Approved: 3-5-03
Date

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM.

The meeting was called to order by Chairperson Senator Stan Clark at 3:30 p.m. on February 13, 2003 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research
Norman Furse, Revisor of Statutes
Ann McMorris, Secretary

Conferees appearing before the committee:
Audrey Nogle - Legislative Research
Bob Day, Dept. Of Social and Rehabilitation Services
Janis DeBoer, acting secretary, Department of Aging
Barb Hinton, Legislative Post Audit
Rosa Molina, Executive Director, Medical Services Bureau, Wichita
Bob Williams, Kansas Pharmacists Association
Jonathan Brunswig, Lakin (pharmacist)
Steve Smith, Hiawatha (pharmacist)
Brad Smoot, Blue Cross-Blue Shield of Kansas
Jim Cleland, Pharmacist - WaKeeney

Chairman Clark introduced Brian Leugs, Regional Director, Rocky Mountain Region, PhRMA, Denver who stood available for questions. Mr. Leugs introduced Nancy Zogleman of Pfizer and Barbara Belcher of Merck who also were available for questions.

Others attending: See attached list

Presentations on Medicaid Pharmaceutical Issues

Audrey Nogle of Legislative Research provided data on (1) Consensus Caseload Estimate for November 6, 2002 on nursing facilities, nursing facilities-mental health, temporary assistance to families, general assistance, regular medical, foster care contract and adoption contract. She cited the increase in regular medical in 2003 was due to the downturn in the economy; and (2) Caseload Expenditures for FY 1995-FY 2004 is a comparison for nursing facilities, nursing facilities-mental health, temporary assistance to families, general assistance, regular medical, foster care contract and adoption contract. (Attachment 1)

Robert Day, Director, Medical Policy/Medicaid presented a slide presentation on Kansas Medicaid: Focus on long term care and prescription. (Attachment 2) He provided information on CMS proposed Medicaid reform but cautioned that this information was preliminary and not complete. (Attachment 3) A paper containing Population Definitions, Acronyms and Definitions, Poverty Guidelines, Medicaid mandatory and optional coverage groups and services and Kansas medicaid preferred drug list was handed out to the committee. (Attachment 4).

Commentary on the slide presentation follows: (Attachment 2)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE PRESIDENT'S TASK FORCE ON MEDICAID REFORM at on February 13, 2003 in Room 234-N of the Capitol.

This is an overview of the Medicaid Program which will include both long term and regular medical. Not included are the 30,000 in the children's health insurance program and the Medikan program which is a state only program.

First few slides dealt with number of Medicaid enrollees per month, enrollees by population, eligibility groups covering various periods of time - primarily increased because of the Temporary Assistance to Families (TAF) population and the softening of the economy which drops people into a lower income category. The 1991 to 1995 growth is due to adding of children and pregnant women at the federal level; 1996 is a peak; and then a drop which are primarily TAF people; 1999 starts the climb and this is related to the children's health insurance program. In 2004 there is another dramatic increase in TAF/PLE (Poverty Level Eligibility) population and slight rise in the aged and disabled population.

Mr. Day then moved to the cost growth by population for Medicaid and long term care and annual growth in long term care costs . Cost growth is driven by increased numbers of people coming into the program and by medical inflation and in utilization of services. Medicare on the acute care side is not a health program but a sickness program. Compare growth in population and growth in utilization and there is an increase each year. Total medical expenditures by service from 1991 to projected 2004 show pharmaceuticals are the largest cost driver. Long term care costs are significant and these include institutions and home costs. Community based services is one of the most significant and successful programs. These programs provide significant assistance to people and have changed their lives in many ways. Federal rules covering pharmacy coverage and percent pharmacy expenditures by population in FY 2002 were discussed.

Considerable discussion on copay set in federal regulation. Average monthly prescription costs FY 1998 thru FY 2002 showed aged, blind and disabled to be considerably higher than TAF/PLE. The list of the ten top drugs by expenditure in FY 2002 for all populations was discussed. Cost control measures implemented in the pharmacy program and the drug utilization in the nursing home setting were considered. In his concluding comments, Mr. Day noted that Medicaid is second only to public education in the number of citizens impacted by its services. Federal Medicaid dollars in the Kansas health system will total over $1.058 billion in FY 2004.

Janis DeBoer, acting secretary, Department of Aging distributed material on (1) long term care services, nursing facility and home and community based services for frail elderly (Attachment 5); (2) Kansas senior pharmacy assistance program (Attachment 6). Ms. DeBoer elaborated on the Department of Aging funding sources, their FY 2002 expenditures, customers served and their HCBS/FE waiting list of 1,036 on 1/31/03. She quoted monthly medicaid averages on customers served and expenditures per customer in FY 1998 through FY 2002 and had comparison graphs. Research on whether home and community-based services were less costly than nursing home care and whether home and community-based services reduce nursing home placement was presented.

Barb Hinton of Legislative Post Audit summarized the issues relating to drugs paid for by Kansas' Medicaid Program from the Performance Audit, Reviewing the Medicaid Program's use of Generic Drugs. Control of the type of drugs prescribed to help ensure that the program pays for the most cost-

effective drug therapy for client's medical conditions was discussed. Control of the types of drugs prescribed to help ensure that the program pays for only the amount of drugs clients need and can or should use and controlling what the state pays for Medicaid prescriptions to help ensure that the program doesn't pay more than it needs to are areas of great concern and have been monitored closely. SRS is working on the issues identified by Post Audit. (Attachment 7)

Rosa Molina, executive director, Medical Service Bureau, Wichita described the three programs provided by MSB: (1) the non-profit pharmacy program; (2) the Voucher Program and (3) the Pharmaceutical Drug Program (PDP). She identified income guidelines for the different programs. She provided a listing of the MSB 2002 statistics. (Attachment 8)

Bob Williams, Kansas Pharmacists Association, handed out his testimony (Attachment 9) which contained the following ideas:

1. Maximizing rebates from drug companies
2. Pharmacy dispensing fees
3. Generic and therapeutic substitution
4. Step therapy
5. Limits on number of prescriptions
6. Prior authorization
7. Drug Utilization and Review (DUR)
8. Disease management programs
9. Beneficiary cost sharing (co-payments)

Mr. Williams then introduced Jonathan Brunswig, President, Kansas Pharmacists Association from Lakin, KS., who provided some background on how he opened two pharmacies in Leoti and Lakin and described the role these pharmacies play in providing pharmacy services to long term care patients. He addressed the process of providing medications to these patients using bubble packs. He described the relationship with physicians and the role the pharmacist plays in providing medications and helping reduce drug cost per patient. (Attachment 10)

Steve Smith, Pharmacist, Hiawatha, Kansas, said he has been a pharmacist for 33 years but is still on the cutting edge of many things. Many years we tried to address the cutting of costs with the white paper that were given by Medicaid and alluded to as the starter dose program and have checked the number of prescriptions that should be allowed and the use of generics. In patient hospital cost has maintained the same proportion expressed as a percentage of the total medicaid budget and the pharmacists' cost of medications is going up. You have to give drug manufacturer's credit - some of these new drugs that are out are fantastic. I have people who are now walking into my store who used to be institutionalized and when you see that level line on inpatient hospitalization, you can see the increased cost of medication. There is a correlation of costs. SRS is going to implement the five prescription brand names. We have some problems - we are working with the physicians. In the nursing home settings, I service patients in eight nursing homes and quite often we use the same drugs in different strengths at different time. When we trigger those people with 9 prescriptions, we will need to work through it. SRS is now looking at their

outliers - 20 to 30% of their patients are driving 80% of the budget. We created a type of care form in our town. When someone comes out of the hospital, I receive a FAX so I start working on this patient's history and medication so that I can better serve the patient and look at the cost factors involved. Sometimes you have to use the high dollar drug as it does the best job. I have a reason on the form why the doctor wants to give a particular medication and we can counsel the patient correctly. Also a question on whether the prescription should be filled or should he get samples? We've set up a system, the physician, pharmacist and the patient to work on the cost factor. You have got to get into managed care to control cost.

Brad Smoot, Kansas Blue Cross-Blue Shield, provided information on the current trends in health care costs. He elaborated on several cost-driving forces that are causing the increases in health care costs and the corresponding insurance premium costs; (1) our aging populations; (2) lifestyle choices; (3) prescription drugs; (4) government regulation; (5) cost shifting and the uninsured; (6) expansion of services; and (7) use of new medical technologies. He noted that in 2000, Kansas ranked ninth in the per capita use of prescription drugs reporting an average of 10.62 scripts per year and BCBS concern in the ability of Kansans to continue to afford health insurance. (Attachment 11)

Jim Cleland, Pharmacist, WaKeeney - Mr. Cleland told the committee that the executive director of the Pharmaceutical Board has a degree in Library Science. He mentioned that the Pharmacy Inspectors are pharmacy technicians not licensed pharmacists. He recommended that the Legislature allow the Board of Pharmacy enough of a budget for a adequate qualified staff to enforce the provisions of the Kansas Pharmacy Act. The State of Kansas is the largest purchaser of drugs in Kansas. Average Wholesale Price (AWP) no longer reflects cost of drugs. Few wholesalers for drugs remain. He brought many bottles of various types of medicines and held up the medicine he was referring to and read the cost information from the label. (Attachment 12)

Heartburn/Prevacid	Average Wholesale Price	*Maximum Allowable Cost*	
Medicaid	AWP	(MAC)	Actual Cost
Ranitidine	1.56	.34	.06
Zantac	780.00/500	170.55	27.19 (5 ½ cents each)
1/day Prevacid	4.63 a pill		3.76

Drugs on Medicaid Preferred list are like owning Boardwalk & Park Place with 4 hotels and 3 houses. They don't need the general population. If you can't afford them, they will just give them to you free at the doctor's office from the drug companies' white sack.

Antibiotics/Allergies			
Zyrtec	3.23		2.55
Claritin	2.11		1.67
Chlorpheniramine	.11		.04

BC-BS and Medicaid - $90 for a runny nose. Kansas Medicaid annual expense $268 Million on Drugs – $20 million rebate. Agree to never charge more than $3.40/prescription. Proposal - state pay acquisitions

cost. Think how much you can bring the cost of drugs down. How much if you "hum on the phone"

	244.20/150	198.,29	98.00
			93.00
Cephelexin	600.69	222.00 - 95.07	40.37
After 90 days			
Prevacid	30mg 4.63	3.76	
Cut to	15mg 4.54	3.69	

Notice - one-half the medication but the price is only reduced by 9 or 7 cents each.

National Democratic Convention paid and sponsored by the Pharmaceutical Industry, so was the Republican Convention.

Itch - Hydroxyzine	95.37	14.59
now	823.14	550.00 (bought up competition)

Wants $10 to fill prescriptions on name brand; $15 to fill prescriptions on generics
$5 copay - send rebate home - set yourself free. People talk to us (pharmacists), they trust us. Doctor asks - how are you doing? Are you taking all your medicines? They lie to the doctor. Pharmacists ask -How are you doing - we find out that they are short of breath. We are the only health care provider that they can walk into without being charged. They trust us.

Antibiotic - go to the emergency room $50 - only give you 1 dose/day
go to the emergency room again - fill out the chart again.
Non-preferred drugs - good enough for the rest of you; not good enough for medicaid

Heartburn - Zyrtec	2.11	1.67	
Chlorpheniramine			.04

$30 coupon - rebate for those that holler

Schizophrenia – use Risperdal which is very expensive. Pill can be broken in half - the only people that get risperdal are on Medicaid or have insurance. He told about Dave who enlisted and was sent to Vietnam. When he returned he had to be hospitalized and heard voices/had bad dreams and nightmares. Takes halodol – 10mg 2xday at 16 cents per day. David worked in local hospital maintenance for 20 years. Halodol keeps the dreams back. Bought brand new 4x4 Dodge PU - making payments on it. Mother died. He took a wonderful drug - 4mg Risperdal/ 4mg adjust dosage/6mg/ added 7mg/8mg. He started worrying about cost which was about $500/month. He got rid of truck/afraid at nights. Admitted to nursing home so he could be watched. Went back home - put gun in mouth. New isn't always better.

Mother in law - 1927 - aggressive behavior - we use powerful new drugs for aggressive behavior. Risperdal was developed for schizophrenia not to drug people to manage behavior problems.
Think boldly doesn't always work.

Runny nose/cold

Erythromycin	94.45/500	40.82/500	8 cents

Viaxin — comes only in 7 day supply bubble pack. It's advertised on TV. Physician wrote prescription for a 10 days supply. Mr. Cleland sent patient back to doctor explaining that the medication is only available in a 7 day supply. Returned with a prescription for 14 days. Mr. Cleland's cost for 14 day supply was $120.08. Medicaid patient paid $3.00 for the $120.08 medication. The blue collar worker has little choice but to use the 8 cent pills.

He proposed that the state negotiate a preferred manufacturer of drugs and durable medical equipment and that the state use its buying power to negotiate lower pharmecutical prices for all pharmacies in the State and also use its buying power to negotiate lower prices for durable medical equipment.

He ended by urging the consideration of the committee on the effect Medicaid has on the pharmacists.

At the close of presentations and the round table discussion, Chairman Clark encouraged the participating audience to provide the committee with more recommendations for the committee's consideration.

The next meeting of the President's Task Force on Medicaid Reform will be on February 17 where long term care will be discussed.

Adjournment.

Respectfully submitted,

Ann McMorris, Secretary

Attachments - 12

Conferee Recommendations to be considered:

______1. Maximizing rebates from drug companies
2. Pharmacy dispensing fees
3. Generic and therapeutic substitution
4. Step therapy
5. Limits on number of prescriptions
6. Prior authorization
7. Drug Utilization and Review (DUR)
8. Disease management programs
9. Beneficiary cost sharing (co-payments)
   (Recommendations 1 thru 9 from Bob Williams, Ks. Pharmacists Assn.)
10. Starter dose program (Steve Smith, Pharmacist, Hiawatha)
11. We created a type of care form in our town. When someone comes out of the hospital, I receive a FAX so I start working on this patient's history and medication so that I can better serve the patient and look at the cost factors involved. Sometimes you have to use the high dollar drug as it does the best job. I have a reason on the form why the doctor wants to give a particular medication and we can counsel the patient correctly. Also a question on whether the prescription should be filled or should he get samples?

We've set up a system, the physician, pharmacist and the patient to work on the cost factor. You have got to get into managed care to control cost. (Steve Smith, Pharmacists, Hiawatha)

12. He recommended that the Legislature allow the Board of Pharmacy enough of a budget for adequate qualified staff to enforce the provisions of the Kansas Pharmacy Act. (Cleland)
13. Proposal - state pay acquisitions cost. (Cleland, WaKeeney)
14. Wants $10 to fill prescriptions on name brand; $15 to fill prescriptions on generics (Cleland)
15. $5 copay - send rebate home - set yourself free. (Cleland)
16. He proposed that the state negotiate a preferred manufacturer of drugs and durable medical equipment and that the state use its buying power to negotiate lower pharmecutical prices for all pharmacies in the State and also use its buying power to negotiate lower prices for durable medical equipment. (Cleland)