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NATIONAL ALLIANCE OF STATE
& TERRITORIAL AIDS DIRECTORS

MANAGING PRESCRIPTION UTILIZATION

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AIDS Drug Assistance Programs and Cost Containment Strategies: Managing Prescription Utilization

INTRODUCTION

Part B of the Ryan White HIV/AIDS Treatment Modernization Act (Ryan White Program) established federally-funded, state-administered AIDS Drug Assistance Programs (ADAPs) to provide HIV medications for low-income, uninsured, and underinsured individuals living with HIV/AIDS in the United States. This is the third in a series of six ADAP technical assistance briefs focusing on cost containment strategies. Other topics include: *Eligibility Criteria, Formulary Management, Insurance Purchasing, Client Cost-Sharing, and Waiting List Management.*

Under Part B of the Ryan White Program, states have wide latitude to structure ADAPs, including guidelines on how clients will access prescriptions. States may use several mechanisms to manage program access and expenditures to maximize ADAP resources and manage prescription utilization.

This brief discusses four main strategies for managing ADAP prescription utilization in light of growing demand and increasingly constrained resources:

- Annual and/or monthly cost caps;
- Restricting prescription supply or refills;
- Use of prior authorization; and
- Clinical reviews of prescribing patterns.

For each strategy, there is an overview of important issues to consider before adopting the strategy, and 'how to' implementation steps. Examples of ADAPs using the strategy are included with a brief description of their experience in terms of the benefits and challenges. The brief concludes with a checklist to assist in implementing management of ADAP prescription utilization.

STRATEGIES FOR MANAGING PRESCRIPTION UTILIZATION:

Annual or Monthly Cost Caps

Given resource limitations, some ADAPs have set a limit or "cap" (annual or monthly) on the amount of money the ADAP will spend on prescriptions for each individual client. ADAPs who experience fluctuating month-to-month expenditures may find it useful to establish a monthly cap on per client expenditures for certain drug classes or types of prescriptions.

ADAPs recognize that their role in the care continuum is to provide the necessary HIV medications that have been prescribed by a treating physician. However as the program has matured over seventeen (17) years, it has become necessary for ADAPs to take responsibility for some level of cost containment as it relates to the provision of medication regimens. ADAPs have traditionally not interjected medication costs into the physician directed prescription process. All ADAPs recognize and honor the premise that an individual's clinical needs outweigh all drug cost concerns. With this premise at the forefront, ADAPs are beginning to explore the option of physician education around regimen costs, particularly in the case of treatment naïve patients. Experience has shown that physicians, when informed about comparative costs of equally effective regimens, are likely to select a less expensive one.

ADAPs can create tools to guide this process by developing a relative pricing scale for regimens recommended in the Department of Health and Human Services Guidelines for the use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. An ADAP can determine the costs of the recommended drug combinations then combine the utilization data to rank the ten most frequently prescribed regimens. This process will yield a relative cost scale that can be used to educate physicians about the impact of prescription costs on ADAP. In cases where the client shows no resistance and a less expensive antiretroviral combination will be as effective as a more costly one, relative costs may prove beneficial.

One way to determine a reasonable annual limit on per client expenditures is to calculate the annual average cost per client for the most recent three year period. Previous experience has shown that the majority of ADAP clients will utilize program resources within the annual average. Clients with more intensive resource needs—including clients requiring salvage therapies—may exceed the cap. It will be important to reassess the cost cap periodically as client enrollment and/or utilization changes, new antiretrovirals (ARVs) become available, and ADAP pricing changes. Once a maximum cap(s) is established, the ADAP must maintain on-going communication with the medication distribution network and monitor monthly client expenditures to ensure adherence by clients, their providers, and the medication distribution system.

Before initiating an expenditure cap, the ADAP should first consider the following:

What alternative resources are available for clients when they reach the cap? The ADAP will need a written policy and procedure to connect clients who have reached their spending cap with another payer source, such as Pharmaceutical Assistance Programs (PAPs), to ensure there is no disruption in prescription coverage for the client. This policy may include notifying the client and their case manager when the client approaches their spending cap to allow time for arranging another payer source. It will be important to make sure clients, case managers, and providers have up-to-date information on available PAPs.

What mechanisms are available to monitor client expenditures, their timeliness, and costs? ADAPs using a Pharmacy Benefits Manager (PBM) or Pharmacy Network Contractor (PNC) should receive monthly expenditure reports from the contractor(s). The

ADAP can require their PBM or PNC to monitor and report individual client expenditures toward the cap.

What if there is no PBM?

In the event that the ADAP does not have a PBM, the ADAP coordinator or other staff member would pay all bills and enter and monitor all expenses. In **South Dakota**, for example, the finance department produces expense reports once a month that are used to corroborate prescription expenditures.

Restricting Prescription Supply or Refills

Prescription supply given to a client: For clients not on a stable regimen, the ADAP may choose to cover a 30-day versus a 90-day supply of ARVs. This reduces the possibility of paying for obsolete medications when a client's regimen or eligibility status changes and reduces the potential for stockpiling medications.

Number of refills without a new prescription: Similarly, the ADAP may limit the number of refills before requiring a new prescription in order to reduce the likelihood of unnecessary, costly refills due to regimen changes or changes in eligibility status. The number of refill limits (e.g., 2-6) may differ for 90-day versus 30-day prescriptions. The ADAP may also limit the total number of refills in a given year for the same reasons.

Refills on medications prior to the end of the month: The ADAP may choose not to authorize refills prior to 21 days after the most recent prescription to limit the possibility of clients receiving extra weeks of medications that may not be needed.

Refills of lost medications without significant justification: The ADAP may limit the number of times it allows refills of 'lost' prescriptions.

Number of medications provided each month: The ADAP may choose to

In 2005, **Missouri** reduced Medicaid spend-down assistance using state general revenue funds from \$500 per client to \$200 client; removed some therapeutic categories from their ADAP formulary (e.g., no more coverage for wasting items); and discontinued co-pay and deductible assistance for clients with commercial insurance and income >200 percent FPL. The Missouri ADAP created space for new client growth in programs and had to adjust assistance as above to remain in budget. While these steps led to savings for the Missouri ADAP, it is hard for Missouri to quantify these savings due to the lowering of the Medicaid income level by their state's legislature and the advent of Medicare Part D.

Oklahoma's client benefit cap was originally implemented in FY1996 to create a more equitable, manageable, and fiscally sound program without having to implement a program waiting list. The benefit cap has been lifted when additional funding has been secured and it has been determined the program would suffer no budget shortfall. The benefit cap has been lifted for FY2007 for this reason. The amount of the benefit cap is based on program budget, utilization trends, average monthly client expenditures, and projected enrollment. Prior to implementing the benefit cap, there was a cap on program enrollment and 30 percent of the program budget was being spent on 7 percent of the program clients. Client drug expenditures are tracked by the ADAP pharmacy and ADAP clients and their case managers are notified within two months of reaching the benefit cap. The Oklahoma ADAP provides any needed documentation for clients to access prescriptions through other resources, specifically through drug manufacturer programs, once the benefit cap has been reached.

limit the number of ARV prescriptions per month. For example, it may allow four ARVs and two medications for the treatment/prevention of opportunistic infections per client per month. Other resources and patient assistance programs must cover any other medication needs.

Use of Prior Authorization

To avoid more stringent cost containment measures, ADAPs may implement a prior authorization process for certain medications. Establishing prior authorization is discussed in the *ADAP and Cost Effectiveness Strategies: Formulary Management* technical assistance brief, with examples provided.

Clinical Reviews or Prescribing Patterns

HRSA expects Part B grantees to include ADAP in their mandated clinical quality management plan, to ensure that: 1) clients receive treatment consistent with current DHHS treatment guidelines; and 2) the ADAP is providing access to, and support for, appropriate medications. The state's ADAP Advisory Committee, experienced pharmacists, and/or HIV/AIDS medical providers can be effective partners in this endeavor by conducting clinical reviews of prescribing patterns.

In addition to assuring consistency with treatment guidelines, such reviews can assess prescribing patterns in relation to clinical disease indicators and relative costs. However, the process for a complete review for all ADAP clients can be technically difficult. This is especially true for smaller states with limited administrative resources, and states where payers such as Medicaid, SPAPs, and/or manufacturers' PAPs provide prescriptions for some ADAP clients.

In such cases, the ADAP might: request data runs from their PBM or another contractor; review prescribing patterns for a sample of clients; or select another quality indicator to assess on a sampling basis. When choosing a quality improvement approach, the ADAP should consider administrative feasibility as well as whether the results are likely to generate significant quality improvement and any anticipated cost savings.

PRESCRIPTION UTILIZATION MANAGEMENT CHECKLIST

- Determine if changes are economically and administratively feasible for the ADAP.
- Anticipate problems that may occur with patient access to medications.
- Develop procedures to rapidly address unintended consequences of patient access to medications.
- Make sure the state, PBM, and/or other medication distribution system has the necessary data infrastructure/capacity to track the client, ADAP utilization, and financial data needed.
- Be familiar with state legislation and administrative regulations that may impact your ability to make changes in ADAP.
- Follow the internal state agency process for review and approval of changes to the ADAP.
- Communicate to the community about why and when the ADAP makes prescription or program utilization changes.
- Establish contract requirements with the ADAP pharmacy network or direct purchase administrative agency for any client or financial data tracking and reporting needs.
- Notify the ADAP pharmacy network or direct purchase administrative agency of any changes.
- Consult other ADAPs that have inves-

tigated and/or changed their eligibility criteria, to find out how they approached it, the results and lessons learned;

- Communicate with your HRSA Project Officer and NASTAD, when the state is considering changing the criteria, when and if significant challenges arise, and when any changes are actually implemented.

RESOURCES

- National Alliance of State and Territorial AIDS Directors (NASTAD) – www.NASTAD.org
- HRSA HIV/AIDS Bureau – www.hab.hrsa.gov
- HRSA 340B Prime Vendor Program – www.340bpvp.com/public/
- HRSA Target Center – Technical Assistance for the Ryan White Community – <http://careacttarget.org/>
- Kaiser Family Foundation – www.kff.org/hiv/aids/us.cfm
- Office of Pharmacy Affairs – www.hrsa.gov/opa
- Pharmacy Services Support Center – <http://pssc.aphanet.org>
- ADAP listserv sponsored by NASTAD – NASTADTA@NASTAD.org
- Kaiser Family Foundation and National Alliance of State and Territorial AIDS Directors, National ADAP Monitoring Project Annual Report. April 2007.
- Ryan White HIV/AIDS Treatment Modernization Act, Pub. L. No 109-415, (2006).
- Current treatment guidelines – <http://aidsinfo.nih.gov>
- Comprehensive information on ARVs and OI medications – www.aidsmeds.com

NASTAD is funded under HRSA Cooperative Agreement U69HA05543 to provide states with technical assistance on ADAP program administration. States interested in investigating cost containment strategies may contact NASTAD at NASTADTA@nastad.org to discuss specific technical assistance needs. Part B grantees and ADAPs may also obtain technical assistance through their HRSA project officer.

NOTES
