

November 29, 2004

SFY 2006-07 Benchmark Rate Study

Oregon Health Plan

Summary Report

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Office for Oregon Health Policy and Research
Department of Administrative Services

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Table of Contents

Preface	iii
Executive Summary	v
Chapter 1	
Introduction	1
Chapter 2	
The Dynamic Healthcare Marketplace	3
Chapter 3	
Methodology	7
Chapter 4	
Results	9
Addendum	
Special Note on Potential Strategies to Reduce Prescription Drug Costs	A-1

Preface

Two reports on the SFY (State Fiscal Year) 2006-07 Benchmark Rate Study are available to the reader depending upon the level of detail desired.

Summary Report

The report you are holding is geared towards the reader who is primarily interested in what the benchmark results are at a general level and the policy implications that they might have. It was written by the Office of Oregon Health Policy & Research at a level that does not assume a level of familiarity with actuarial concepts. Benchmark rates are only given at the category of service (COS) level (Hospital, Physician, Chemical Dependency, etc.). The reader is directed to the section of the Technical Report that provides further information on a subject.

Technical Report

A companion report is available for the reader who is interested in detailed descriptions of the calculations used in the methodology to establish benchmark rates and/or historical reimbursement rates for one or more of the service categories. This report was written by Mercer Government Human Services Consulting and also includes appendices that provide benchmark rates by sub-COS (e.g., Dental - Restorative, Other Services - Home Healthcare/ Private Duty Nursing) and eligibility category (e.g., TANF Adults, OHP Families). For a copy of the Technical Report, please visit our website at www.ohpr.state.or.us/hsc/index_hsc.htm or call (503) 378-2422.

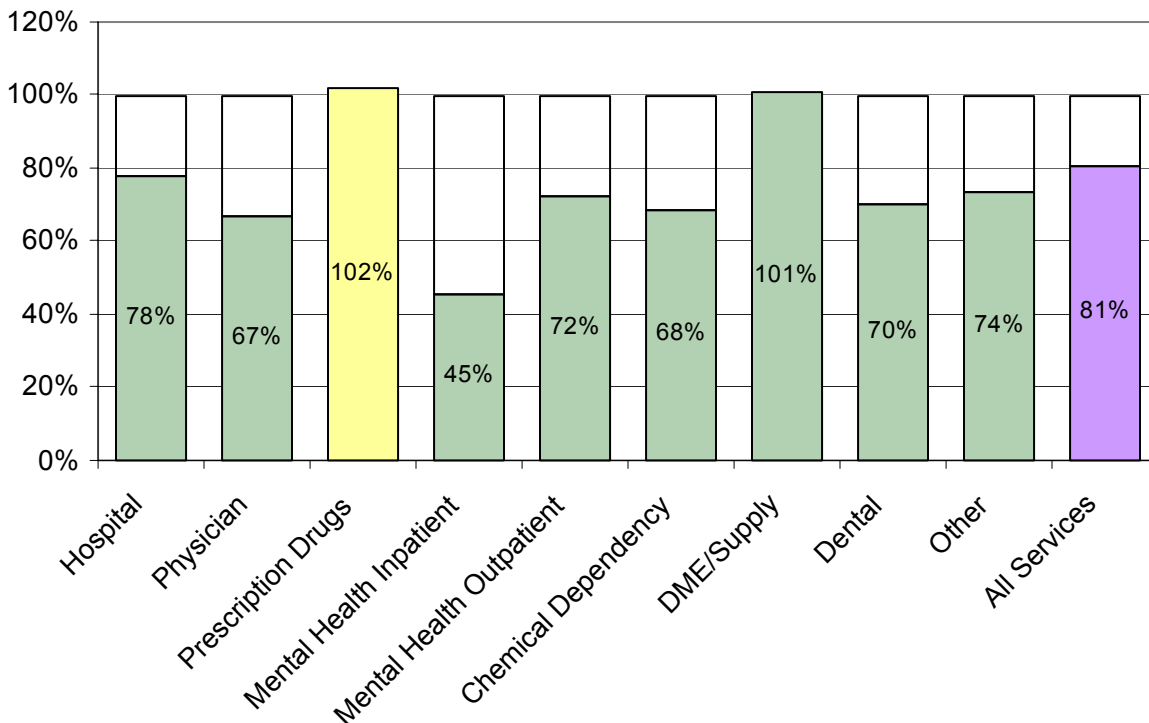
Executive Summary

When the Oregon Health Plan (OHP) was initially implemented, one of the cornerstones of the plan was to increase access to benefits by bringing payments to providers more in line with their costs of providing care. Satisfaction with the OHP ran high with providers and plans during its early years, but declining state revenues have led to a consensus among those providing OHP benefits that payments have not kept up with increasing healthcare costs. House Bill (HB) 3624, passed during the 2003 legislative session, was seen as an attempt to explicitly quantify how much payments are differing from costs, by setting benchmark rates for the major categories of healthcare services to which reimbursements can be compared. In addition, these benchmark rates can be used to measure the relative equity of payments among the providers of these services.

HB 3624 directed the Health Services Commission (HSC) to work with an actuary to establish these benchmark rates. The initial goal of the Commission was to use a common measuring tool across all categories of service, such as a percentage of Medicare reimbursement. This was not possible, however, since not all categories had a common payer and actual cost data was not available for many. Therefore, one of five different methodologies was used to develop a unit cost benchmark, depending on the best information on cost available for each service category.

The figure below, discussed in more detail in Chapter 4, provides a comparison of fee-for-service

Comparison of 2002 Medicaid FFS Reimbursements to 2002 FFS Unit Cost Benchmarks



(FFS) reimbursements during the historical data period to the FFS unit cost benchmarks established during this process. This figure can be used to determine how best to achieve equity among providers when future funding decisions affecting the Oregon Health Plan are made. The last column in the chart indicates that all service categories could be reimbursed equally at 81% of cost if current resources were redistributed. It should be noted that a true unit cost benchmark could not be calculated for prescription drugs due to the proprietary nature of the necessary data. It is assumed that the State is already paying at or above cost for prescription drugs based upon a review of profit margins and with no information to the contrary. Because of this, historical reimbursement rates can be used as a benchmark from which to compare future expenditures (as shown in the figure). An addendum to this report presents best practices being employed by other states that Oregon could use to help control costs in this area.

Chapter 1 Introduction

When the Oregon Health Plan (OHP) was initially implemented, one of the cornerstones of the plan was to increase access to benefits by bringing payments to providers more in line with their costs of providing care. Satisfaction with the OHP ran high with providers and plans during its early years, but declining state revenues have led to a consensus among those providing OHP benefits that payments have not kept up with increasing healthcare costs. House Bill (HB) 3624, passed during the 2003 legislative session, was seen as an attempt to explicitly quantify how much payments are differing from costs, by setting benchmark rates for the major categories of healthcare services to which reimbursements can be compared. In addition, these benchmark rates can be used to measure the relative equity of payments among the providers of these services.

HB 3624 charges the Health Services Commission (HSC) to “retain an actuary to determine the benchmark for setting per capita rates necessary to reimburse prepaid managed care health services organizations and fee-for-service (FFS) providers for the cost of providing health services” under OHP. It also specified that these benchmark rates be established for six different service categories. The HSC added three categories, indicated by an asterisk (*) below, because of the manner in which the State currently capitates for these services. The resulting nine service categories for which results are presented in this report are:

- Hospital Services
- Physician Services
- Prescription Drugs
- Inpatient Mental Health Services*
- Outpatient Mental Health Services*
- Chemical Dependency Services*
- Durable Medical Equipment/Supplies
- Dental Services
- Other Services

HB 3624 further directs the Department of Human Services (DHS) to explain any differences between FFS rates and per capita costs for the 2005-07 biennium and the corresponding benchmark rates to the 73rd Oregon Legislative Assembly.

The HSC released a Request For Proposals in November 2003, which eventually led to the awarding of a contract with Mercer Government Human Services Consulting (Mercer) the following month. Mercer was viewed as having strong experience in the Medicaid rate-setting field, and had previously worked with OHP on actuarial issues.

After contracting with Mercer, the HSC established the HSC Actuarial Advisory Committee to act as a resource for providing ongoing input into the process. This stakeholder group is made up of a knowledgeable group of representatives from hospitals, physicians, pharmacies, mental health and chemical dependency organizations, the durable medical equipment (DME) industry, dentistry, home health, and the fully capitated health plans contracted with the State. Mercer met with the full Commission and the Advisory Committee four different times each over the first nine months of 2004, culminating in the work presented in this report.

Chapter 2 The Dynamic Healthcare Marketplace

It is important to set the context of the report in terms of the current healthcare marketplace. After a brief period of stabilization in the mid-90's due to the influence of managed care, healthcare premiums are again experiencing double-digit growth rates. Many examples can be given as factors contributing to this renewed trend, among them are: technological advancements, Americans' ever increasing expectations of and demand for healthcare services, an aging US population, direct-to-consumer advertising (particularly by pharmaceutical manufacturers), and the implementation of the Health Insurance Portability and Accountability Act (HIPAA).

One should also understand where the healthcare dollar comes from and how it is distributed to providers. In Oregon, as for the US as a whole, employers cover 56% of the population for their healthcare services. An additional 7% of Oregonians have individual insurance, for a total coverage of 63% through the commercial market. The rest are covered through Medicaid, Medicare, or are uninsured as indicated in Figure 2.1¹. Healthcare spending by service category in the Oregon Health Plan is distributed as shown in Figure 2.2. This distribution is shown as both a percentage of total spending and as the amount spent on average for services in a category per person per month (PMPM).

While this report focuses on the cost of healthcare services, and draws some conclusions about the equity of historical reimbursements across provider categories, one should also keep in mind the widely divergent levels of profit being experienced by these providers. A national study shows prescription drug manufacturers (14.3%) and DME manufacturers (9.7%) are showing a much higher profit level than all other services as depicted in Figure 2.3². Separate statistics on Mental Health and Chemical dependency

Figure 2.1
Payer Sources in Oregon: 2001-02

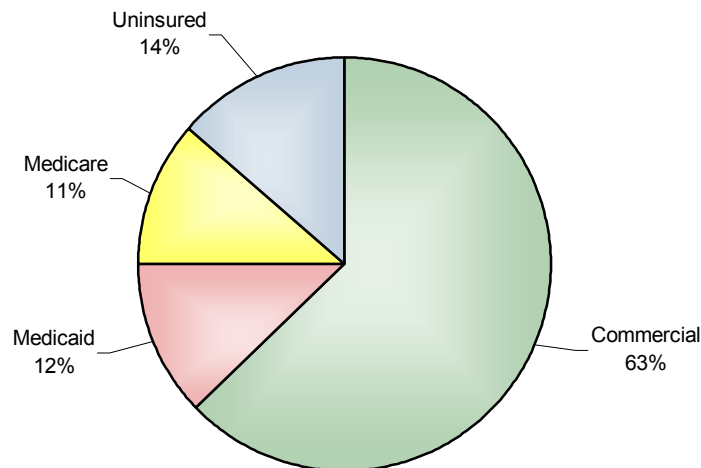


Figure 2.2
Healthcare Spending for OHP (FFS and Managed Care): SFY 2002-03

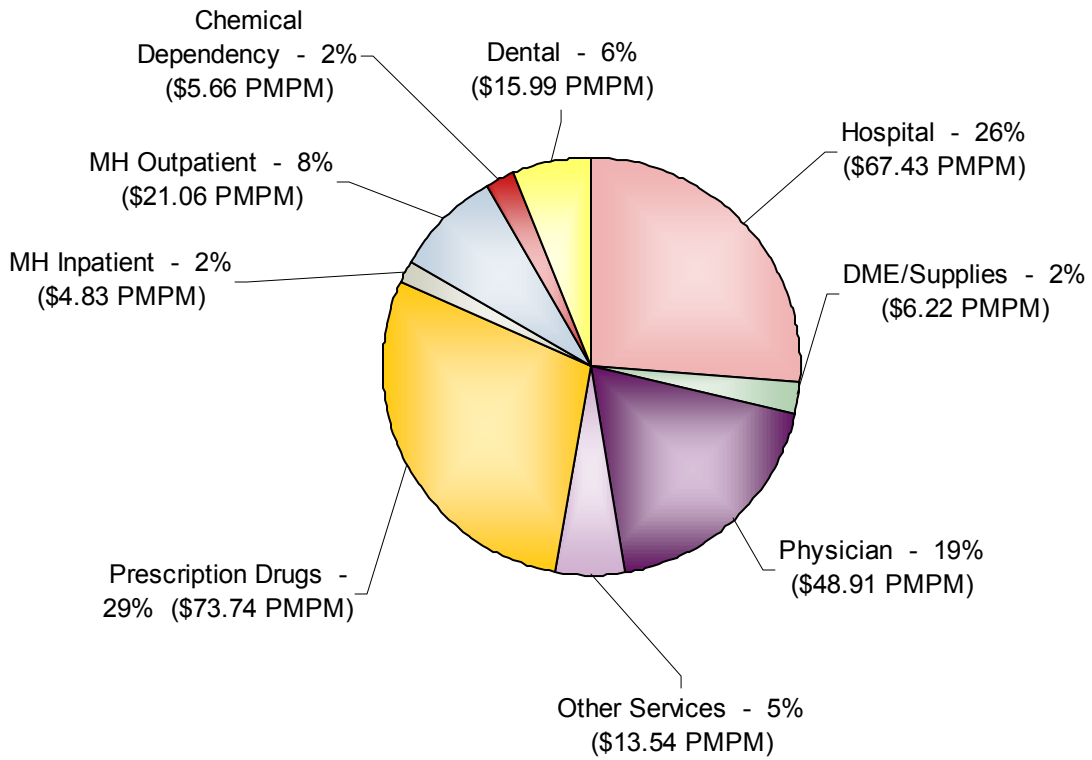
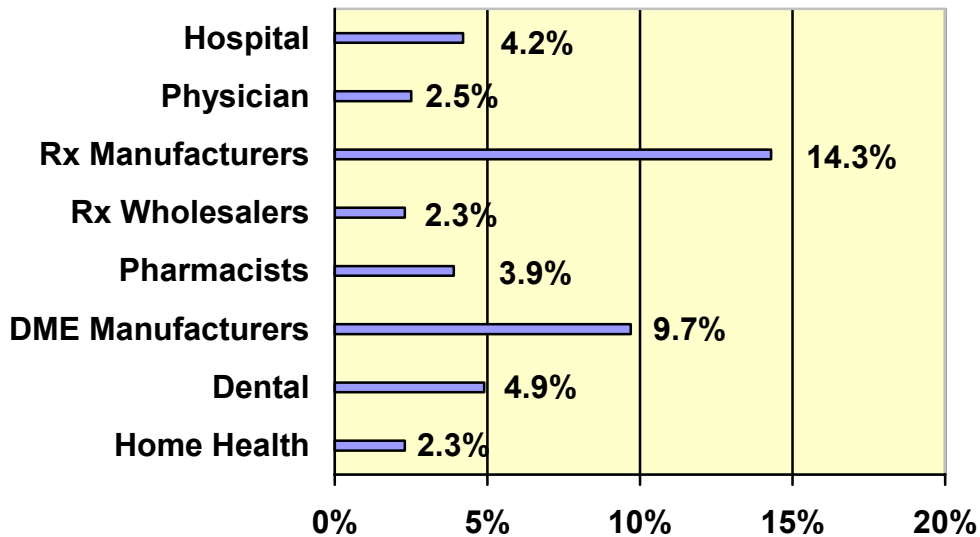


Figure 2.3
Profit Margins by Category of Service: 2003-04



provider profit margins were not available. Please note that inpatient mental health services are included as part of the profitability of the hospital category, while outpatient mental health and chemical dependency providers are not a part of the physician category.

Within the Oregon Health Plan, managed care organizations have experienced modest profit margins at best over the last two years. The fully capitated health plans had weighted average profits of -1.75% in 2002 and 5.67% in 2003. Dental care organizations showed profits of -1.28% and -0.66% for 2002 and 2003 and mental health organizations experienced profits of -1.36% and 1.08% over the two-year period. See Chapter 2 of the Technical Report for a listing of profit margins by individual managed care organization.

Current Environmental Factors

Stakeholders and others involved in this process stressed the importance of the environmental factors that shape the current healthcare landscape that serve to explain some of the results reported in this study. A listing of some of these factors unique to the various service categories appears below, while a more in-depth discussion appearing in Chapter 6 of the Technical Report.

Hospital

- Low number of hospital beds per person compared to other states
- Recent trends showing significantly increasing average lengths of stay
- Staffing shortages
- Utilization patterns that are unique to Oregon

Physician

- Lower Medicaid and Medicare participation due to decreasing reimbursement rates
- Projected pay cuts for Medicare services through 2012, which could be exacerbated by the inclusion of a prescription drug benefit in Medicare
- The perception that Medicare fee schedules do not account for Oregon-specific costs
- Increases in medical malpractice insurance rates, particularly for some specialty groups

Prescription Drugs

- Increasing drug utilization and rising unit costs leading to double-digit trend rates for near future
- Direct-to-consumer advertising
- Manufacturers focus on “me-too” drugs (e.g., cholesterol lowering agents, antidepressants), which look to shift market share rather than fill a new need

Mental Health

- National trends showing declining reimbursement for mental health services
- Budget shortfalls resulting in reduced State funding for mental health services
- Recent legislation calling for at least of 75% of future services to follow evidence-based practices by the year 2009

DME/Supplies

- Medicare reimbursement rates frozen at current levels until 2008
- Medicare opening up some DME/Supplies for competitive bid

Dental

- Healthy provider participation rate in OHP compared to Medicaid programs in other states

Chapter 3 Methodology

The initial goal of the HSC was to use a common measuring tool across all categories of service in establishing the benchmark rates called for by HB 3624. However, such a methodology would need to rely on the use of the same type of data for all service categories. Using a percentage of Medicare reimbursement as such a tool was examined, but Medicare either does not cover or significantly limits the provision of some of these services. In addition, it typically takes about eight months to have a request for state specific data to be filled, which would not have allowed for the completion of this study prior to the 2005 legislative session. It was furthermore concluded that a single methodology could not be based on cost data since it did not exist for all of the categories of service. A total of five different approaches were developed that take advantage of the best information available for each category of service (COS). They are used in developing the benchmark rates according to the following hierarchy, depending on the data obtainable for each COS as indicated:

1. The **Provider Cost Data Approach** was used when OHP specific cost data was available, such as hospital cost reports. (Hospital, Mental Health Inpatient, Mental Health Outpatient, Chemical Dependency, Other Services: Home Healthcare/Private Duty Nursing)
2. The **Alternative Fee Schedule Approach** was employed if the available cost data was not specific to OHP. Here an existing commercial or Medicare fee schedule was modified to develop a fee schedule that approximates cost of service. (DME, Dental, Other Services: Ambulatory Transportation)
3. The **Average Market Reimbursement Approach** was used when there was no cost data available and services are equally covered by Medicaid, Medicare, and commercial plans. The approach used the average reimbursement received from the three major payer sources as a proxy of cost. This assumes that market forces are at work so that this reimbursement level is just adequate enough to cover costs to the individual physician. (Physician)
4. When no cost information was available and Medicaid is a disproportionate payer source or the sole source for a service category, the **Modified Medicaid Data Approach** was used. Here an adjustment was made to OHP FFS reimbursements to approximate provider costs. (Other Services: Hospice, Other Transportation, Vision)
5. In the case of prescription drugs, limited cost data was available and current reimbursements were assumed to already be at or above cost based upon a review of profit margins. By looking at best practices being used to control their drug expenditures, or **Benchmarking Against Better Purchasing Approaches**, Oregon can examine ways to reduce these costs in the future. (Prescription Drugs)

Benchmark rates for FFS and managed care were derived using one of these five methods for the July 1, 2001 - June 30, 2003 period (hereafter referred to as 2002). The 2002 unit cost benchmarks represent an approximation of the provider's cost to supply the service,

less an estimate of copayments and the amount paid by other payer sources (e.g., Medicare, worker's compensation) -- in other words, that portion of the cost of care that the State is responsible for.

The 2002 time frame corresponds to the dates for which the most recent OHP historical data was available. As previously discussed, some benchmarking approaches used this historical Medicaid experience as a data source. Establishing benchmark rates for the 2002 also allows for comparisons to be made to historical reimbursements over the same time period.

Finally, benchmark rates were calculated for the study period from July 1, 2005 - June 30, 2007 (hereafter referred to as 2006). Adjustments were made to the 2002 benchmark rates to account for inflationary cost increases, utilization trends and program changes implemented after July 1, 2001 (see Appendices C and D of the Technical Report for a detailed listing of these program changes and Chapter 6 of that report for a discussion of some of the more significant ones). Please see Chapter 6 of the Technical Report for a detailed discussion on the calculations made for each COS in arriving at the 2002 and 2006 benchmark rates and the 2002 historical reimbursement rates.

Chapter 4 Results

Before examining the unit cost benchmarks for the service categories, some understanding of the units of service represented in the underlying data is necessary. It should be noted that the historical data included variation in the definition of units within service categories. Figure 4.1 lists the various units represented within each category. While the number of admissions, days, or scripts filled follows a standard definition, a claim could include a months worth of visits to a provider or a single one. Examples for the other types of units can be just as striking; “services” for the Physician COS (category of service) could represent the number of lab tests or surgical procedures performed and “CPT code units” for the DME/Supplies COS could represent the number of packages including 50 syringes or 500 syringes. Costs given on a per unit basis in this or the Technical Report in which a COS contains multiple units of service should therefore be interpreted with caution. While these numbers are valid for the comparative purposes for which this study is intended, they have limited value in isolation since the blended unit of service has little meaning. It is suggested that industry standards for units of service be considered when performing future rate setting exercises for OHP.

Figure 4.1
Units of Service Represented in the Historical Medicaid Data by Category of Service

Category of Service (COS)	Type of Unit
Hospital	Admits/Claims
Physician	Claims/CPT Code Units/Visits/Services
Prescription Drugs	Claims/Scripts Filled
Mental Health Inpatient	Days/Services
Mental Health Outpatient	Claims/Services
Chemical Dependency	Services
DME/Supplies	CPT Code Units/Services
Dental	Services
Other Services	Admits/Claims/CPT Code Units/Services

Figure 4.2 provides a summary of the results related to the FFS unit cost benchmarks for the nine different service categories. The first column shows the 2002 FFS historical reimbursement rate derived from the historical Medicaid data set described in Chapter 3. The second column gives the 2002 FFS unit cost benchmark for each category of service (COS) using one of the five approaches as described in Chapter 3. The third and final column provides the 2006 FFS unit cost benchmark for each service category. In all instances, these costs represent the projection of the 2002 FFS unit cost benchmark

Figure 4.2
FFS Historical Reimbursement and Unit Cost Benchmarks by Category of Service

Category of Service (COS)	Historical 2002 FFS Reimbursement Rate per Unit	2002 FFS Unit Cost Benchmark	2006 FFS Unit Cost Benchmark
Hospital	\$ 264.93	\$ 345.49	\$ 437.60
Physician	\$ 51.44	\$ 76.87 ³	\$ 85.67
Prescription Drugs	\$ 45.40	\$ 44.65	\$ 51.20
Mental Health Inpatient	\$ 244.98	\$ 540.47	\$ 672.15
Mental Health Outpatient	\$ 65.37	\$ 90.17	\$ 101.11
Chemical Dependency	\$ 39.69	\$ 58.14	\$ 64.92
DME/Supplies	\$ 1.43	\$ 1.41	\$ 1.50
Dental	\$ 31.69	\$ 45.31	\$ 52.51
Other Services	\$ 31.99	\$ 43.45	\$ 47.69

forward to the midpoint of the 2005-07 biennium, as requested in statute. The differences in the two benchmarks represent the net of adjustments for trend and program changes. A true unit cost benchmark could not be calculated for prescription drugs due to the proprietary nature of the data. It is assumed that the State is already paying at or above cost for prescription drugs based upon a review of profit margins and with no information to the contrary. Because of this, historical FFS reimbursement rates are used as a benchmark from which to compare future expenditures. See the addendum to this report for a description of best practices being employed by other states that Oregon could use to help control costs in this area.

Figure 4.3 shows the summary of results for the managed care unit cost benchmarks. The 2002 managed care unit cost benchmark appears in the first column. A projection forward of this unit cost to the study period in a similar manner to that just described for the 2006 FFS benchmarks results in the 2006 managed care unit cost benchmark, appearing in the second column of the figure. It is strongly suggested that comparisons not be made between the FFS and managed care benchmarks. Unit costs can differ based on the mix of services provided in each setting and variations in reporting. First, delivery systems may differ in case mix severity. In addition, just as there is variation in units of service within a service category, there is also variations in the way reporting of units occurs between delivery systems. If the same service is usually billed in 15 minute increments for FFS and 1 hour increments at the request of a managed care organization, the unit cost for managed care would be artificially inflated. Finally, and most importantly, unit costs do not reflect utilization or the total cost of care. As such, the setting with higher unit costs could have lower total costs for that category or visa versa. This could be true if one delivery system saw a significantly smaller number of (on average) more expensive cases than the other.

Figure 4.3
Managed Care Unit Cost Benchmarks by Category of Service

Category of Service (COS)	2002 Managed Care Unit Cost Benchmark	2006 Managed Care Unit Cost Benchmark
Hospital	\$419.39	\$538.60
Physician	\$74.20	\$ 83.78
Prescription Drugs	Data Not Available	Data Not Available
Mental Health Inpatient	\$634.94	\$795.99
Mental Health Outpatient	\$49.62	\$ 56.64
Chemical Dependency	\$28.84	\$ 32.92
DME/Supplies	\$2.52	\$ 2.68
Dental	\$49.49	\$ 57.83
Other Services	\$69.95	\$ 77.40

All of the numbers shown here are for the total OHP population (OHP Plus and OHP Standard). Breakouts for each COS by OHP eligibility group (e.g., Chemical Dependency: OHP Adults and Couples, Dental: Old Age Assistance with Medicare) can be found in Appendix F of the Technical Report. Rates by sub-COS (e.g., Physician: X-ray, Other Services: Home Healthcare/Private Duty Nursing) are available in Appendix E of that report. Stakeholder input directed that these rates represent statewide unit cost benchmarks, but be aware that variation by such factors as geographic region, provider setting, and individual facility will occur.

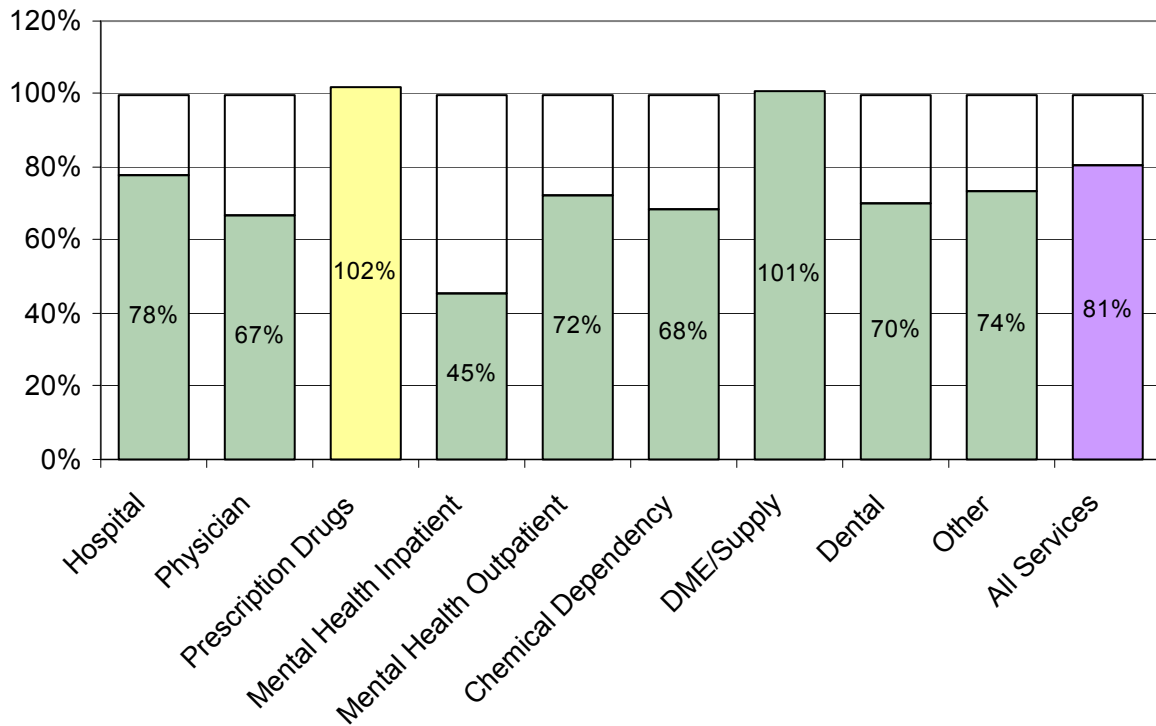
It is important to note that all of the numbers used in making these calculations represent a point estimate within a range of acceptable values. Various assumptions were necessary when producing these results and are disclosed in the Technical Report. Other cautions should be noted when examining the benchmark rates given the limitations of the data available and the scope of the project (see Chapters 3 and 4 of the Technical Report for a complete discussion of the limitations associated with this study). Also, these benchmark rates should not be viewed as rates that can be used to set reimbursement under OHP. As these rates are meant to represent the cost of care, they are not consistent with the Centers for Medicare and Medicaid Services (CMS) requirements for capitation rate development under Medicaid (what can reasonably be paid to an effectively and efficiently run managed care plan).

Figure 4.4 provides a comparison of FFS reimbursements during the 2002 historical data period to the 2002 FFS unit cost benchmarks established during this process. This figure can be used to determine how best to achieve equity among providers when future funding decisions affecting the Oregon Health Plan are made. The last column in the chart indicates that all service categories could be reimbursed equally at 81% of cost if current resources were redistributed. A chart similar to Figure 4.4 comparing 2002 managed care billed charges to the 2002 unit cost benchmarks was not performed as the results would not provide useful information. Having information on the amounts

actually paid by the managed care plans to their providers would show which sectors are fairing better than others, but this data is considered proprietary and was not available. In addition to being able to draw some high level conclusions about the equity of reimbursement as a percentage of provider cost among the service categories studied, the report shows where further analysis could be focused. The area of chemical dependency was particularly lacking good data. This is of course in addition to the need for acquisition cost data for prescription drugs. Finally, future iterations of this project would benefit from the ability to obtain detailed Oregon specific Medicare data.

HB 3624 directs the Department of Human Services to submit a report to the 73rd Oregon Legislative Assembly by February 1, 2005. Their report is to compare the rates on which the department's budget is based for the 2005-07 biennium and the benchmark rates contained in the Technical Report. Differences in rates are to be disclosed with both the amount and reason for any variances given.

Figure 4.4
Comparison of 2002 Medicaid FFS Reimbursements to 2002 FFS Unit Cost Benchmarks



¹ Kaiser Family Foundation – State Health Facts Online, 2001-02.

² Hospital, Rx Manufacturers: Kaiser Family Foundation, Trends in Indicators in the Changing Health Care Marketplace, 2004 Update

Physician, RX Wholesalers, DME Manufacturers, Dental: Corporate Profitability by Industry, www.bizstats.com

Pharmacists: National Community Pharmacists Association, 2003 NCPS-Pfizer Digest

Home Health: CMS Health Care Industry Market Update – Home Health, September 22, 2003

³ This 2002 FFS unit cost benchmark for Physician converts to an approximate amount of \$38.78 per relative value unit (RVU). This compares to the current FFS RVU conversion factor of \$25.95, which has not changed in five years.

Addendum Special Note on Potential Strategies to Reduce Prescription Drug Costs

While the focus of this study was on the creation of the benchmark rates, challenges relating to the difficulty in obtaining cost data on prescription drugs and strong input from stakeholders prompted the Health Services Commission to look further into issues related to this service category.

Controlling the costs of prescription drugs is viewed as a key component to maintaining the sustainability of the Oregon Health Plan. As noted in Chapter 3 of this report, this limited cost information led to the decision to use historical reimbursements as a benchmark. This addendum examines ways in which Oregon can reduce pharmaceutical costs in the future, using the 2002 reimbursement benchmark as a measure of progress.

There are two basic components that determine what is spent on prescription drugs -- the price paid and the level of utilization. First, the levels of discounts that the State receives off of the average wholesale price (AWP) were examined. Oregon pays AWP - 11% for drugs acquired in an inpatient hospital setting, with a dispensing fee of \$3.91, and AWP - 15% for drugs in from retail and outpatient hospital pharmacies, with a dispensing fee of \$3.50. This compares favorably to a sample of 12 other state Medicaid programs. For brand name drugs, which account for 85% of Oregon's expenditures, discount rates in these states ranged from a low of AWP - 5% to a high of AWP - 15%. Three states achieve even higher discounts (AWP - 27% to AWP - 50%) by negotiating separate rates for certain generic drugs (which Oregon does not do). Only one other state had a lower dispensing fee than the \$3.50 Oregon pays to retail pharmacies, at \$3.40. Three other states have lower dispensing fees for institutional pharmacies, ranging from \$1.89 - \$3.65.

While Oregon is doing well in terms of the discounts received on prescription drugs, there are still plenty of opportunities for Oregon to reduce costs. The following list identifies the "best approaches" being used by other states that could help Oregon control the utilization portion of the equation. It should be noted that the range of potential savings shown are for the FFS program only. These estimated savings reflect the experience of other states and are not a result of an analysis of Oregon specific data. Additionally, the amount of savings for some of these items can vary significantly according to how lenient of an exception process is put into place and not all of the savings are cumulative if multiple approaches are initiated. Those measures that would require legislation to be fully implemented are indicated with an asterisk (*).

- **A mandatory preferred drug list (PDL)*** - Oregon currently has a voluntary PDL, which recommends (but does not require) the use of the most cost-effective drugs within a drug class (e.g., lipid lowering agents). Making it mandatory would allow for supplemental rebates, which could result in an additional savings of up to 6-10% of the total amount spent on prescription drugs for the FFS program (an estimated \$5 M - \$8 M annual savings for the 2005-07 biennium).

- **340b program maximization** - Significant discounts are available to government-supported facilities that participate in the program as covered entities that serve vulnerable populations. As of July 2004, Oregon has 224 eligible clinics/facilities that participate in this program, which is an average rate compared to other states. Maximizing this program could provide gross savings of as much as 11-15% of the remaining FFS 340b drug expenditures. Oregon is currently conducting a pilot project that would determine how much of this savings would be offset by increased administrative costs and higher payments made for other health services if more OHP clients received care at 340b facilities.
- **Dose optimization*** - When a drug is prescribed to be taken multiple times a day, it may be clinically appropriate to take a single larger dose of that medication. The larger doses are often sold at a price equal to or only marginally above the cost of the smaller doses, so savings as much as 0.5 - 1.0% can be achieved depending on the target medications. Oregon is currently working towards implementing such a program for a limited number of mental health drugs.
- **Step therapy clinical edits*** - This method requires that less expensive, usually generic, drugs are tried first. Prescriptions for more expensive medications are allowed only if earlier courses of treatment fail. Typical savings can range from 1.0 - 1.5%.
- **Mandatory acquisition cost data reporting*** - Texas has had a program in place for about 10 years which requires pharmacies to disclose the price paid to manufacturers to obtain prescription drugs. The state has then expanded its MAC list to regulate prices for all drugs (not just those generics available from multiple sources as in Oregon) based on this information. While the resources necessary to implement such a program are substantial, net savings could be as high as 4%.
- **Quantity limits*** - Establishing a maximum number of prescriptions that can be prescribed for or filled by a patient within a month or a limit on the number of pills that can be obtained with a single prescription. OHP currently has a program in place in which drug management is provided for clients with 15 or more prescriptions over a six-month period. Savings are variable and can reach 0.5 - 1.5% depending on the target medications.
- **Disease management programs** - Variable savings can be achieved by implementing programs that manage the care and control costs for prevalent diseases. Oregon currently has programs targeted for asthma, diabetes, congestive heart failure, depression, and other high cost cases.
- **Bulk purchasing*** - Pooling the purchasing power of the State results in better negotiated prices for all prescription drugs needed across agencies and programs. Oregon is just preparing to implement a program that is expected to cover 10,000 lives when it goes into effect in January 2005. Oregon's program does not currently plan to cover OHP, but will include some state agencies, local governments, school districts and seniors.
- **Capturing the prescriber identifier** - Enhances the success of other pharmacy management initiatives.
- **Electronic prescribing** - Provides the ability of the physician to access patient specific information through a handheld device that can lead to a more appropriate therapy and can allow for the prescription to be transmitted to the pharmacy.