



An Evidence-based Approach to Controlling Arkansas Medicaid Drug Costs



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Background

Medication costs are among the fastest growing components of Medicaid spending. In Arkansas Medicaid, the compound annual growth rate of medication costs exceeded 16 percent over the past nine state fiscal years. To combat this growth, the University of Arkansas for Medical Sciences (UAMS) College of Pharmacy collaborated with the Arkansas Department of Health and Human Services (DHHS) to create an Evidence-based Preferred Drug List (PDL) for Arkansas' Medicaid.

Objectives

- ☞ Create a PDL selection process focusing on clinical evidence as the primary deciding factor for inclusion on the PDL.
- ☞ Use Arkansas physicians and pharmacists to evaluate clinical data and make PDL recommendations.
- ☞ Solicit manufacturer supplemental rebates to reduce medication costs to the State, but use this information only after clinical evidence has been evaluated.
- ☞ Develop a simple, yet sophisticated Prior Authorization (PA) process administered by clinical pharmacists using prescription and medical claims data to make PA determinations.

Methods

A Drug Review Committee (DRC), composed of Arkansas physicians and pharmacists, meets monthly. The DRC receives public comment from interested parties about medications subject to review. Committee members receive comprehensive reviews of the evidence on medications in a category, and study this and other information over the time until the next DRC meeting. Among the topics of concern to the DRC are safety, effectiveness, comparative efficacy, and subpopulations. At the next monthly DRC meeting, the committee discusses the evidence and summarizes their findings as a recommendation.

The DRC recommendation is passed to the Drug Utilization and Cost Committee (DUCC). The DUCC is composed of UAMS and DHHS physicians and pharmacists. The DUCC reviews the current net costs to Arkansas Medicaid, and opens sealed net price bids submitted by manufacturers. Costs and use patterns are analyzed in light of the clinical DRC recommendations, and a consolidated recommendation is made to DHHS.

DHHS acts on the combined recommendations, and ultimately selects agents for the PDL. Providers and the public are notified of the PDL selection, and implementation occurs within 60 days. After implementation, all prescriptions for non-preferred medications require a PA.

Prior Authorizations can only be obtained for non-preferred drugs by calling the EBRx PA Call Center. This center within the UAMS COP is staffed by pharmacists.

Results

Implementation of Therapeutic Classes

- From January 2005 to May 2006, twelve therapeutic classes have been implemented on the PDL

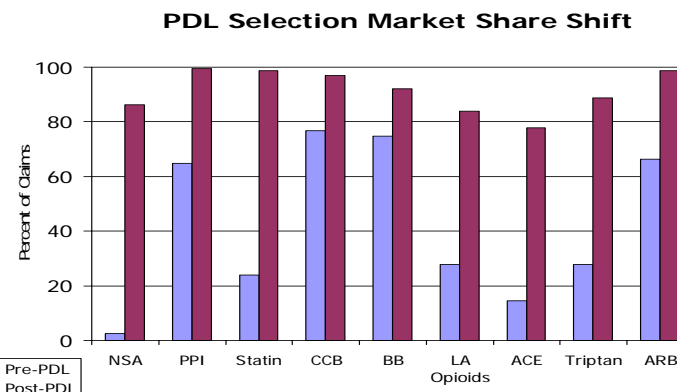
Average Cost Per Prescription in PDL Categories

- Has been reduced in every category
- Eight categories have experienced net cost reductions of greater than 30 percent (Triptans, Statins, ACE Inhibitors, Skeletal Muscle Relaxants, Beta Blockers, Non-Sedating Antihistamines, Long Acting Opioids, and Proton Pump Inhibitors); four of these categories have seen net cost reductions of greater than 50 percent.

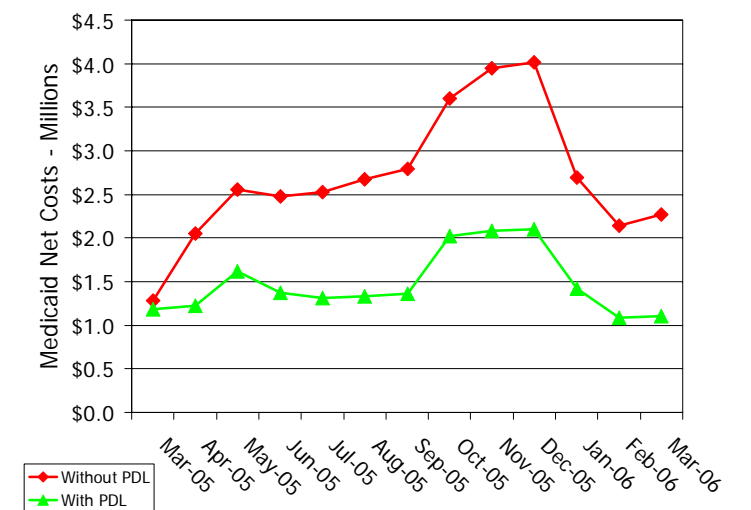
Total Direct Pharmacy Program Savings

- From March 2005 to April 2006, total pharmacy benefit savings is \$17,000,000.

PDL Market Share Changes



Net Cost Changes with PDL



Conclusions

- ☞ The savings represented occurred as the result of shifting market share to the most effective, least expensive product(s).
- ☞ The significant shifts are a direct result of aggressive provider education prior to the implementation of "hard edits" requiring prior authorization prior to dispensing a non-preferred product.
- ☞ Pharmacist administered PA process has transformed 'access roadblock' into clinical encounter between two healthcare professionals.