacy Overview

- SoonerCare Average Membership

June 2013 to November 2013	Monthly Average
SoonerCare Members	793,776
SoonerCare Utilizers of Pharmacy Benefit	193,097
% of Utilizing Members	24.3%

- SoonerCare Monthly Utilization and Reimbursement

November 2013	Members Served (Utilizers)	Number of Paid Prescriptions	Total Reimbursement
Adult	80,643	268,951	$18,099,997
Child	119,236	251,597	$17,310,569
Total	199,879	520,548	$35,410,566

- Average Pharmacy Reimbursement Per Member Per Month (June – November 2013) = $45

Pharmacy Program Review
SoonerCare Pharmacy Overview (cont'd)

- Reimbursement and Claims Statistics for November 2013

	Total Reimbursement Amount	Number of Paid Prescriptions	Average Reimbursement per Prescription	Dispensing Rate
Generic	$11,187,232	457,256	$ 24	88%
Brand Name	$24,100,812	60,980	$395	12%
Total	$35,288,044	518,236	$ 68	

- Specialty drug = 12.6% of total drug reimbursement (June – November 2013)

Pharmacy Program Review
Introduction

- This section explores areas identified by OHCA as areas of focus and includes:
  - Outpatient pharmacy reimbursement and pharmacy benefit structure, including
    - ingredient cost,
    - dispensing fee,
    - prescription limits, and
    - prior authorizations (PA) programs.
  - Specialty pharmaceutical and physician-administered drugs reimbursement.
  - 340B program reimbursement policy.
  - Current claims processing system.
  - Federal and supplemental rebate collections.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement

- The standard approach is to pay a drug **ingredient cost** plus a **dispensing fee**.
  - CMS is urging states to become more transparent in their reimbursement methodologies.
- Ingredient cost – generally lower of the following:
  - Estimated Acquisition Cost (EAC)
    - For most states, the EAC is calculated by using Average Wholesale Cost (AWP) less a discount percentage and/or the WAC plus a markup percentage.
  - Federal Upper Limit (FUL)
  - State Maximum Allowable Cost (SMAC)
  - National Average Drug Acquisition Cost (NADAC) – NEW
  - Usual and customary charge (U&C)

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Ingredient Cost Benchmarks

State	Ingredient Cost	SMAC Program
Oklahoma	Lower of AWP minus 12%; WAC plus 5.6% (if AWP is not available); ASP plus 6% (injectable drug); SMAC; or FUL.	Yes
Arkansas	AWP minus 20% (generic); AWP minus 14% (brand).	Yes
Idaho	Average AAC, or where there is no average AAC reimbursement is WAC.	Yes
Louisiana*	Average AAC plus 1% for single-source products or Average AAC plus 10% for multi-source products or where there is no Average AAC, reimbursement is WAC for traditional drugs and WAC plus 5% for specialty drugs.	Yes
New Mexico	Lower of AWP minus 14%; WAC as submitted to State; manufacturer price as submitted to State; or pharmacy invoice price as obtained through audits.	Yes
North Carolina	Specialty drugs WAC plus 1% (or AWP minus 15.83% if WAC is unavailable); non-specialty drugs WAC plus 2.7% (or AWP minus 14.42% if WAC is unavailable); for the contraceptive drugs (Implanon and Mirena) WAC plus 6%; in addition to lower of WAC reimbursement, SMAC or FUL.	Yes
Texas	Lower of AWP minus 15%; Net cost to wholesaler plus 12%; Average Direct Chain Contract Price; or SMAC.	Yes

***** Louisiana pricing based upon pending State Plan Amendment approval by CMS.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Ingredient Cost

Assessment and Findings

- Brand drug discounts are based on AWP and WAC discounts
  - Not discounted as deeply as the other state Medicaid benchmarks
  - OHCA's generic dispensing rate (GDR) is significantly higher than many commercial and other Medicaid programs at 88%;
    - GDRs reported by twenty-five Medicaid programs in October 2013 ranged between 72%-88% with an average of 79%.

Opportunities

- OHCA should continue to investigate alternative ingredient cost reimbursement methodologies, which may result in a more transparent payment for pharmaceuticals to the providers.
  - OHCA should pay particular attention to the brand drug reimbursement strategy.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Dispensing Fee Benchmarks

State	Dispensing Fee	Date of Most Recent Cost of Dispensing Survey
Oklahoma	$4.02	2003
Arkansas	$5.51	June 2001
Idaho	Tiered dispensing fees: • Fewer than 39,999 claims a year = $15.11 • Between 40,000 and 69,999 claims per year = $12.35 • 70,000 or more claims per year = $11.51	August 2011
Louisiana*	$10.51 includes State provider fee; $10.13 for drugs obtained through the 340B Drug Pricing Program, which includes the State provider fee.	June 2011
New Mexico	$2.50 except in the instances when pharmacist uses product selection, in which case it is $3.65.	N/A
North Carolina	Dispensing fee is $2.00 (brand); Tiered dispensing fees (generic): • Greater than or equal to 80% of claims are generic per quarter = $7.75 • Greater than or equal to 75% and less than 80% of claims are generic per quarter = $5.50 • Greater than or equal to 70% and less than 75%of claims are generic per quarter = $2.00 • Less than 70% of claims are generic per quarter = $1.00	December 2010
Texas	$6.50**	N/A

* Louisiana pricing based upon pending State Plan Amendment approval by CMS.

** Fixed dispensing fee for Texas Medicaid. Additional variable, generic and delivery incentive fees are reimbursed if applicable.

Assessment and Findings

- Oklahoma has a flat dispensing fee of $4.02.
  - Refer to the NPRM section of this report for ACA requirements and financial evaluations surrounding reimbursement.

Opportunities

- As Medicaid programs move to a benchmark more reflective of AAC, they will also be expected to adopt a professional dispensing fee that more closely aligns with the actual cost a pharmacy incurs to dispense a prescription.
  - Mercer suggests that OHCA completes a cost of dispensing survey with pharmacy providers.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Total Reimbursement Benchmarks

State	Ingredient Cost	Dispensing Fee
Oklahoma	Lower of AWP minus 12%; WAC plus 5.6% (if AWP is not available); ASP plus 6% (injectable drug); SMAC; or FUL.	$4.02
Arkansas	AWP minus 20% (generic); AWP minus 14% (brand)	$5.51
Idaho	Average AAC, or where there is no average AAC reimbursement is WAC.	Tiered dispensing fees: • Fewer than 39,999 claims a year = $15.11 • Between 40,000 and 69,999 claims per year = $12.35 • 70,000 or more claims per year = $11.51
Louisiana*	Average AAC plus 1% for single-source products or Average AAC plus 10% for multi-source products or where there is no average AAC, reimbursement is WAC for traditional drugs and WAC plus 5% for specialty drugs.	$10.51 includes State provider fee; $10.13 for drugs obtained through the 340B Drug Pricing Program, which includes the State provider fee.
New Mexico	Lower of AWP minus 14%; WAC as submitted to State; manufacturer price as submitted to State; or pharmacy invoice price as obtained through audits.	$2.50 except in the instances when pharmacist uses product selection, in which case it is $3.65.
North Carolina	Specialty drugs WAC plus 1% (or AWP minus 15.83% if WAC is unavailable); non-specialty drugs WAC plus 2.7% (or AWP minus 14.42% if WAC is unavailable); for the contraceptive drugs (Implanon and Mirena) WAC plus 6%; in addition to lower of WAC reimbursement, SMAC or FUL.	Dispensing fee is $2.00 (brand); Tiered dispensing fees (generic): • Greater than or equal to 80% of claims are generic per quarter = $7.75 • Greater than or equal to 75% and less than 80% of claims are generic per quarter = $5.50 • Greater than or equal to 70% and less than 75% of claims are generic per quarter = $2.00 • Less than 70% of claims are generic per quarter = $1.00
Texas	EAC is the lower of AWP minus 15%; Net cost to wholesaler plus 12%; Average Direct Chain Contract Price; or MAC.	$6.50**

* Louisiana pricing based upon pending State Plan Amendment approval by CMS.

** Fixed dispensing fee for Texas Medicaid. Additional variable, generic and delivery incentive fees are reimbursed if applicable.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Prescription Limits

- Prescription limitations restrict the number of prescriptions that the payer will reimburse for a member in a given time period – typically 30 days.
- Often in Medicaid programs, particular therapeutic classes of medications (e.g., HIV/AIDS medications, behavioral health medications, contraceptives) and populations (e.g., children, pregnant women, members residing in long term care facilities, and members with HIV/AIDS) are not subjected to this monthly prescription limitation.
- Some Medicaid programs apply specific limits to the number of brand prescriptions reimbursed each month.
- SoonerCare has a six prescription (new or refill) per month limit per adult member.
  - Only two of the six prescriptions may be filled with a brand medication. An override for an additional brand medication may be obtained based on medical necessity.

Assessment and Findings

- Prescription limits can minimize the misuse and overuse of medications, but they can increase the risk of compromising patient care and administrative workload.
- Restricting the number of prescriptions may force the member to choose between two or more medically necessary prescriptions.

Opportunities

- Consider excluding additional medications from the monthly prescription limit policy and expanding maintenance drug list.
- OHCA should consider removing generic maintenance medications from the monthly limits.
- OHCA should consider making the maintenance list available as 90 day or three month supplies instead of only 100 units.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Prior Authorization

- Prior authorization (PA) programs have been used in Medicaid programs for many years, primarily targeting high cost medications, medications for which there is a high potential for misuse or abuse and medications requiring close monitoring.
  - The goal is to assure that therapy is delivered in the most medically appropriate and cost effective manner.

Assessment and Findings

- The OHCA PA program began in 1993 and had been regularly expanded.
  - Encompasses 10 major therapeutic categories and over 300 products
  - Working together, staffs from OHCA, PMC, and the DUR Board have built a solid program.
    - Currently developing criteria for oncology products.
  - Statutory prohibitions in place that prevent applying prior authorization criteria to HIV and Hepatitis C medications.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Prior Authorization (cont'd)

Opportunities

- Mercer has identified 10 additional medication classes (including Hepatitis C and HIV agents) that are typically subject to clinical PA Preferred Drug List placement in the commercial and Medicaid programs.
  - Mercer estimates potential annual savings from implementation of PA and supplemental rebates of approximately $2 million or 0.5% of annual pharmacy spend for these drug classes.
- Since HIV and Hepatitis C drugs account for approximately half of the estimated $2 million annual savings noted, Mercer suggests that OHCA seriously consider modification of statutes to allow implementation of clinical PA and utilization management for HIV and Hepatitis C drugs.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Specialty and Physician Administered Drugs

- "Specialty Pharmacy" - high cost medications, which may require special handling, clinical monitoring, and/or administration by a healthcare provider and are used to treat chronic, complex diseases.
  - Specialty drugs comprise approximately 1% of total prescriptions nationally, but represent 25%-30% of overall prescription drug costs.
  - Average specialty drug cost of more than $2,000 per utilizer per month.
    - Price inflation and new drug approvals driving anticipated annual trends of 18%-20% in 2014 and 2015.
- Specialty medications are classified as either self-administered by the patient or physician-administered in a health care facility.
  - The self-administered medications are typically billed and paid through the outpatient pharmacy benefit using the drug's NDC.
  - Physician-administered medications are billed and paid through the medical benefit.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Specialty and Physician Administered Drugs (cont'd)

Assessment and Findings

- J-Code Maximum Allowable Cost (JMAC) prices are used to reimburse specialty medications billed through either the medical distribution (e.g., physician administered) or outpatient pharmacy distribution channels.
  - JMAC reimbursement ensures consistent reimbursement across both distribution channels.
- OHCA-reported specialty pharmaceutical spend is approximately 12% of total drug spend or $48 million annually.
  - The JMAC program medications are a portion of the total specialty drug spend.
  - Approximately 1% of total drug claims and 6% of paid amount have an established JMAC price.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Specialty and Physician Administered Drugs (cont'd)

April 2013 – June 2013 Paid Claims	Paid Amount	Prescription Count
Medical Distribution Channel		
JMAC Drug Claims	$850,347	11,780
Total Drug Claims	$6,311,753	105,192
Percent of Total Drug Claims	13%	11%
Outpatient Pharmacy Distribution Channel		
JMAC Drug Claims	$5,817,266	1,189
Total Drug Claims	$100,986, 310	1,515,794
Percent of Total Drug Claims	6%	0.1%
Total		
JMAC Drug Claims	$6,667,613	12,969
Total Drug Claims	$107,298,063	1,620,986
Percent of Total Drug Claims	6%	1%

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Specialty and Physician Administered Drugs (cont'd)

Opportunities

- Consider expanding its JMAC list and implementing variable discounts for other select products or therapy classes that are high cost and self administered (e.g., Hepatitis C and Rheumatoid Arthritis therapies).
  - Estimated cost to implement of approximately $50,000 and annual savings of approximately $3 to $5 million.
- Consider implementation of additional utilization management programs such as a restricted specialty provider network or targeted clinical case management strategies.
  - Based on industry standards research, Mercer estimates that OHCA could achieve between 1% and 2% of specialty drug spend through pharmacy channel management (e.g., restricted network), and between 4% and 6% through specialty clinical and ongoing case management.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – 340B Program

- The 340B Drug Pricing Program is a Federally-administered program that allows Covered Entities (CEs) to purchase outpatient medications at or below a defined discount price.
  - Requires drug manufacturers who participate in the Medicaid Drug Rebate Program to sell outpatient drugs to CEs at a price that will not exceed the amount determined under a statutorily defined formula.
    - Can offer significant savings to Medicaid agencies over normal retail pharmacy reimbursement rates.
- The Affordable Care Act (ACA) expanded the definition of CE to allow more hospitals to participate and increased the number of contract pharmacy arrangements allowed by each CE.
  - ACA requires states to define in their State Plan how they will reimburse 340B covered entities for 340B qualified medications.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – 340B Program Benchmarks

State	Ingredient Cost	340B Dispensing Fee	Non-340B Dispensing Fee
Arizona	AWP minus 15%; FQHCs and FQHC Look-alikes at the lesser of billed charges or the 340B ceiling price.	$2.00 (FFS only); $8.75 (FQHCs and FQHC Look-alikes)	$2.00 (FFS only); $8.75 (FQHCs and FQHC Look-alikes)
Florida	Lower of AWP minus 16.4% or WAC plus 1.5%. 340B entities, FQHCs, and their contractors must bill at AAC.	$7.50	$3.73
Kentucky	WAC plus 3.2% (generic); WAC plus 2%; or if WAC is unavailable, the provider will be required to contact the manufacturer for WAC or produce and invoice price. 340B entities will be reimbursed at 340B acquisition cost.Additional $0.125 per IU for clotting factor.	$5.00 (generic); $4.50 (brand)	$5.00 (generic); $4.50 (brand)
Massachusetts	WAC plus 5% (all drugs except 340B billed drugs); actual acquisition cost (340B billed drugs). Additional $0.09 per IU for clotting factor.	$10.00	$3.00
West Virginia	AWP minus 15% (brand); AWP minus 30% (generic) 340B entities must submit the 340B acquisition cost.	$8.25	$2.50(brand); $5.30(generic)

Assessment and Findings

- Federally Qualified Health Centers are the only CEs that are regulated by OHCA.
- OHCA acknowledges that there is a need to align billing practices among CEs.

Opportunities

- Implementing a reimbursement rate for CEs that consists of a 340B cost (340B ceiling price) plus a professional dispensing fee.
- Implement specific disease management programs utilizing selective contracting that encourages 340B optimization and enhances care coordination and drug utilization patterns while improving quality of care.
  - Start with Hemophilia management.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Claims Processing

- States are required to have a mechanized claims processing and information retrieval system - Medicaid Management Information System (MMIS).
- OHCA's current MMIS vendor is Hewlett Packard (HP).
  - During State Fiscal Year 2013, HP processed approximately 6.4 million pharmacy claims for SoonerCare members.
  - HP provides all general claims adjudication services, but the contract does not include pharmacy claim prior authorization services or rebate management as they are performed by PMC and the State, respectively.

Assessment and Findings

- Services provided by HP are considered basic, standard MMIS offerings.
- Concern was noted from pharmacy staff related to system outages.
  - Although less frequent in the last six to nine months, staff expressed concern that they would like HP to be more accountable for identifying outages internally and proactively notifying OHCA staff when they occur.
- HP analysts do not understand OHCA's intentions related to technical system change; OHCA does not understand HP's coding language.
- OHCA Legal Unit is responsible for monitoring the MMIS performance requirements for the entire MMIS contract.

Opportunities

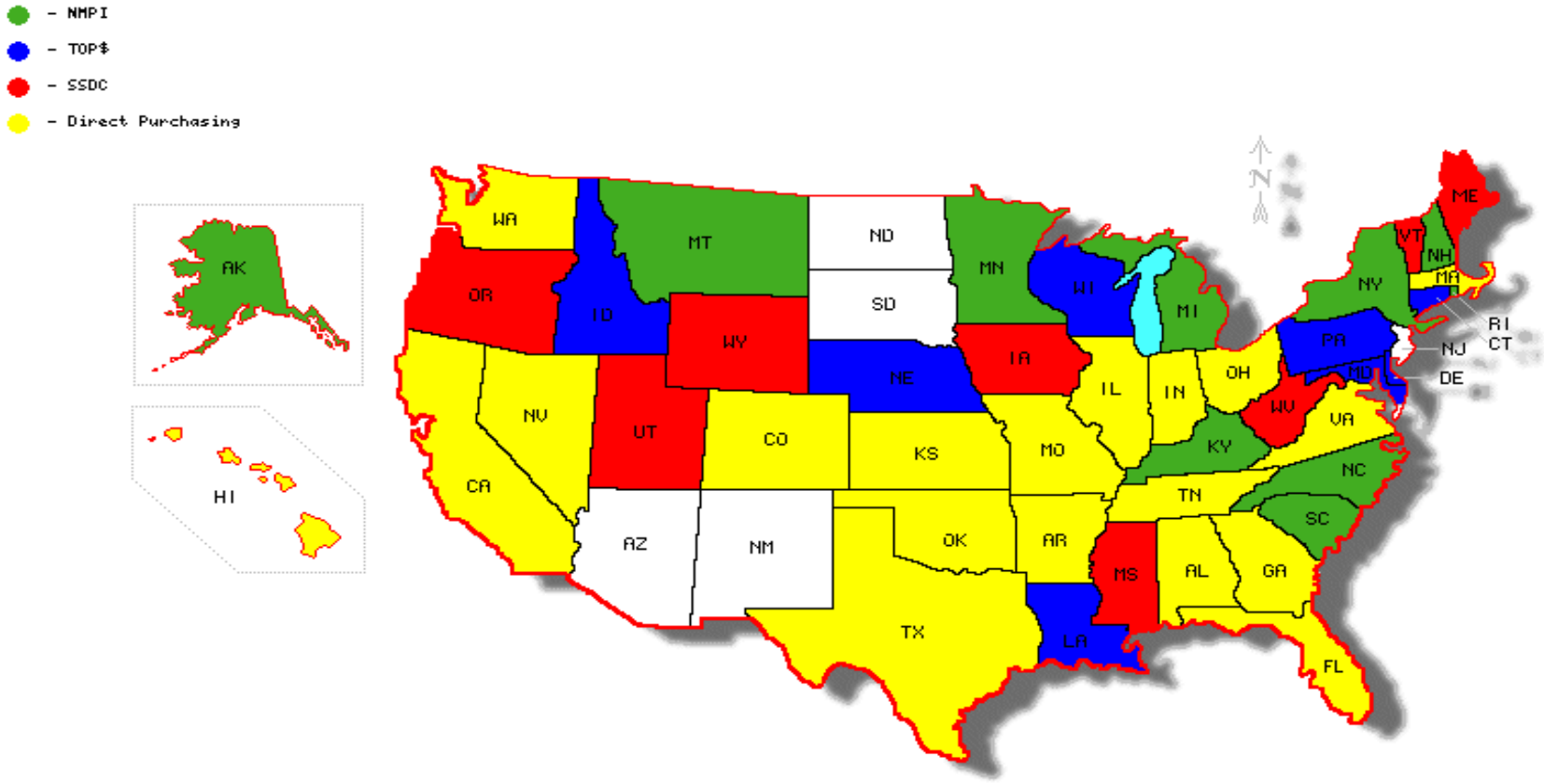
- Collaborate with HP to evaluate options to make the system change process less cumbersome, including HP employing a dedicated pharmacy business analyst and/or system engineer.
- Work to improve communications across OHCA departments to facilitate monitoring of current performance requirements and penalties.
  - Request comprehensive performance guarantees in future contract, focusing on guarantees related to system availability, claims processing accuracy, and plan administration accuracy.
  - Tie performance guarantees to specific dollar penalties and a monitoring process which includes performance reports to assure that the penalties are enforced in cases where the performance guarantees are not met.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Federal and Supplemental Rebate Programs

- OBRA 1990 created the Medicaid Drug Rebate Program requiring manufacturers exchange rebates for Medicaid drug product coverage.
  - States have the option of pursuing supplemental rebates with drug manufacturers.
- Supplemental rebate programs are constructed as either Single-State Supplemental Rebate programs or Multi-State Pooled Purchasing arrangements.
- There are three multi-state purchasing pools approved by CMS:
  - NMPI, administered by Magellan Medicaid Administration (MMA), includes 10 member states and the District of Columbia.
  - TOP$, administered by MMA includes eight member states.
  - SSDC, independently administered by the eight member states with the assistance of a contracted supplemental rebate vendor – Goold Health Systems (GHS).

Pharmacy Program Review

Outpatient Pharmacy Reimbursement – Federal and Supplemental Rebate Programs (cont'd)



Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Federal and Supplemental Rebate Programs (cont'd)

State	Time Period (SFY)	CMS Rebates	Supplemental Rebates	Total Rebates	Supplemental Rebate Program (Vendor)	Generic Dispensing Rate
Oklahoma	2013	44.5%	2.6%	47.1%	State	89%
Arkansas	2012	N/A	N/A	47.5%	State (HP)	81%
Idaho	2013	50.6%	2.5%	53.1%	Multi-state pool (TOP$ - Magellan)	84%
Iowa	2012	49.8%	6.4%	56.2%	Multi-state pool (SSDC – GHS)	77%
Kansas	2012	43.4%	0.8%	44.2%	State (HP)	72%
Montana	2012	47.0%	2.5%	49.5%	Multi-state pool (NMPI - Magellan)	76%
Nebraska	2012	47.1%	2.8%	49.9%	Multi-state pool (TOP$ - Magellan)	81%
Texas	2012	47.5%	3.5%	51.0%	State (Magellan)	73%
Utah	2012	33.7%	1.6%	35.4%	Multi-state pool (SSDC – GHS)	78%

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Federal and Supplemental Rebate Programs (cont'd)

Assessment and Findings

- OHCA has collected
  - ~ $1.7 billion in federal rebates since 1990.
  - $59.5 million in state supplemental rebates since 2003.
- OHCA's drug rebate program staff includes four employees under a program manager and has responsibility for all processes involved with rebate invoicing, collection, dispute resolution, receipting, and disposition of rebate revenue received for all eligible outpatient and physician administered drugs for federal and supplemental rebate program.
- OHCA received a finding- and deficiency-free audit from the Office of the Inspector General in September 2013 for its compliance with Federal Medicaid drug rebate program requirements.

Pharmacy Program Review
Outpatient Pharmacy Reimbursement – Federal and Supplemental Rebate Programs (cont'd)

Opportunities

- Continue to "test the waters" by engaging the major pools to present potential savings analyses.
- Mercer has identified several drug classes which are included in other Medicaid PDL programs in the prior authorization section and recommends that OHCA include a supplemental rebate analysis when evaluating those drug classes.
- Review potential savings opportunities for rebates on diabetic supplies (e.g., meters and test strips) and take action to implement a diabetic supply program within the next calendar year.
  - OHCA that they will be moving forward with this initiative in the spring of 2014.

Section #2
NOTICE of PROPOSED RULE MAKING (NPRM) REVIEW

NPRM Review
Introduction

- CMS published a NPRM titled “Covered Outpatient Drugs” (CMS-2345-P), on February 2, 2012 in the Federal Register.
  - Revises requirements pertaining to Medicaid reimbursement for covered outpatient drugs.
- The key sections of the NPRM that will potentially impact Medicaid outpatient pharmacy programs include:
  - Changes to the reimbursement of covered outpatient drugs.
  - Implications to the Federal Upper Limit (FUL).
  - Changes to the Medicaid Drug Rebate Program.
  - Revisions to the definition of covered outpatient drugs.
  - Changes in definition of Average Manufacturer Price (AMP).
  - Modifications to the State Plan.
- Final rule and guidance publication is anticipated for May/June 2014.

NPRM Review
Reimbursement of Outpatient Covered Drugs

	Drug Spend Based On Current EAC methodology	Drug Spend Based On NADAC rates	Spend Based On Average AAC Rates (Drug Medicaid Benchmark State)
Estimated Annual Ingredient Cost	$390,561,000	$357,244,000	$350,096,000
Estimated Annual Difference From Current EAC Methodology	N/A	($33,317,000)	($40,465,000)
Percentage Difference Between Current EAC Methodology	N/A	-9%	-10%

NPRM Review
Reimbursement of Outpatient Covered Drugs (cont'd)

- Neither NADAC nor benchmark Average AAC rate files can completely replace the current OHCA methodology.
  - Secondary reimbursement methodology would need to price claims.
    - ~1% of claims or 14% of costs without NADAC rate and ~ 4% of claims or 28% of costs without benchmark average AAC rate.
  - Neither NADAC nor benchmark Average AAC rate files contain many ingredient cost rates for non-drug products.
  - A larger percentage of brand NDCs and claim costs do not have NADAC prices available.
    - NADAC pricing methodology excludes specialty pharmacies.
    - ~ 2% of all brand claims (17% of brand claims costs) in the data used for this analysis could be considered to be specialty drugs and did not have NADAC prices.
      - Top 10 NDCs without NADAC pricing represent $20.5 million and 5% of OHCA's annual total drug spend.

NPRM Review
Reimbursement of Outpatient Covered Drugs (cont'd)

	With Current Dispensing Fee	With $7.50 Dispensing Fee	With $10 Dispensing Fee	With $15 Dispensing Fee	Cost Neutral Dispensing Fee
Estimated Annual Drug Spend - Current EAC	**$414,935,000**	$436,035,000	$451,193,000	$481,508,000	$4.02
Estimated Annual Drug Spend - NADAC	$381,618,000	$402,718,000	$417,876,000	$448,192,000	$9.51
Estimated Annual Drug Spend - Average AAC	$374,470,000	$380,412,000	$410,728,000	$441,044,000	$10.69

NPRM Review
Reimbursement of Outpatient Covered Drugs (cont'd)

Action Required for Compliance with Proposed Rules

- Evaluate options between NADAC, an Oklahoma-specific average AAC or alternative benchmark, or whether an argument could be made that the current methodology is reflective of marketplace AAC to CMS.
  - Mercer notes that if OCHA adopts the NADAC, an alternative benchmark for any products that do not have a NADAC will still be needed.
  - Mercer believes this step will be a 3 to 6 month process.
- Conduct a cost of dispensing study to determine the cost of dispensing prescriptions to SoonerCare members.
  - Mercer believes this step will be a 6 to 9 month process.

NPRM Review
Reimbursement of Outpatient Covered Drugs (cont'd)

- Determine the OHCA preferred approach of ingredient and dispensing fee reimbursement and submit a SPA to CMS.
  - Mercer believes that once a decision has been made, CMS approval of a new model would occur within 6 to12 months.
- Change Administrative Rules and provider manuals as necessary, contingent upon Oklahoma's rule making process and legislative approval.
  - Determine MMIS changes needed in the claims processing system to support pharmacy claim adjudication based on changes to the pharmacy reimbursement methodology.
  - MMIS system changes, including testing, will be a 9 to 12 month process.

NPRM Review
FUL Implications

- FUL program was established by CMS to ensure that Medicaid takes advantage of lower market prices for certain multiple-source drugs.
- The proposed rule changes the FUL formula to be calculated at no less than 175% of the weighted AMP to ensure adequate reimbursement to pharmacies.
- Post-ACA FUL rates have more breadth than pre-ACA rates, but still not quite as extensive as the OHCA SMAC program.
  - 85% of all generic NDCs have a SMAC price.
  - 52%-67% of all generic NDCs have a FUL price.
  - Approximately 50% of the drugs covered by the OHCA SMAC program were not covered by the draft FULs.
  - Post-ACA FULs are 22% lower than OHCA SMAC rates for the same time period.

NPRM Review
FUL Implications

Action Required for Compliance with Proposed Rules

- Commit necessary resources to expand the State's FUL monitoring program.
  - Mercer recommends OHCA conduct a paid claims review of all multiple source drugs monthly for the first 3 to 6 months and quarterly thereafter.
  - Mercer believes this enhanced monitoring program could be implemented within 1-3 months of AMP-based FUL rate implementation.

NPRM Review
Drug Rebate Program

The ACA made three substantial changes to the Medicaid Drug Rebate Program:

(1) Increasing the minimum rebate amount for all covered outpatient drugs and differentiating the minimum rebate amount for specific drug indications.
  - For most single source or innovator multiple source drugs, the base rebate amount increased from 15.1% to 23.1% of AMP.
  - For non-innovator multiple source (generic) drugs, the base rebate amount increased from 11% to 13% of AMP.
  - For single source drugs with only a pediatric indication and clotting factors, the base rebate amount increased from 15.1% to 17.1% of AMP.

Action Required for Compliance with Proposed Rules

- Continued monitoring of rebate revenues as an important contributor to State General Funds.

NPRM Review
Drug Rebate Program (cont'd)

(2) Establishing a separate calculation for the Unit Rebate Amounts (URAs) for a drug that is a line extension. Line extensions are defined as a new formulation of a drug, such as an extended release formulation or for the treatment of a newly approved indication for an already marketed drug.

Action Required for Compliance with Proposed Rules

- If required in the final rule, develop a mechanism to identify circumstances under which alternative URAs should be applied based on prescribed use for individual patients.
  - Mercer believes that contingent upon competing priorities, an MMIS change of this magnitude could take 9-12 months.
- Solicit stakeholder input and engagement if hard edits are employed. Communication plan is estimated to take 6-9 months.
- Pursue additional CMS funding for MMIS changes needed to comply with requirement.
  - Mercer believes this process could take 6-9 months.

NPRM Review
Drug Rebate Program (cont'd)

(3) Allowing Medicaid pharmacy programs to collect rebates for drugs dispensed to beneficiaries enrolled in a Medicaid MCO.

Action Required for Compliance with Proposed Rules

- This section of the NPRM was previously made retroactive to the effective date of the ACA.
- No immediate actions necessary as OHCA operates on a fee-for-service model.
  - Any future considerations or modeling of expenses associated with managed care should include this requirement.

NPRM Review
Definition of Covered Outpatient Drugs

- CMS has provided clarification regarding the definition of a covered outpatient drug and the limiting definitions.
  - NPRM defines covered outpatient drugs as not including any drug product or biological used for a medical indication which is not a medically accepted indication.
  - *The NPRM does not define a medically accepted indication.*
- If the regulation is implemented with the same definition for medically accepted indication as the statute, then states could be required to collect the medical indication or diagnosis code for any drugs prescribed and omit reimbursement for any indication that was not approved by the FDA or cited/approved for inclusion in a medical compendia.
  - An intensive education program and data collection effort would be needed to implement this requirement.

NPRM Review
Definition of Covered Outpatient Drugs (cont'd)

Action Required for Compliance with Proposed Rules

- If this requirement does make the final rule, work with other states to conduct and maintain an analysis and list of the FDA approved indications and citations/recommended inclusions in the compendia.
  - Work with the State's MMIS to collect diagnoses for prescriptions and to maintain the list of approved indications from the FDA/compendia.
- Conduct an analysis of claims for persons utilizing these products in conflict with the medical indication and clarify if the drug was prescribed in a manner inconsistent with medically accepted indications.
- Modify MMIS to pay for only drugs used to treat approved indications.
  - OHCA should pursue enhanced funding from CMS for needed system changes.
  - Mercer recommends this occur along a 6-9 month project timeline parallel to that in the previous section.

NPRM Review
Changes in definition of AMP

- FUL can be calculated at no less than 175% of the weighted AMP.
- Requires CMS to disclose online the weighted average of the most recently reported AMP for multi-source drugs and requires manufactures to report to CMS the total number of units used to calculate the monthly AMP in order for CMS to determine the weighted average.
- The NPRM also discusses identifying 5i drugs and including them in AMP.
  - CMS defines 5i drugs to be those that are typically administered via inhalation, infusion, instillation, implantation, and injection.

Action Required for Compliance with Proposed Rules

- At present, the associated overall fiscal impact are indeterminate, and anticipated changes related to 5i drugs are negligible relative to other aspects of NPRM compliance.
  - Mercer does not believe any OHCA action is required.

NPRM Review
Modifications of State Plan

- Requires states to identify their 340B ingredient cost reimbursement and dispensing fee methodologies in their state plans.
  - The 340B statute does not mandate the use of a 340B rate (acquisition cost billing or otherwise) that must be paid by the Medicaid programs.
- Requires states to submit a SPA when changing their professional dispensing fee, including an evaluation of the unique circumstances for 340B CEs or Indian Health Service and tribal pharmacies.
- The NPRM proposes several programmatic changes to the 340B program
  - Expanding the types of entities eligible to participate in 340B program.
  - Removing children's hospitals from the orphan drug exclusion.
  - Clarifying how manufacturers are to treat orphan drugs sold to new CEs.
  - Requiring that manufacturers not pay rebates if an MCO pays for the drugs and the drugs are under a 340B program.

NPRM Review
Modifications of State Plan (cont'd)

Action Required for Compliance with Proposed Rules

- If OHCA decides to cover investigational drugs, the Medicaid State Plan would need to be amended.
- OHCA will need to update its State Plan to include a 340B reimbursement strategy.
  - Engage all 340B CEs in the State to ensure stakeholder concerns are addressed in the reimbursement strategy.

Section #3
COST BENEFIT ANALYSIS
University of Oklahoma - Pharmacy Management Consultants

Cost Benefit Analysis
Introduction

- This section reviews contracted services provided by PMC in the following areas:
  - Pharmacy help desk
  - Clinical PA processing
  - Drug Utilization Review (DUR) Board support and clinical services
  - Prospective DUR (ProDUR) and Retrospective DUR (RetroDUR)
  - State Maximum Allowable Cost (SMAC) program
  - Pharmacy Lock-In
  - Pharmacotherapy management, specifically the Therapy Management Initiative (TMI)
- Mercer reviewed efficiencies OHCA may gain if OHCA were to use a competitive procurement process and completed a financial benchmark review of the OHCA/PCM contract.

Cost Benefit Analysis
Overall Contract Assessment

- Mercer's analysis indicate that PMC's current not-to-exceed contract of $4,000,000, inclusive of other salaries and benefits, travel, capital expenses, and other program costs, is in the middle of Mercer's cost benefit analysis estimates, but well below the fees projected for a competitive bid.

	PMC		Benchmark	
Total Estimated Costs	**Low**	**High**	**Low**	**High**
Help Desk	$1,030,000	$1,160,000	$1,000,000	$1,200,000
Clinical PA Processing	$1,180,000	$1,310,000	$1,980,000	$5,030,000
DUR Board	$440,000	$500,000	$210,000	$450,000
ProDUR and RetroDUR	$110,000	$140,000	$1,370,000	$4,410,000
SMAC	$110,000	$140,000	$90,000	$310,000
Lock In	$130,000	$150,000	$250,000	$530,000
Therapy Management Initiative	$30,000	$50,000	$10,000	$100,000
Subtotal	$3,030,000	$3,450,000	$4,910,000	$12,030,000
Other Expenses	$640,000	$640,000	TBD	TBD
Additional Contract Staff	$125,000	$250,000	TBD	TBD
Total	$3,795,000	$4,340,000	$4,910,000	$12,030,000

Cost Benefit Analysis
Help Desk - Background

- PMC help desk is to “be available to medical and pharmacy providers to assist them in optimizing a member’s therapy, treatment, and/or pharmacy benefits.”
- PMC operates the OHCA help desk from 8 am to 7 pm Monday through Friday, 9 am to 5 pm on Saturday, and 11 am to 5 pm on Sunday.
- PMC’s help desk staff includes a 0.75 FTE manager, 3 supervisors, 14 help desk representatives and an IT technician.
- The contract between PMC and OHCA specifies the following performance guarantees for the help desk:
  - Monthly average service level of 80% or higher (i.e., 80% of calls answered within 30 seconds).
  - Abandoned call rate not to exceed 10% of calls received after being placed in queue.
    - PMC has always been compliant with these performance guarantees.

Cost Benefit Analysis
Help Desk – Background (cont'd)

SFY 2013 PMC Help Desk Statistics	Total	Monthly Average
Inbound Calls Offered	132,087	11,007
Inbound Calls Answered	130,245	10,854
Outbound Calls	2,032	169
% of Calls Answered within 30 Seconds (service level)	-	86%
Average Answer Speed (in seconds)	-	0:19
Average Length of Call	-	2:51
Abandoned Calls	1,606	134
Average Abandonment Time	-	1:14
% of Calls Abandoned (not answered)	-	1.2%

Cost Benefit Analysis
Help Desk – Assessment and Opportunities

- Mercer recommends the following Help Desk improvement opportunities:
  - Consider clarifying the frequency of the reporting (for example, annually) for each of the performance guarantee measures.
    - Clarify contract language to further explain (with example) the calculation of the ‘penalty’ and consider stating minimum and/or maximum dollar amounts, to the extent Oklahoma law allows in vendor contracts.
  - Consider negotiating higher percentage performance guarantee thresholds congruent with marketplace standards.
  - Consider requiring vendor to conduct and report on annual member and provider customer satisfaction surveys that contain both qualitative and quantitative measures and allow for comments and suggestions.

Cost Benefit Analysis
Help Desk – Cost Benefit Analysis

- PMC's estimated help desk fees are between $1.30 and $1.50 per enrollee with indirect costs.
  - Current fees are equivalent to the benchmark.

Help Desk	PMC		Benchmark	
	Low	High	Low	High
Annual Costs	$1,030,000	$1,160,000	$1,000,000	$1,200,000

Cost Benefit Analysis
Clinical PA – Background

- PMC manages the evaluation of medication coverage and OHCA requires PMC to:
  - Provide resulting determination responses to the dispensing pharmacy within 24 hours from the time the completed request is submitted.
  - Confirm all coverage denials by a licensed clinical pharmacist.
  - Respond in writing to letters from providers and patients with questions about the PA process.
  - Provide information, technical expertise and/or testimony as needed by OHCA PA grievance/legal procedure.
  - Submit monthly reports to OHCA.
  - Process and document Level One Reconsiderations of denied prior authorization petitions.

Cost Benefit Analysis
Clinical PA – Background (cont'd)

- PMC must process at least 90% of PA requests within 24 hours of receipt of a completed petition.

PMC Clinical PA Activity Summary	SFY 2013
Total Regular PAs	81,327
Total Overrides	18,934
Total PA Reviews	**100,261**
% of PA Reviews Meeting 24-hour Turnaround Requirement	**99.9%**

- PMC reported that approximately 84% of the PAs were approved and 16% were denied during SFY 2013.

Cost Benefit Analysis
Clinical PA – Assessment and Opportunities

- Mercer believes PMC's PA processing services and quality are comparable to other states' and commercial PBM's PA programs.
  - OHCA reported overall satisfaction with PMC's clinical PA service.
  - The volume of PA review requests and the approval rates are similar compared to other Medicaid programs.
  - PMC is exceeding the 90% 24 hour turnaround requirement and has always been compliant with this measure.
- PMC reported that it is preparing to adopt additional quality control measures.

Cost Benefit Analysis
Clinical PA – Assessment and Opportunities (cont'd)

- Mercer recommends the following improvement opportunities for Clinical PA processing:
  - Consider making the frequency of the performance guarantee measurement equivalent to the reporting frequency.
  - Currently the performance guarantee is based on a daily outcome review, but PMC reports the measure as a monthly average.
  - Clarify contract language to explain (with example) the calculation of the 'penalty' and issuing minimum and/or maximum penalty dollar amounts, to the extent Oklahoma law allows in vendor contracts.

Cost Benefit Analysis
Clinical PA – Cost Benefit Analysis

- PMC estimated costs are approximately between $12.30 and $12.50 per PA review with indirect costs.
  - This estimate includes overhead, telecom/network, technology and labor costs.
- Mercer estimates that OHCA would pay between $2 and $5 million based on clinical PA review costs observed in benchmark states and commercial PBM contracts.

	PMC		Benchmark	
Clinical PA Processing	**Low**	**High**	**Low**	**High**
Annual Costs	$1,180,000	$1,310,000	$1,980,000	$5,030,000

Cost Benefit Analysis
DUR Board Support – Background

- The primary goal of the DUR Board is “to enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use. This goal is accomplished primarily by educating physicians and pharmacists to ensure that drug therapy is appropriate, safe and effective.”
- OHCA contracts with PMC to provide DUR Board support services.
  - PMC is required to deliver pharmacy research and consulting services to the DUR Board and OHCA staff.
- PMC indicated 3 FTE pharmacists and 0.5 FTE clerical staff allocated to support the DUR Board activities.
  - Additional PMC staff are available as needed.

Cost Benefit Analysis
DUR Board Support – Assessment and Opportunities

- Mercer reviewed samples of the monthly DUR Board packets, reports, and the CMS Annual Drug Utilization Review and also attended the September DUR Board meeting.
  - Compared to other states, the OHCA's DUR Board meetings are more frequent.
  - PMC staff conducts all of the clinical research for the drug reviews and they are unique to the SoonerCare program.
- Mercer believes the monthly DUR board meetings and ongoing research and monitoring of the program is a benefit to OHCA.
- There is a contractual performance requirement related to DUR services.
  - If PMC does not provide the CMS Annual DUR report to OHCA within 15 days prior to the CMS deadline, OHCA will withhold 10% of the month due invoiced amount.
  - PMC has always been compliant with this measure.

Cost Benefit Analysis
DUR Board Support – Cost Benefit Analysis

- Mercer's estimated benchmark costs are slightly lower than estimated PMC's costs.

	PMC		Benchmark	
DUR Board	**Low**	**High**	**Low**	**High**
Annual Costs	$440,000	$500,000	$210,000	$450,000

- Under a competitive procurement process, OHCA may receive offers that leverage national clinical and support staff.
- Given the frequency of meetings required and the extensive support provided to the DUR Board from the contractor, Mercer believes that any successful bidder would need to dedicate additional resources as compared to a typical commercial DUR or Pharmacy and Therapeutics Committee structure.

Cost Benefit Analysis
ProDUR and RetroDUR Support – Background

- OHCA contracts with PMC to provide ProDUR, RetroDUR, and related educational services.
  - As part of the ProDUR program, PMC provides the clinical pharmacy support and updates POS quantity limits and edits for drugs that are commonly billed with incorrect units.
  - For RetroDUR, PMC maintains 4 modules and produces quarterly mailings.
  - PMC provides routine ProDUR and RetroDUR reports and produces the annual CMS report to assist OHCA with program monitoring.
    - PMC also responds to OHCA's ad hoc reporting requests.
  - OHCA and PMC DUR staff collaboratively determine the annual RetroDUR program priorities, program improvements and strategy.
- PMC allocates approximately 0.75 FTE pharmacist and 0.2 FTE clerical staff to support and manage the ProDUR and RetroDUR programs.
  - Additional PMC staff are available as needed.

Cost Benefit Analysis
ProDUR and RetroDUR Support – Assessment and Opportunities

- Mercer believes PMC and OHCA have developed a cooperative relationship and a common goal to build robust ProDUR and RetroDUR programs.
- PMC demonstrated that they are pro-active as they dedicate resources to monitor the pharmaceutical marketplace.
  - Several ProDUR step therapy enhancements are planned for 2014.
- Mercer notes that PMC provides dedicated IT staff to code report requests, test and analyze newly programmed edits/audits in the MMIS and conduct data analysis.
  - PMC reported it has access to OHCA's data warehouse which allows them to use both medical and pharmacy data in their analyses.
    - This is unique as most commercial pharmacy vendors do not easily integrate medical data into analyses.
  - The PMC IT staff complete many ad hoc requests at no cost to OHCA to help monitor the pharmacy program.

Cost Benefit Analysis
ProDUR and RetroDUR Support – Cost Benefit Analysis

- Mercer estimates PMC's ProDUR and RetroDUR costs are between $110,000 and $140,000 annually including indirect expenses.
- Mercer estimates other Medicaid and commercial programs pay between $1,370,000 and $4,410,000 for combined ProDUR and RetroDUR services.
  - Commercial PBMs typically charge for RetroDUR services on a per claim basis, ranging from $0.15 per claim to $0.50 per claim.
  - Mercer estimates that ProDUR expenses in Medicaid programs range between $0.10 and $0.20 per claim when itemized.

	PMC		Benchmark	
ProDUR and RetroDUR	**Low**	**High**	**Low**	**High**
Annual Costs	$110,000	$140,000	$1,370,000	$4,410,000

Cost Benefit Analysis
SMAC – Background

- State Maximum Allowable Cost (SMAC) pricing is a cost containment initiative used by program administrators to encourage pharmacy providers to purchase and dispense the most-cost effective generic products.
- PMC manages the SMAC program for OHCA and provides the SMAC rates, research and related reporting services.
- PMC employs between 0.3 and 0.5 FTE throughout the year, depending on the SMAC update cycle, to manage the SMAC program.
- The OHCA/PMC contract specifies two performance guarantees for the SMAC program:
  - OHCA will withhold 10% of the next months' invoice price for PMC's failure to provide the SMAC review and/or updates within the agreed upon timeframe.
  - OHCA will withhold 10% of the next months' invoice price for PMC's failure to provide the semi-annual SMAC review and/or updates within the agreed upon timeframe.
  - PMC has always been in compliance with these measures.

Cost Benefit Analysis
SMAC – Assessment and Opportunities

- The breadth (number of drugs on the SMAC list) of OHCA's SMAC list is comparable to the breadth of state benchmark MAC lists.
- OHCA's overall effective AWP and WAC discounts suggest slightly greater average SMAC prices compared to benchmark states' MAC effective discounts.

SMAC List	OHCA SMAC	State A SMAC	State B SMAC	Commercial PBMs MAC
Breadth Analysis				
Total GCNs on SMAC	1,652	1,789	897	700 to 2,200
Overlapping GCNs	N/A	1,207	601	N/A
Oklahoma SMAC Price Higher	N/A	650	305	N/A
Oklahoma SMAC Price Lower	N/A	556	296	N/A
Depth Analysis				
Overall Effective AWP Discount of SMAC List	AWP-80%	AWP-82%	AWP-83%	AWP – 70% to AWP – 85%
Overall Effective WAC Discount of SMAC List	WAC-28%	WAC-29%	WAC-33%	N/A
Dispensing Fees	$4.02	$4.00-$4.25	$6.25-$6.50	$0.90-$1.75

Cost Benefit Analysis
SMAC – Assessment and Opportunities (cont'd)

- Increase the frequency of full SMAC pricing reviews and updates to at least quarterly.
- Consider specifying in the performance guarantees whether the penalties are calculated per incident and/or are cumulative in a month.
- Consider stating minimum and/or maximum dollar amounts for performance guarantee penalties, to the extent Oklahoma law allows vendor contracts.

Cost Benefit Analysis
SMAC – Cost Benefit Analysis

- Mercer estimates PMC's SMAC management fee is between $110,000 and $140,000 annually including indirect expenses.
- Typically, MAC program fees are included in commercial PBMs base administrative fee and not identified separately.
- For Medicaid programs, states pay contractors between $90,000 and $310,000 annually.
  - The higher end of this range reflects more frequent SMAC reviews, where all GCNs are reviewed and updated at least quarterly.

	PMC		Benchmark	
SMAC	**Low**	**High**	**Low**	**High**
Annual Costs	$110,000	$140,000	$90,000	$310,000

Cost Benefit Analysis
Pharmacy Lock-In – Background

- In January 2006, PMC assumed the management of OHCA's Pharmacy Lock-In Program. The OHCA Pharmacy Lock-In Program assists health care providers with monitoring the potential abuse or inappropriate utilization of controlled prescription medications (narcotics) by SoonerCare members.
- Currently, there are 376 SoonerCare members enrolled.
  - On average in SFY 2013, PMC reviewed 180 SoonerCare members' medication and medical services utilization profiles per month.
- PMC staffing for the Lock-In Program includes a 0.6 FTE pharmacist and 1 FTE administrative coordinator.
  - IT staff also contribute 1 to 2 hours per week to support the program.
  - PMC does not charge extra for reporting and monitoring, or appeals, but does pass-through mailing costs.

Cost Benefit Analysis
Pharmacy Lock-In – Assessment and Opportunities

- PMC's use of the retrospective claims review process is resource intensive but beneficial for identifying polypharmacy and pharmacy and provider utilization issues.
  - PMC's plans to increase future automation for claims analysis will enhance the program's future effectiveness and outcomes.
- PMC indicated that it has started to monitor emergency fill requests and temporary prior authorization overrides for Pharmacy Lock-In members.
  - Early detection of these potential abuse patterns would likely result in greater program adherence and savings.
- Other state programs do not have the level of service flexibility that PMC offers.
  - PMC does not limit the number of profile reviews it conducts.
  - PMC provides monthly reporting and anticipates conducting a savings and outcomes analysis without an additional charge to OHCA.

Cost Benefit Analysis
Pharmacy Lock-In – Cost Benefit Analysis

- Mercer estimates PMC's costs for Pharmacy Lock-In services is between $130,000 and $150,000 annually including indirect expenses.
- PBMs and other contractors often charge a la carte for appeal and hearings support related to lock-in programs.
  - PMC does not charge a la carte for these services; they are included in the overall contract costs.

	PMC		Benchmark	
Pharmacy Lock-In	**Low**	**High**	**Low**	**High**
Annual Costs	$130,000	$150,000	$250,000	$530,000

Cost Benefit Analysis
Therapy Management Initiative – Background

- PMC has managed OHCA's Therapy Management Initiative (TMI) since 2004.
- OHCA's TMI, monitors SoonerCare members who are eligible for the Home and Community-Based Waiver Program and who receive a large number of prescriptions or very expensive prescriptions each month.
- Currently, there are 430 SoonerCare members who are tracked and monitored in PMC's TMI database.
  - PMC reviews approximately 40 cases per month; ninety percent of them PMC identifies through the prior authorization process and the remaining ten percent are referrals.
- PMC's TMI staffing includes a 0.2 FTE pharmacist and University of Oklahoma pharmacy students who assist with research and data gathering as needed each month.
  - PMC does not charge extra for reporting.

Cost Benefit Analysis
Therapy Management Initiative – Assessment and Opportunities

- The TMI program's success is attributable to strong IT support that assists with customizing PMC's member tracking database and access to members' historical and real-time pharmacy and medical claims data.
- PMC places a strong emphasis on contacting physicians associated with TMI enrolled members to facilitate communication and continuity of care.
- Although PMC reports on monthly and quarterly TMI activities performed, PMC has not provided financial impact or pharmacy or medical outcomes analyses to OHCA.
  - Mercer recommends OHCA and PMC explore using University pharmacy students or staff to evaluate the quantitative and qualitative outcomes of the TMI program to determine if expanding this program would be justified.
  - Mercer recommends that OHCA and PMC review other Medicaid state program evaluations similar to the TMI to obtain benchmarks or review potential study design options.

Cost Benefit Analysis
Therapy Management Initiative – Cost Benefit Analysis

- Mercer estimates PMC's TMI fees are between $30,000 and $50,000 annually including indirect costs.
- In general, fees for similar programs are calculated on a per clinical review basis or per member per month (PMPM), and sometimes vendors offer program savings guarantees.
- Mercer estimates the charge for a similar program would be between $10,000 and $100,000.
  - Reporting would likely be an additional charge.

	PMC		Benchmark	
TMI	**Low**	**High**	**Low**	**High**
Annual Costs	$30,000	$50,000	$10,000	$100,000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