State Notes

TOPICS OF LEGISLATIVE INTEREST

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Prescriptions for Cost-Containment: Michigan's Efforts to Manage Pharmaceutical Expenditures

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Between fiscal year (FY) 1998-99 and FY 2006-07, total Medicaid expenditures in Michigan increased by approximately 82.1%. Simultaneously, Michigan's Medicaid enrollment expanded to reach a current caseload of just over 1.5 million individuals; this represents an increase of nearly 50.0% in less than a decade. Also, despite State efforts to constrain spending, Senate Fiscal Agency projections suggest that total Medicaid expenditures in FY 2007-08 will exceed $9.0 billion for the first time. Table 1 provides a brief summary of Medicaid expenditures in Michigan between FY 1998-99 and the current fiscal year.

Table 1

Michigan Medicaid Program Spending and Caseloads
(Millions of Dollars)

Fiscal Year	Medicaid Total Spending	Percentage Change	Medicaid Caseload (actual)	Percentage Change
1998-99	$4,797.3		$1,068,158	
1999-00	4,970.6	3.61%	1,066,131	(0.19)%
2000-01	5,518.1	11.01	1,117,594	4.83
2001-02	5,890.9	6.76	1,211,816	8.43
2002-03	6,478.4	9.97	1,296,374	6.98
2003-04	7,022.6	8.40	1,374,206	6.00
2004-05	7,624.3	8.57	1,437,983	4.64
2005-06	7,977.9	4.64	1,475,741	2.63
2006-07	8,734.8	9.49	1,536,000	4.08
2007-08 Estimated	9,268.0	6.10	1,581,000	2.93
Chge from FY '98-99 to FY '07-08	4,470.7		512,842	
Percentage Change	93.19%		48.01%	

One line item in the Medicaid budget that has not necessarily followed the prevailing pattern is the pharmaceutical services line. Over the past several years, pharmaceutical expenditures under Michigan's fee-for-service program have not kept pace with increases in aggregate Medicaid spending. Because the enactment of Medicare Part D effectively shifted responsibility for the prescription drug costs of many of the highest-need patients away from Medicaid, states have been challenged to develop cost-containment strategies aimed at various other subsets of the Medicaid population. Through a variety of strategic initiatives, which are discussed below, Michigan has realized significant progress in its efforts to restrain General Fund/General Purpose (GF/GP) spending on prescription drugs. Before the adoption of these initiatives, Medicaid pharmaceutical expenditures had been increasing at rates in excess of 10.0% per year. In contrast, prescription drug expenditures in FY 2006-07 were only about 0.6% higher than in FY 2005-06, as shown in Table 2.

Table 2

Michigan Medicaid Program Pharmaceutical Fee-for-Service Spending (Millions of Dollars)			
Fiscal Year	Pharmaceutical Spending	Percentage Change	Pharmaceutical Spending as % of Medicaid Total
1998-99	$264.9		5.52%
1999-00	320.1	20.84%	6.44
2000-01	465.5	45.42	8.44
2001-02	552.2	18.63	9.37
2002-03	616.1	11.57	9.51
2003-04	641.5	4.12	9.14
2004-05	648.5	1.09	8.51
2005-06[a)]	655.1	1.02	8.21
2006-07[a)]	658.8	0.56	7.54
2007-08[a,b)]	680.1	3.23	7.30

[a)] Includes Medicare Part D expenditures. [b)] Estimated using FY 2007-08 Executive current services base.

Michigan's Preferred Drug List and the Michigan Multi-State Pooling Agreement

Since 2002, the Michigan Medicaid program has employed a preferred drug list, known as the Michigan Preferred Product List (MPPL), for two principal purposes, both of which are aimed at cost-containment. First, an enumerated listing of "preferred" products allows the State to negotiate supplemental rebates from pharmaceutical manufacturers in exchange for the inclusion of specific drugs in the MPPL. Second, the MPPL has been used to encourage the use of generic drugs in cases in which affordable alternatives to higher-cost drugs exist. Michigan's preferred drug list is periodically reviewed and updated by the 11-member Pharmacy and Therapeutics Committee, which includes both pharmacists and physicians who have served Medicaid-eligible patients. In 2004, about 70.0% of all drugs prescribed to Medicaid recipients in Michigan were included in the preferred drug list.

In 2003, Michigan and Vermont jointly launched the Michigan Multi-State Pooling Agreement (MMSPA), also known as the National Medicaid Pooling Initiative (NMPI), in an effort to obtain additional discounts from pharmaceutical manufacturers via the establishment of a multistate market. In the nearly five years since, Alaska, Hawaii, Nevada, New Hampshire, Minnesota, and Montana have received authorization from the Centers for Medicare and Medicaid Services to join the project. Michigan achieved approximately $8.0 million in savings in 2004 as a result of pooled purchasing, according to the Kaiser Family Foundation. Numerous other states have established similar alliances in an effort to reinforce their ability to negotiate fair prices and supplemental rebates from suppliers of prescription drugs.

Data collected by the Department of Community Health (DCH) provide sufficient evidence to indicate that Michigan has generated considerable savings as a result of these reforms. During FY 2006-07, Michigan collected over $18.0 million in supplemental prescription drug rebates; this equates to an 11.0% increase in total rebates to the State Medicaid program. In addition, a report prepared by the U.S. Department of Health and Human Services in 2004 determined that 55.0% of all drugs prescribed to Medicaid recipients in Michigan were generics, and that Michigan had achieved a generic substitution rate of 90.0%. For each of these indicators, Michigan ranked above the national average.

Pharmacy Quality Improvement Project

The Pharmacy Quality Improvement Project (PQIP), first implemented in 2005, seeks to ensure that physicians prescribe drugs to mental health patients in accordance with evidence-based treatment guidelines. In other words, PQIP monitors the prescribing practices of Medicaid-participating physicians to create greater uniformity regarding which drugs are prescribed and their dosages. The program was designed to approximate existing prescription monitoring programs in other states that reportedly had improved treatment outcomes and reduced pharmaceutical expenditures. One such program in Missouri achieved a 98.0% reduction in the number of patients receiving prescriptions for the same medication from multiple doctors in its first year of operation.

According to a brief prepared by the DCH in February 2007, PQIP has been an effective tool for limiting prescription drug redundancy. The brief refers to an impact analysis comparing the prescribing habits of about 600 physicians both before (May 2005) and after (January 2006) a PQIP intervention; the analysis indicated a 22.0% reduction in pharmaceutical claims and a 21.0% decline in costs. Through this initial evaluation, the DCH determined that the program produced cost savings of approximately $1.7 million during the six-month intervention period. In light of the program's strong early performance, PQIP has received two year-long extensions. Additionally, a work group within the DCH Mental Health Advisory Committee meets quarterly to provide project oversight and performance assessments. In February 2006, opiates were added to the catalogue of drugs monitored by PQIP, suggesting that future expansions of the program may be possible.

Medicaid Managed Care

Before the mandated shifts to managed care occurred between FY 1997-98 and 1999-2000, Michigan's Medicaid program reimbursed health care providers primarily through fee-for-service arrangements. In the past decade, however, more than 60.0% of all Medicaid recipients have been enrolled in an approved health maintenance organizations (HMO) plan. This striking transition toward a managed care model in Michigan coincided with a national trend during the 1990s in which Medicaid managed care increased nearly tenfold.

Generally speaking, Michigan and other states adopting managed care methodologies were spurred on by early predictions of cost-containment and the desire for greater operational stability. Whether and to what extent these benefits have been realized remain somewhat ambiguous. A study conducted by the Rockefeller Institute of Government at SUNY-Albany claims that Michigan achieved savings of about $120.0 million in 1998 as a result of managed care implementations. It should be noted, however, that any initial savings associated with managed care may not reflect actual program performance. According to a nationwide analysis published by the Urban Institute in 2003, "managed care did not translate into dramatically slower growth in program costs per beneficiary. . . [s]tudies that focus on long-term cost savings are needed to assess the extent to which initial savings may have eroded."

Managed care providers have not been as effective as Michigan's fee-for-service program in limiting the growth of prescription drug expenditures. While HMOs offering prescription drug coverage to Medicaid recipients have developed their own tailored drug formularies, they have not

benefited from participation in the fee-for-service preferred drug list or the multistate pooling agreements. As Table 3 indicates, spending by HMOs on prescription drugs increased by nearly $69.0 million between 2005 and 2007. Also, despite the fact that HMOs were subject to increasing caseloads during this period, the rising cost of prescription drugs was the primary impetus for this striking growth in spending. The experience of HMOs in Michigan between 2005 and 2007 lends additional support to the hypothesis that cost-containment measures aimed at the fee-for-service population have been successful in limiting State spending on prescription drugs.

Table 3

Prescription Drug Expenditures by HMOs: FY 2005-2007

	2005	2006	2007[a]
Community Choice Michigan	$17,985,642	$19,861,387	$21,043,345
Great Lakes Health Plan	32,494,879	41,681,414	53,359,936
Health Plan of Michigan	30,526,409	34,090,247	42,320,477
HealthPlus Partners	24,349,911	22,306,136	23,301,223
M-Caid (Now Blue-Caid)	5,173,693	4,805,333	5,412,916
McLaren Health Plan	17,257,440	19,674,945	22,448,173
Midwest Health Plan	18,178,662	18,391,623	21,075,132
Molina Healthcare of Michigan	47,638,163	70,302,334	70,399,812
OmniCare Health Plan	18,832,159	18,117,385	19,027,939
Physicians Health Plan of Mid-Michigan-Family Care	6,138,809	6,061,360	5,642,301
Priority Health Government Programs	14,790,437	16,608,186	16,642,961
Total Health Care	13,865,018	13,001,169	14,328,340
Upper Peninsula Health Plan	9,447,188	9,953,822	10,574,507
Total	**$256,678,410**	**$294,855,341**	**$325,577,062**
Percent Change		**14.9%**	**10.4%**

[a] Projected

Medicare Part D

Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Medicare Part D prescription drug program became operative on January 1, 2006. The program offers Medicare recipients the option of enrolling in a variety of tailored plans that subsidize the cost of prescription drugs. In addition, the MMA dictates that individuals who are dually-eligible for Medicare and Medicaid be automatically enrolled in Medicare Part D. As of 2002, these "dual-eligibles" (primarily low-income senior citizens and disabled persons) represented 14.0% of the Medicaid population but were the beneficiaries of 40.0% of all Medicaid spending nationwide. Approximately 190,000 dual-eligibles living in Michigan are currently enrolled in a Medicare Part D prescription plan.

While the Medicare program has assumed oversight of the prescription drug needs of many Medicaid recipients, the State has not been released from its fiscal responsibility for these individuals. A mechanism commonly referred to as the "clawback" requires Michigan to reimburse the Federal government through monthly payments designed to approximate the amount that the State would have spent on prescription drug coverage under Medicaid absent the prescription drug benefit enacted by the MMA. As reported in Table 4, these payments totaled about $127.0 million in FY 2005-06 and about $178.0 million in FY 2006-07. In addition to

the effect of the clawback payments, Michigan is forced to account for the loss of revenue that would have resulted from the Federal contribution to Medicaid had the Medicare prescription drug benefit not been enacted. The total costs of the foregone revenue and the clawback payments also are reflected in Table 4.

Table 4

Medicare Part D Expenditures (millions of dollars)		
Fiscal Year	**GF/GP Clawback**	**Total Expenditures**
2005-06	$127.5	$288.5
2006-07	177.8	407.6
2007-08	178.2	425.4

Despite predictions that the costs associated with Medicare Part D would outweigh any savings realized by the State in the form of reduced Medicaid pharmaceutical expenditures, total costs have remained relatively stable. As shown in Table 5, the growth rate in prescription drug expenditures has been between 4.0% and 5.0% since the enactment of the Medicare prescription drug benefit. When compared with the large escalations in pharmaceutical expenditures in Michigan between 2000 and 2005, these year-to-year increases appear quite restrained.

Table 5

Total Prescription Drug Spending on Medicaid Recipients			
	FY 2004-05	**FY 2005-06**	**FY 2006-07**
Fee-for-Service Expenditures	$648,522,000	$366,611,500	$251,197,400
HMO Expenditures	$256,678,410	$294,855,341	$325,577,062
Medicare Part D	0	$288,537,400	$407,611,200
Total Pharmaceutical Expenditures	**$905,200,410**	**$950,004,241**	**$984,385,662**
% Change (Year-to-Year)		4.9%	4.1%

Conclusion

During the first half of this decade, the growth in Medicaid enrollments and expenditures in Michigan contributed to the State's emerging budgetary constraints. Through the application of innovative cost-containment initiatives, such as the MPPL, MMSPA, and PQIP, the State has achieved modest success in limiting the growth of Medicaid prescription drug expenditures. While the implementation of the Medicare prescription drug benefit may have limited Michigan's ability to expand existing strategies for cost-containment, it does not appear to have overshadowed the constructive effects of these strategies.