COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

November 1, 2007

The Honorable Abel Tapia, Chairman
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Tapia:

This letter is presented to the Joint Budget Committee (JBC) of the Colorado General Assembly in response to footnote 23 of Senate Bill 07-239:

> *The Department is requested to provide a report to the Joint Budget Committee by November 1, 2007 regarding the amount spent on pharmaceuticals by each managed care organization (MCO) that contracts with the Department in the Medicaid program. Included in the report should be information on the prices that each MCO pays for each prescription drug provided on its formulary. The report should compare the prices that each MCO pays compared to the prices the Department pays in the fee-for-service program for the same drug. In making such comparison, the Department should include in its pricing the amount of rebates that the Department receives from drug manufacturers for each drug. The report should also provide information on which drugs are covered on each MCO's formulary compared to the list of drugs available in the fee for service program.*

As you are aware, footnote 23 and other footnotes were vetoed by the Governor, and on the final day of the legislative session, both chambers of the General Assembly overrode the vetoes. The Governor did instruct the Department to comply, to the extent feasible, with footnote 23.

> *This footnote requests that the Department of Health Care Policy and Financing prepare a detailed report "regarding the amount spent on pharmaceuticals by each managed care organization (MCO) that contracts with the Department in the Medicaid program,"and provide this report to the Joint Budget Committee by November 1, 2007. Because the MCOs are private entities, neither the Department of Health Care Policy and Financing nor the State have control over the availability of the requested information, let alone the timing with which these MCOs provide information that may be requested. Because the Department does not control this information it cannot assure full compliance with this footnote. The Governor is, however, directing the department to request this information from the MCOs and to comply with this footnote to the extent that the information is available from the MCOs.*

To comply with this footnote to the extent that the information is available from the MCOs, the Department has requested and received information from both of the Department's contracted managed care plans.

1. *The amount spent on pharmaceuticals by each managed care organization (MCO) that contracts with the Department in the Medicaid program.*

   Denver Health and Hospital Authority spent $10,304,159 for pharmaceuticals under its Medicaid managed care program for the fiscal year ended June 30, 2007. Rocky Mountain Health Plans spent $16,012,946 for pharmaceuticals under its Medicaid managed care program for this same period. This information was reported directly from the MCOs and was not authenticated by the Department.

2. *Included in the report should be information on the prices that each MCO pays for each prescription drug provided on its formulary.*

   Comparing prices of the numerous drugs that each MCO covers to the prices the Department pays in the Medicaid fee-for-service program and including the pricing of rebate amounts is a significant assignment. To complete this task, the Department must create a large database to manipulate and analyze the data, as the sources of the information are different and are not directly comparable. For example, Medicaid fee-for-service paid claims information is available in the Department's Decision Support System (which does allow the Department to query all paid pharmacy claims), the drug rebate information is available in Drug Rebate Analysis and Management System (which does not have a direct query tool) and the MCOs will need to provide the information in a completely different format. The Department does not have the internal resources to complete this task and estimates it would require an intern working at least 24 hours a week for 6-months to complete. For a statistical analyst internship, the Department estimates the cost at $18/hour for 24 weeks for a total of $11,730 including Medicare and PERA benefits. Further, it should be understood that these funds would not be used to reimburse the MCOs for querying, reorganizing and submitting the data to the Department. This would also require a substantial amount of work from the MCOs.

3. *Prices the Department pays in the fee-for-service program for the same drug. In making such comparison, the Department should include in its pricing the amount of rebates that the Department receives from drug manufacturers for each drug.*

   A. The Medicaid fee-for-service program uses the following pricing methodologies for pharmaceuticals with the methodology resulting in the lowest price being used:

      - Average wholesale price (AWP) minus 13.5% for brand name drugs
      - Average wholesale price (AWP) minus 35% for generic drugs
      - Direct price plus 18%

- State Maximum Allowable Cost (M.A.C.), pharmacy acquisition cost of generic drugs available in the state marketplace plus 18%
- Federal Upper Limit (FUL)

B. In addition, the Medicaid fee-for-service program pays a dispensing fee as follows:

- The dispensing fee for retail pharmacies is $4.00
- Institutional pharmacies receive a fee of $1.89
- Governmental pharmacies that have the cost of dispensing covered as part of an all-inclusive Medicaid payment receive no fee
- Dispensing physicians whose office or sites of practice are located more than 25 miles from the nearest participating pharmacy receive a fee of $1.89

The Medicaid fee-for-service program has drug rebates that range from 22.3% to 30.9%, depending on the drug and manufacturer.

4. *The report should also provide information on which drugs are covered on each MCO's formulary compared to the list of drugs available in the fee for service program.*

Here are restrictions on medications through the Medicaid fee-for-service program that Denver Health and Hospital Authority might cover. The Department has chosen to exclude some of the categories listed below and some the Department will pay for with a prior authorization.

A. Only those drugs supplied by companies participating in the federally approved Medicaid drug rebate program are regular drug benefits.

B. The following drug categories may be excluded from being a drug benefit or may be subject to prior authorization:

- Agents when used for anorexia or weight gain
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for symptomatic relief of cough and colds
- Agents when used to promote smoking cessation
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Non-prescription drugs
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

- Less-than-effective drugs (LTE) identified by the Drug Efficacy Study Implementation (DESI) program
- Barbiturates
- Benzodiazepines

C. Aspirin and insulin are the only Over The Counter (O.T.C.) Drugs that are regular benefits without restriction. All other O.T.C. Drugs must be prior authorized before a client may receive them as a drug benefit.

D. Drugs not covered by rebate agreements may be reimbursed only if the Department has made a determination that the availability of the drug is essential, such drug has been given 1-A rating by FDA, and prior authorized.

E. Medicare Part D Drugs shall not be covered by Medicaid for Part D Eligible Individuals.

F. The excluded drugs listed above shall be covered for Part D Eligible Individuals in the same manner as they are covered for all other eligible Medicaid clients.

G. Drugs or drug categories which are subject to prior authorization, maximum reimbursement constraints such as State M.A.C. or the Federal Upper Limit are identified in provider bulletins. Advice from the Drug Use Review Board is used to determine which drugs will be subject to, prior authorization or exclusion, or State M.A.C.

If you have any questions, please contact Jerry Smallwood, Managed Care/Behavioral Health Section Manager at 303/866-5947.

Sincerely,

Joan Henneberry
Executive Director

JH:js

Cc: Representative Bernie Buescher, Vice-Chairman, Joint Budget Committee
Senator Moe Keller, Joint Budget Committee
Senator Steve Johnson, Joint Budget Committee
Representative Jack Pommer, Joint Budget Committee
Representative Al White, Joint Budget Committee
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