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Pharmacy Benefits

Table 4-1: Prescription Drug Landscape

Landscape	Michigan	National Average
Retail prescription price	\$60.14	\$58.49
Number of prescriptions per capita	10.9	11.15

Source: Kaiser Family Foundation

Major Developments:

- » Priority Health offers medication therapy management for commercial members who seek service at two of its largest provider groups. Employers are demanding it, but few commercial health plans offer the service.
- » Evidence-based pharmacy benefits are making their presence felt as certain drug classes face tighter restrictions. It's the shape of things to come as more payors take aim at costs.
- » Michigan ranks third in the country for e-prescribing volume. Efforts to promote e-prescribing have room to grow, and federal stimulus money could accelerate the effort.

Priority Brings Medication Therapy Management To Commercial Side

The concept of putting chronically ill patients with multiple comorbidities and polypharmacy in regular contact with a clinical pharmacist continues to grow in popularity and produce evidence of success. Priority Health in Grand Rapids is now in the second year of a medication therapy management program that it hopes to expand to serve more commercial members.

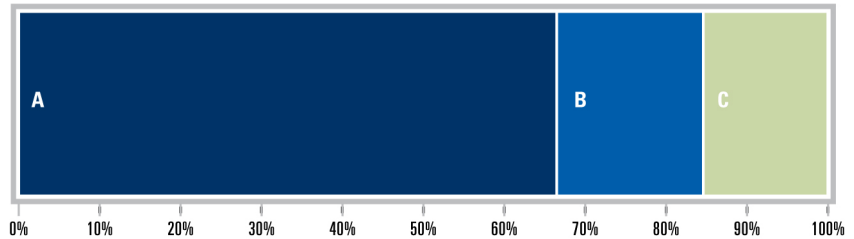
Priority now has about 200 members who have utilized the service. Partnering with two of the largest physician organizations in its network, this pilot program goes beyond the MTM programs that insurers must provide if they offer a Medicare Part D prescription drug benefit. The pilot serves Priority's commercial members, which number 463,967 as of January 2010 (HealthLeaders-InterStudy).

Launched in April 2009, the program is open on a voluntary basis to members with two or more chronic illnesses and five or more chronic therapies. Eligible patients are placed in an electronic registry. A pharmacist reviews the patient's charts, consults with his or her doctors and meets one-on-one with the patient to help identify problems. These can include incorrectly taking medication, forgetting to take medication, dosages that are too small or too large, drug-drug interactions, side effects and unnecessary duplications. Eligible patients frequently have multiple physicians and pharmacies who may not share information.

Table 4-2: Michigan Rx Lives By Sector

July 2009

A Commercial	5,638,922 (66.49%)
B Medicaid populations	1,536,129 (18.11%)
C Medicare beneficiaries	1,305,279 (15.39%)



Source: HealthLeaders-InterStudy

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The goal of MTM is to improve health and control costs, though it does not generally reduce pharmacy spending except in those cases where it eliminates duplication or unnecessary prescriptions. Generally pharmacy spending goes up because compliance with regimens improves. The payoff comes from avoided emergency treatment or hospitalization, and a generally more productive employee. Primary-care physicians also see a time savings, as they can focus on the patient’s condition rather than spend an entire visit discussing medication. Practice productivity improves when the patient can be handed off to the clinical pharmacist for a medication review.

“We were able to identify across our commercial book that 5 percent of members would hit those thresholds to get in,” said Erica Clark, senior clinical pharmacy manager with Priority Health. “That’s right at the national average that might need this type of intervention. We kept it to a narrow scope to begin with, but more people could benefit.”

For Priority, the opportunity would be more than 23,000 commercial members, but challenges exist that limit expansion. Broader proliferation of MTM in the commercial population remains limited by network capabilities as not every physician group has a pharmacist or is willing to hire one. The two physician practices Priority chose for the pilot—MMPC, which recently merged with the Spectrum Health Medical Group, and the Lakeshore Health Network in the Muskegon area—are two of its largest network practices, and both are heavily involved in the company’s patient-centered medical home initiative as well.

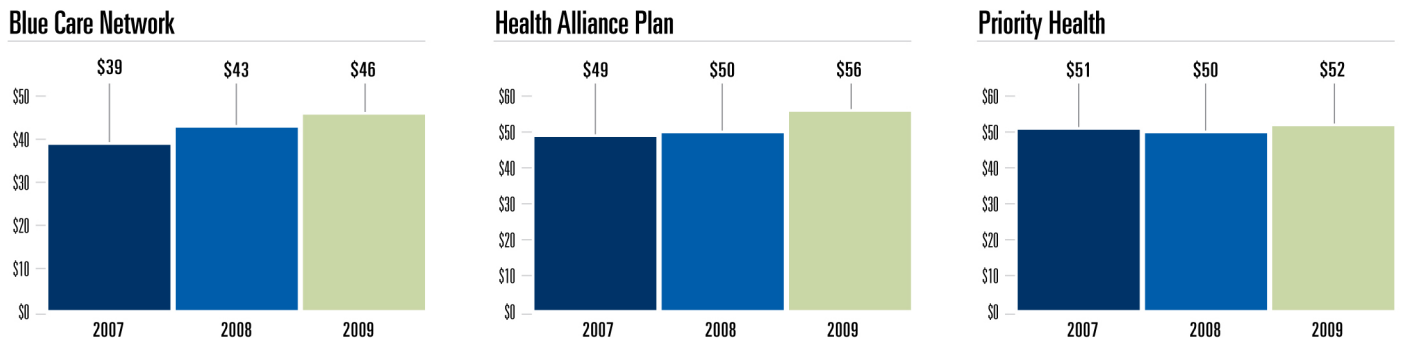
Once that hurdle is cleared, sending the pharmacist enough patients is an ongoing chore. Currently, only Medicare Part D plans are required to offer MTM, and Medicare requirements call for fewer services and fewer conditions for eligibility. MTM has not caught on with commercial health plans, except where large, self-insuring employers have demanded it. But to the extent that provider groups can provide a clinical pharmacist, health plans can reimburse them on a fee-for-service basis, as CPT codes for MTM became available in 2008.

Clark said it also remains a challenge to prove that MTM works. “We are taking a risk with this pilot. There’s lots of literature on the role of the pharmacist, but it’s not as clear-cut as the other things we pay for.”

Priority currently is measuring success by improvements in process, member satisfaction and provider satisfaction. Priority tracks how many medication problems the program identifies and resolves, and that figure stands on average at 4.5 per patient through the first 15 months. Patient and provider satisfaction are both high. “We are hoping for improvement in health and cost outcomes, but it’s premature to look at that data at this point,” Clark said.

Brand Newland, PharmD, MBA, vice president of Outcomes Pharmaceutical Health Care, an Iowa-based company that manages MTM programs through a nationwide network of community-based pharmacists, said all payor groups can make use of MTM. Outcomes is the contractor for Humana’s Medicare MTM programs, along with the Medicare plans of CareFirst BlueCross BlueShield, Medica Health Plans, Hawaii

Table 4-3: Michigan HMO Pharmacy Spending Per Member, Per Month (Three Largest HMOs)



Source: HealthLeaders-InterStudy

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“When Outcomes introduced its MTM program in 1999, a key question we had to answer was, ‘why will the customer want to buy these services?’” Newland said. “For a healthy 40-year-old who only uses one or two meds, perhaps only occasionally, why would he pursue MTM? MTM is really about prevention. For working age people, we are interested in keeping them from getting to where they may need multiple medications. Our network of community pharmacists can work with them on education about a new OTC product and how it might interact with other products they might already be taking. Or, the pharmacist can work with the covered patients to find equally effective, lower-cost alternatives. For patients with more complex medication regimens, the MTM network pharmacists can provide comprehensive medication reviews to help patients to get organized with their medications.”

What it means

Medication therapy management provides a value-added service to patients, physicians, pharmacists and payors. For drug manufacturers, the benefits of better compliance are clear as well, even if there is a small tradeoff when the process of MTM identifies duplicative or unnecessary prescriptions. The bugs are not quite worked out of how to provide or pay for MTM, however. The reimbursement codes exist, but they require a critical mass of patients that not all practices or markets can meet. This problem will be alleviated as new patient populations and group sponsors buy in. Models that rely on pharmacy networks, rather than physician group practices, to host clinical pharmacists will likely reach into more sparsely populated markets. MTM administrative companies have sought to fill the market need for developed networks of pharmacist providers while at the same time offering payors the necessary reporting and ROI measurement.

Drug manufacturers could play a role in aiding the expansion, partnering with the under-utilized but willing resource of pharmacy networks and local pharmacists around particular disease states relevant to their portfolios in MTM initiatives.

Ulcer Drugs Show Effects Of Management Efforts

Michigan payors won’t hold back on imposing utilization management tools to control prescription drug utilization. The example of proton pump inhibitors shows just how willing they are to take medical evidence and use both clinical and cost considerations in determining how to cover certain medications.

Proton pump inhibitors, or PPIs, accumulated \$13.7 billion in U.S. sales in 2008 from 113.4 million prescriptions as a class, making them the third-largest selling class of drugs. PPIs have proven effective for a number of gastrointestinal disorders, including gastroesophageal reflux disease (GERD). Because the incidence of these indications can’t account for the volume of prescriptions for PPIs, there’s a growing understanding that they are overprescribed, with three studies suggesting that between 53 and 69 percent of PPI prescriptions are for inappropriate indications (Archives of Internal Medicine).

Two things have happened that have encouraged payors to take actions that have driven down PPI prescribing in recent years. First, patents expired on two of the leading sellers in the class, TAP Pharmaceuticals' Prevacid in 2009, and AstraZeneca's Prilosec, which was once the best-selling drug in the world, in 2005. Both became available in over-the-counter versions.

"PPIs are used for a range of stomach acid disorders from heartburn to more serious conditions such as Zollinger-Ellison syndrome and Barrett's esophagitis," said Antonio Petitta, Health Alliance Plan's vice president of pharmacy care management. "The majority of PPI use is for heartburn. There are now two PPIs available in over the counter forms, Prilosec OTC and Prevacid, for use with heartburn. Because they're available over the counter, some groups now restrict prescription PPI coverage to the more serious conditions. The standard HAP formulary still covers PPIs for all conditions; however, a generic PPI must be used as first-line therapy. The branded PPIs are non-formulary."

Second, comparative effectiveness research via a multi-state alliance known as the Drug Effectiveness Review Program found little difference in effectiveness among the various competitors.

The DERP, an alliance of 12 state Medicaid programs—which included Michigan's until it was cut from the budget late last year—is based at the Center for Evidence-Based Policy at the Oregon Health and Science University in Portland. It seeks out and examines pharmaceutical research in the pursuit of lower costs and higher quality care using systematic review, a specific discipline that calls for drawing on drug comparison studies that meet only the highest standards for freedom from bias. DERP reports become the basis for evidence-based medicine.

As a result of DERP's analysis, Michigan Medicaid plans have been able to price-shop on PPIs and buy the one that offered the best deal, without concern for effectiveness since they are all the same. Commercial insurers and other payors have taken notice, and they too have begun to restrict PPIs—even going so far as to not cover them at all for most indications.

The largest payors have taken the toughest stance. When the United Auto Workers took over administering the health benefits of 875,000 retired hourly workers from General Motors Corp., Ford Motor Co. and Chrysler LLC on Jan. 1, 2010, the new UAW Retiree Medical Benefits Trust did not include coverage of PPIs for anything except cases of Zollinger-Ellison syndrome and Barrett's esophagitis. For GM and Chrysler beneficiaries, this was not completely new. They had lost coverage of PPIs as part of the two companies' bankruptcy proceedings in mid-2009. Retirees of Ford, which did not go through bankruptcy, lost PPI coverage on Jan. 1, when all UAW retirees began receiving coverage from the Retiree Medical Benefits Trust.

Group commercial insurers have been slower to respond, but their demands are shifting as well. HealthPlus of Michigan covers Nexium on Tier 3, as do Blue Cross Blue Shield of Michigan and Priority Health. All cover generic omeprazole on Tier 1, but restrictions are starting to creep in. Priority Health, for example, has quantity limits on the generic drug, and Aetna has both quantity limits and prior authorization. Total Health Care, generally regarded as the most restrictive commercial drug plan in the state, covers the generic with quantity limits. Total does not cover Nexium at all on its commercial plan.

"The extent to which proton pump inhibitors are being covered by insurers is being driven by employers," said Carrie Germain, senior director of pharmacy services for HealthPlus of Michigan: "Some larger employers have decided to discontinue proton pump inhibitor coverage with exceptions for special circumstances—for example, conditions that could be a precursor to cancer. HealthPlus works with employer groups to customize coverage for proton pump inhibitors, often with a preference for generics, since proton pump inhibitors can be very costly."

What it means

Nexium, the fifth-best-selling drug in the world, will go off patent in 2014, and Aciphex does the same in 2013, foretelling even more scrutiny for PPIs. But in the broader view, the treatment of PPIs serves as a

preview of the kind of pressures health plans will bring to bear as comparative effectiveness review informs more purchasing in a post-reform environment.

Payors will continue to look for savings in key therapeutic classes—statins, PPIs, non-sedating antihistamines, non-steroidal anti-inflammatory drugs, ACE inhibitors and angiotensin receptor blockers and antidepressants. Expect more value-based tiering and utilization management with evidence-based support.

Collaboration Expanding To Meet E-prescribing Challenges

Doctors looking for a bigger payday have new opportunities this year from employing meaningful use of electronic medical records and electronic prescribing. Since Michigan is among the leaders in electronic prescribing, and two of the state's top payors are leaders in that effort, cooperation between providers and health plans could change the dynamics of prescribing in the market.

“This is the year doctors will be saying, if I can start using meaningful use criteria for electronic medical records and start using e-prescribing, I can get rewarded on both fronts,” said Greg Forzley, M.D., chief medical information officer at Saint Mary's Health Care in Grand Rapids. He also chairs the board of the Michigan State Medical Society and is the state-appointed Michigan Health Information Technology Commission chair. The HIT Commission is guiding the state's move to electronic health records, including the development of a statewide health information exchange.

As part of the funding that the federal stimulus law made available for expansion of HIT, Medicare will begin rewarding providers with higher reimbursements for their use of e-prescribing as well. The incentive program provides for additional payment to prescribers who e-prescribe in 2010 equal to 2 percent of their total Medicare payments for the year. The incentive amount is reduced to 1 percent in 2011 and 2012, and is finally reduced to 0.5 percent in 2013. Penalties for physicians who do not adopt e-prescribing systems begin at 1 percent in 2012 and increase to 2 percent by 2014 before the program sunsets.

Michigan ranks third in the nation for the use of e-prescribing, winning SureScripts' 2009 Safe-Rx Award. The Southeast Michigan E-prescribing Initiative, or SEMI, with Health Alliance Plan and Blue Cross Blue Shield of Michigan as the leading participating payors, were cited as key contributors to Michigan's e-prescribing success at the Safe-Rx Awards, given each year to the 10 states that transmit the most electronic prescriptions. Michigan providers have transmitted 7.5 million prescriptions electronically, 90 percent of them transmitted by physicians participating in SEMI, which dates to February 2005.

The long e-prescribing experience explains how providers have changed or cancelled more than 670,000 prescriptions due to drug interaction warnings and changed or cancelled more than 53,600 due to allergy warnings to date as a result of SEMI. In addition to the increased safety, SEMI has brought cost savings from 157,000 prescriptions changed or cancelled due to formulary warnings. Henry Ford Medical Group, one of the participating physician practices, raised its generic dispensing from 57 percent to 73 percent through the initiative.

“Michigan's successful experience with e-prescribing is a real-life example of how physicians, employers and insurers can dramatically improve patient safety and control healthcare costs,” said Matthew Walsh, HAP associate vice president of purchaser initiatives. “The measurable results of prescribing over 7.5 million electronic prescriptions have clearly demonstrated improvements in safety, effectiveness, efficiency and patient centeredness.”

The medical society offers doctors educational resources and help navigating the regulations to assure they meet CMS requirements to qualify for the increased funds from e-prescribing and EHR use. SEMI suffers mainly from geographic constraints. Getting e-prescribing beyond Southeast Michigan faces challenges that the MSMS and others are working to reduce.

Other factors exist that will limit the continued growth of e-prescribing. Michigan's struggling economy has held back IT investment in general. Also, though CMS' recently issued meaningful-use rules allow electronic

prescribing of controlled substances, Michigan law forbids it. A change in state law would be necessary to prescribe drugs such as narcotics and pain medications electronically. Medicare's e-prescribing incentive program also won't inspire pediatricians to adopt the technology because they serve no Medicare patients, although there are Medicaid incentives for which pediatricians may qualify.

The trend toward more mail-order delivery of drugs and the advent of \$4 generics—and in the case of the Meijer and K-mart retail chains in Michigan, free selected generic antibiotics—also increases the likelihood that patients are filling prescriptions by methods that aren't recorded by an electronic network. That could result in incomplete or misleading data for providers.

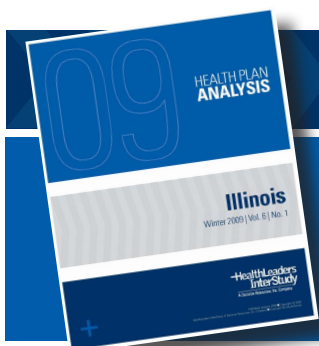
Rural parts of the state will be slow to adopt e-prescribing as well, since high-speed internet connections are necessary and those areas lack broadband infrastructure. Forzley said grants exist to resolve these issues, and they'll be resolved in coming years.

CMS' recent release of the meaningful-use criteria for EHRs reduced the threshold for e-prescribing from 75 percent to 40 percent of prescriptions for physicians to qualify for rewards. This lowering of the bar will expand payment for IT and increase its proliferation. But HAP leaders were disturbed that two criteria they see as important to maximizing the value and effectiveness of e-prescribing were negotiated out of the final rule—the requirement for connectivity to mail-order fulfillment, and the requirement for eligibility-driven formulary information in the EHR.

“Specifically, benefits for companies such as GM, Ford and Chrysler or the UAW—who carve out the pharmacy benefit—can be misidentified in the EHR if eligibility is not involved,” said Mihir Patel, Pharm.D., a SEMI consultant with Point of Care Partners. “In addition, having eligibility-driven formulary enhances the efficiencies that can be achieved for both prescribers and pharmacies. The SEMI e-prescribing program has insisted on eligibility-driven formulary for several years. It is a common, industry accepted technology that most, if not all, leading EMR providers can do.”

What it means

Not all e-prescribing is created equal. As a practical matter, due to the pioneering work of SEMI, most vendors of EHRs will build the mail-order and eligibility-driven formulary elements in for purchasers in Southeast Michigan. But elsewhere in the state, in precisely those areas where the greatest opportunity for e-prescribing to deliver value exists, the lack of these requirements will result in less value. ■



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