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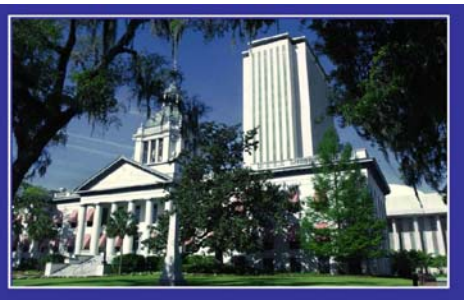

September 2008 **Report No. 08-55**

Medicaid Reform: Oversight to Ensure Beneficiaries Receive Needed Prescription Drugs Can Be Improved; Information Difficult for Beneficiaries to Locate and Compare

at a glance

Medicaid Reform capitated health plans have more flexibility in developing their preferred drug lists than do traditional Medicaid plans. Although the Agency for Health Care Administration expects plan beneficiaries to have access to the same drugs that would be available to them under traditional Medicaid fee-for-service, it relies on plans' assurances that they will provide the drugs needed by their beneficiaries. While the agency has some processes to identify problems beneficiaries experience related to receiving drugs, oversight can be improved. Our analyses showed that Reform capitated plans' preferred drug lists do not contain all of the drugs or therapeutic classes of drugs available through Medicaid fee-for-service. While not listing a drug does not necessarily mean the plan will not cover the drug, beneficiaries may have to go through additional steps such as obtaining prior authorization or step therapy before they can receive the drug.

Although obtaining information about prescription drug coverage is important to many Medicaid beneficiaries, it is difficult for them to locate and compare Reform plans' drug offerings and prior authorization requirements. To address this issue, the agency has established a special needs unit to help beneficiaries determine which plans cover the drugs they need. In addition, the agency is developing an electronic tool that choice counselors can use to help beneficiaries compare prescription drug coverage among the plans.

Medicaid Reform

The 2005 Legislature authorized the Agency for Health Care Administration (AHCA) to reform the state Medicaid program with the intent of improving health outcomes of Medicaid beneficiaries and achieving budget predictability. [1] AHCA obtained a federal waiver and legislative approval to implement a managed care pilot program, which began providing services to Medicaid beneficiaries in Broward and Duval counties in September 2006. AHCA expanded the pilot to Baker, Clay, and Nassau counties in September 2007. [2] AHCA will need legislative approval to expand Medicaid Reform beyond these five counties. [3]

The major premise of Medicaid Reform is to improve health care services by giving managed care health plans flexibility to better meet the specific needs of Medicaid beneficiaries and to promote competition among these plans. Under Medicaid Reform, health plans can develop customized benefits packages for different

[1] Chapter 2005-133, *Laws of Florida.*

[2] AHCA received approval to implement an 1115 Research and Demonstration Waiver application from the Centers for Medicare and Medicaid Services in October 2005. The Legislature approved implementation of the waiver in December 2005 (Chapter 2005-358, *Laws of Florida).*

[3] Chapter 2005-358, *Laws of Florida,* established a goal of statewide implementation by June 2011 in accordance with waiver requirements but requires AHCA to obtain legislative approval to expand implementation beyond the pilot sites.

beneficiary groups. Medicaid Reform is intended to empower beneficiaries by offering them more managed care options and encouraging them to take an active role in their health care. Medicaid Reform beneficiaries receive detailed information on their health plan choices and assistance from specially trained choice counselors to help them select a Reform plan that best fits their needs. Beneficiaries can earn monetary credits for participating in certain healthy behaviors that they can use to purchase health-related products.

Participation in Medicaid Reform in the pilot counties is mandatory for certain low-income children and families and aged and disabled beneficiaries. These include families who have incomes at or below 23% of the federal poverty level, children who live in families that earn up to 200% of the federal poverty level (depending on the children's ages), and individuals who are age 65 and older or disabled and receive federal Supplemental Security Income.[4] Other beneficiaries may choose to participate in Medicaid Reform, including children in foster care, individuals with developmental disabilities, and Medicare beneficiaries who are also eligible for Medicaid (dual eligibles).

As required by Chapter 2005-133, *Laws of Florida*, this is one of a series of reports presenting the results of OPPAGA's evaluation of the Medicaid Reform managed care pilot programs. This report reviews prescription drug coverage within Medicaid Reform and addresses three questions.

- What are AHCA's requirements for prescription drug coverage in Medicaid Reform and how does AHCA ensure that Reform plans meet these expectations?
- How does prescription drug coverage under Medicaid Reform HMOs differ from prescription drug coverage under the state's Medicaid fee-for-service program?
- What challenges have beneficiaries faced in accessing information about Medicaid Reform plans' prescription drug coverage?

[4] In 2008, 23% of the federal poverty level is $4,048 per year for a family of three; 100% of the federal poverty level is $17,600 for a family of three; and 200% of the federal poverty level for a family of three is $35,200.

What are AHCA's requirements for prescription drug coverage in Medicaid Reform and how does AHCA ensure that Reform plans meet these expectations?

AHCA allows Medicaid Reform capitated health plans more flexibility in developing preferred drug lists (PDLs) than it does non-Reform plans. Even so, AHCA expects that Medicaid Reform beneficiaries should be able to access the same prescription drug services offered to beneficiaries in Medicaid fee-for-service. However, AHCA has limited processes in place to ensure that Medicaid Reform health maintenance organizations (HMOs) meet this expectation and that beneficiaries receive needed prescription drugs.

Under Medicaid fee-for-service, physicians and other providers can prescribe beneficiaries any drug that is listed on the Medicaid PDL. For the most part, fee-for-service beneficiaries can get any drug listed on the Medicaid PDL as long as the prescriber indicates the drug is medically necessary.[5, 6] If beneficiaries need a drug that is not on the PDL, providers must first seek authorization from AHCA.

Under Medicaid Reform, capitated health plans can establish their own PDLs and AHCA primarily relies on assurances that the plans will provide the drugs needed by their beneficiaries.[7, 8] While non-Reform capitated plans also can establish their own PDLs, they are required to include at least two drugs, when available, in each therapeutic category covered by the Medicaid fee-for-service PDL.[9] AHCA does not impose this requirement on Medicaid Reform capitated plans.

[5] Section 409.912(39)(a)1., *F.S.*

[6] The state's Medicaid fee-for-service PDL is a listing of prescription drug products recommended by the Medicaid Pharmacy and Therapeutics Committee as efficacious, safe, and cost-effective choices. Only a few of the drugs on the PDL require prior authorization, such as drugs that are limited in their therapeutic scope but very expensive.

[7] Because AHCA currently reimburses Reform provider service networks (PSNs) on a fee-for-service basis, contracts state these plans can either use the Medicaid fee-for-service PDLs or develop their own PDLs; to date; all Reform PSNs use the Medicaid fee-for-service PDL.

[8] Medicaid Reform and non-Reform HMOs use committees similar to the state's Medicaid Pharmacy and Therapeutics Committee to develop their PDLs.

[9] This requirement in the non-Reform contract references state law that also requires that the Medicaid fee-for-service PDL include at least two drugs in each therapeutic category.

However, like non-Reform capitated plans, Medicaid Reform health plans must provide beneficiaries the drugs listed on their PDLs and have processes in place that allow beneficiaries to receive other needed drugs. Also, like non-Reform capitated plans, Reform capitated plans are to develop prior authorization guidelines which must be approved by AHCA. In addition, all plans must establish and follow procedures required by the Hernandez Settlement Agreement. [10]

In the absence of more specific contract guidelines, AHCA needs to have processes in place to ensure that beneficiaries of Reform HMOs can access the same drugs that are available to Medicaid fee-for-service beneficiaries. However, AHCA's processes are limited. Although AHCA requires that Reform HMOs annually submit their PDLs to AHCA, staff do not review the PDLs to assess how they compare to drugs that Medicaid fee-for-service provides to beneficiaries. Staff also do not compare Reform HMO plans' PDLs with their non-Reform counterparts to assess whether additional flexibility has resulted in more or less restrictive drug lists. In addition, although AHCA requires Reform HMOs to submit their prior authorization processes, AHCA does not review these to ensure that timeframes for approvals and appeals procedures are reasonable. Of the five Reform HMO plans' prior authorization procedures that we reviewed, three plans' procedures did not include specific standards for approving drugs that require prior authorization. [11]

AHCA staff use plans' quarterly grievance reports and fair hearings pursued by beneficiaries as well as the agency's centralized complaint database to alert it to problems that beneficiaries may have accessing needed drugs. However, these information sources are limited and may not reflect the extent of access issues. Quarterly grievance reports provide aggregate information about the total number of complaints that a plan processes and do not identify the number of complaints related to accessing prescription drugs. [12] In addition, beneficiaries can pursue external grievance hearings through the Subscriber Assistance Program, Beneficiary Assistance Program, or a Medicaid Fair Hearing. However, to pursue the Subscriber Assistance or Beneficiary Assistance Programs, beneficiaries must first exhaust plans' internal grievance processes. [13] Beneficiaries must also document their grievances and represent themselves in these hearings, unless they have an attorney to represent them in the hearing. [14] These requirements could make the process difficult and burdensome for beneficiaries to undertake.

The centralized complaint database contains complaints submitted by beneficiaries and providers through the Choice Counseling program, the Medicaid area offices, and AHCA headquarter offices. AHCA reviews complaints monthly, ensuring that each complaint is resolved including those related to prescription drugs. [15] However, complaint information relies on beneficiaries knowing that they can report problems to sources other than their health plans and taking steps to do so. [16]

[10] As part of the Medicaid HMO contract, plans agree to ensure that pharmacies comply with the settlement agreement from *Hernandez, et al.* v. *Medows* when pharmacies refuse to fill beneficiaries' prescriptions. It requires Medicaid HMOs to train pharmacies about information that should be given to beneficiaries, conduct annual on-site surveys of at least 5% of their pharmacies, establish an ombudsman to assist beneficiaries, and maintain a log of all correspondence with beneficiaries.

[11] We reviewed the prior authorization procedures for only the five Reform HMO plans for which AHCA had conducted annual reviews as of July 2008.

[12] These reports provide aggregate information on the number of complaints and appeals that a plan processes, how long it takes to resolve the issues, and how the issues are resolved. Beneficiary complaints and appeals are categorized by broad issue areas such as benefits and services and enrollment and disenrollment.

[13] The Medicaid Fair Hearing Process, the Subscriber Assistance Program, and the Beneficiary Assistance Program are processes that Reform beneficiaries can complete for grievances or complaints if they are unsatisfied with their health plan's decisions regarding their care.

[14] Since September 2006, six Medicaid Reform grievances have gone to a Medicaid Fair Hearing, of which two were related to problems receiving needed prescription drugs. The single issue that has gone to a hearing for the Beneficiary Assistance Program was related to prescription drugs. No issues have gone to the Subscriber Assistance Program

[15] In May 2008, the agency began conducting monthly contract management oversight meetings to enhance overall oversight of Reform and reviews information gathered from various sources, such as the grievance reports and centralized complaint database, to identify potential issues to address.

[16] The member handbooks that health plans send to beneficiaries when they enroll are required to include information for how to address complaints or problems.

How does prescription drug coverage under Medicaid Reform HMOs differ from prescription drug coverage under the state's Medicaid fee-for-service program?

Even though AHCA intends that beneficiaries in Medicaid Reform HMOs have access to the same prescription drug coverage provided by Medicaid fee-for-service, our analyses of the Reform HMO plans' PDLs found that these lists do not include all of the drugs and therapeutic classes included on the Medicaid fee-for-service PDL. This is also the case for those drugs most commonly used by Medicaid fee-for-service beneficiaries. [17] While not listing a drug on a plan's PDL does not necessarily mean that the drug will not be made available for beneficiaries, their doctors may need to go through additional steps such as obtaining prior approval before they can prescribe the drugs.

Reform HMO plans' PDLs do not include many of the drugs and therapeutic categories included on the Medicaid fee-for-service PDL. To examine how prescription drug coverage under Medicaid Reform differs from prescription drug coverage under the state's Medicaid fee-for-service program, we compared the PDLs for 10 of the 11 Reform HMOs to the state's Medicaid fee-for-service PDL. [18] Our analysis determined that Reform HMO plans' PDLs do not include some drugs offered under Medicaid fee-for-service. Exhibit 1 shows that compared to the Medicaid fee-for-service PDL, Reform HMO plans' PDLs included from 48% to 89% of the listed drugs. [19] Further, 5% of the drugs on the Medicaid fee-for-service PDL are not included in any of the Medicaid Reform HMO plans' PDLs and approximately one-third (34%) are not included in 6 of the 10 HMO plans' PDLs that we reviewed.

Exhibit 1
Reform HMOs Do Not Include All Drugs Listed on the Medicaid Fee-for-Service PDL

Reform HMO	Percentage Compared to Medicaid FFS PDL
AMERIGROUP	56%
Buena Vista [1]	89%
Freedom Health	48%
HealthEase [2]	51%
Humana	72%
Preferred Medical Plan	54%
Staywell [2]	51%
Total Health Choice	49%
United Healthcare	76%
Vista Healthplan of South Florida [1]	89%

[1] Buena Vista and Vista Healthplan of South Florida are owned by the same parent company and have the same PDL.
[2] Staywell and HealthEase are owned by the same parent company and have the same PDL.
Source: OPPAGA analysis of Medicaid fee-for-service PDL and Reform HMO PDLs obtained from AHCA.

Further, none of the HMO plans' PDLs cover all 347 therapeutic classes covered by the Medicaid fee-for-service PDL; only 162 or 47% of these therapeutic categories are included on all 10 HMO PDLs that we analyzed. The coverage range for these therapeutic categories varies among the plans from 63% to 95%.

None of the Reform HMO plans' PDLs included all of the most expensive and/or most prescribed drugs used by beneficiaries served under fee-for-service. [20] To determine the extent to which Reform HMO plans' PDLs include the drugs that are commonly used by beneficiaries under Medicaid fee-for-service, we compared plans' PDLs to the most expensive and most prescribed drugs under Medicaid fee-for-service. Exhibit 2 shows that for the 15 drugs that make up the 10 most expensive and/or most prescribed brand name drugs provided to Medicaid fee-for-service beneficiaries, only three of these drugs are on all 10 of the Reform HMO plans' PDLs that we reviewed. [21] For the most part, the HMOs included at least one drug in the therapeutic classes that contain these drugs. However, as shown in Exhibit 2, the HMOs that do not include

[17] Because Reform PSNs have all adopted the state's Medicaid fee-for-service PDL, the prescription drug coverage under Reform PSNs does not differ from coverage provided by Medicaid fee-for-service.

[18] We could not analyze the PDL from one Reform HMO, Universal, because its PDL file did not contain national drug codes.

[19] The Reform HMOs include a larger percentage of the drugs listed on the Medicaid PDL for non-injectable drugs compared to the PDL for injectable drugs. For example, only 7% of the drugs on the injectable PDL were included on all 10 of the Reform HMO plans' PDLs that we reviewed compared to 33% of the non-injectable drugs.

[20] For this report, the most expensive drugs are those drugs for which the most funds were spent from January to March 2008.

[21] Our analysis compared Medicaid Reform HMO plans' PDLs to the drugs most commonly prescribed to beneficiaries in Medicaid fee-for-service for which the state paid at least $1,000 in claims for Medicaid fee-for-service beneficiaries from January to March 2008.

Synagis, Abilify, Singulair, or Truvada on their PDLs also do not include any drugs in the therapeutic classes that contain these drugs. (See Appendix A for similar information comparing Medicaid Reform HMO plans' PDLs to the top 50 most expensive and/or most prescribed drugs for Medicaid fee-for-service beneficiaries.)

Although Reform HMOs provide drugs not on their PDLs, they may sometimes require physicians to first obtain prior authorization or require beneficiaries to go through step therapy. To determine whether Medicaid Reform HMOs provide drugs not listed on their PDLs, we examined their drug claims from October 2007 through March 2008. We found that during this time frame, from 4% to 36% of the unique drugs prescribed by Reform HMOs were for drugs not included on their PDLs. [22] We also found that for the 15 most expensive and/or most prescribed drugs displayed in Exhibit 2, eight or more Reform HMOs had claims for each of these drugs. As an example, although only 4 of the 10 PDLs that we analyzed include Prevacid on their PDLs, eight HMOs had claims for Prevacid.

However, before receiving prescriptions for these drugs, Reform beneficiaries or their physicians will likely be required to go through additional steps, such as prior authorization or step therapy. [23] For example, for the brand name drug Risperdal, which is an antipsychotic medication that is commonly prescribed for autism and mental illness, three Medicaid Reform HMOs require doctors to obtain prior approval before prescribing Risperdal, that beneficiaries first go through step therapy before prescribing Risperdal, and/or place quantity limits on the drug. [24] (See Appendix B for information related to Reform HMO plans' restrictions for the 15 most commonly used drugs by Medicaid fee-for-service beneficiaries.)

[22] This information is based on Reform HMO claims, which range in number from less than 1,000 claims to approximately 200,000. The purpose of presenting this information is to demonstrate that Reform HMOs allow Medicaid beneficiaries to receive drugs that are not on their PDLs and is not for demonstrating whether the number of drugs that plans allowed beneficiaries to receive was sufficient to meet the needs of their beneficiaries.

[23] Step therapy requires a physician to prescribe a less expensive prescription drug to treat a condition before progressing to a more costly drug.

[24] We reviewed the drug restriction status for 8 out of 11 Reform HMO plans based on availability of PDLs on plans' websites.

Exhibit 2
Of the Top 15 Drugs That Comprise the 10 Most Expensive and/or Most Prescribed Drugs to Medicaid Fee-for-Service Beneficiaries, Only 3 Drugs Were Included on All 10 of the Reform HMO PDLs We Reviewed [1]

Brand Name Drug	Common Use	Number of Plans That Include the Brand Name Drug on Their PDL	Number of Plans That Include at Least One Drug in the Therapeutic Class
PREVACID	Stomach acid	4	10
SEROQUEL	Antipsychotic	9	10
SYNAGIS	Antiviral	5	5
RISPERDAL	Antipsychotic	10	10
ABILIFY	Antipsychotic	6	6
SINGULAIR	Asthma	8	8
NEXIUM	Stomach acid	3	10
ZYPREXA	Antipsychotic	4	10
TRUVADA	HIV/AIDS	9	9
PULMICORT	Asthma	10	10
ADVAIR	Asthma	10	10
XOPENEX	Asthma	5	10
LEXAPRO	Depression/Anxiety	3	10
NASONEX	Nasal allergies	6	10
PROAIR HFA	Asthma	8	10

[1] These 14 drugs represent the 10 most expensive and/or the 10 most prescribed drugs that are included on the Medicaid fee-for-service PDL and are listed from highest to lowest expenditures for Medicaid fee-for-service beneficiaries.
Source: OPPAGA analysis of Medicaid fee-for-service prescription drug data and Reform HMO plans' PDLs submitted to AHCA in October 2007.

What challenges have beneficiaries faced in accessing information about Medicaid Reform HMO plans' prescription drug coverage?

Under Medicaid Reform, beneficiaries can call health plans directly about their drug coverage and/or view PDLs on the plans' websites. However, both of these methods have posed challenges to Reform HMO beneficiaries, especially those who depend on drug regimens to control chronic health conditions.

Concerns about Reform beneficiaries' ability to determine whether the drugs they need are covered by specific plans have been raised since the beginning of Reform. Stakeholders and independent researchers have reported that information specific to Reform plans' prescription drug coverage is difficult to obtain and compare across plans. Specifically, these sources have reported that it is time-consuming for beneficiaries to collect drug coverage information by phone, and beneficiaries are sometimes transferred multiple times before receiving information. In addition, the sources have reported that some plans' customer service representatives are unable to provide accurate information to queries about drug coverage or are unwilling to provide drug benefit information to persons not already enrolled in the plans.

In response to these difficulties, AHCA amended Reform contracts in October 2007 to require plans to post their PDLs on their websites. However, our review of Reform plans' websites identified problems similar to those found by other stakeholders, indicating that obtaining and comparing information about prescription drugs remains difficult. Some plans do not provide a link to their PDL on the plan's website or the links provided are difficult to locate. As part of our review, we accessed plans' websites four separate times during a four-month period (between May and August 2008) and had varying success in locating PDLs for all 11 Reform HMO plans; we could not access from four to six PDLs on each of these occasions. For example, one Reform HMO's website was under construction the first three times we tried to access it. Although the Medicaid Reform choice counseling website contains links to each of the Reform HMOs' websites, these links are to the plans' home pages, not directly to the PDLs. Once beneficiaries locate a plan's website, they must click on anywhere from two to six links to reach the plan's PDL.

It also can be difficult and time-consuming for beneficiaries to determine whether a specific Medicaid Reform HMO covers particular drugs and to compare coverage after finding this information on the plans' internet sites. The Medicaid Reform HMOs organize their PDLs in different ways and use different symbols and abbreviations to inform beneficiaries of requirements such as prior authorization or step therapy. For example, while most of the PDLs that are online use "PA" and "ST" to indicate when a drug requires prior authorization or step therapy before the plan will allow it to be filled, two Medicaid Reform HMOs use the abbreviation "DER" to denote prior authorization and refer to step therapy as "step edit." [25] Further, although most of the Medicaid Reform HMOs provide their PDLs in list form, they organize and categorize drugs in varying ways, and some plans use a print format that is easier to read than other plans. In addition, one plan provides their PDL via a search tool that requires beneficiaries to input the drug name or scroll through an alphabetized list. These differences make the process of searching for specific drugs on plans' PDLs time consuming and onerous for beneficiaries to compare offerings across plans.

Another challenge facing beneficiaries in choosing among Medicaid Reform HMO plans is that the plans may impose limits on prescription drug services. [26] Reform plans may either limit the number of prescriptions that beneficiaries receive each month or establish a dollar limit that beneficiaries may not exceed annually. Seven of the 11 Medicaid Reform HMOs currently place these types of limits on prescription drug benefits. [27]

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[25] DER stands for Drug Evaluation Review.

[26] Medicaid Reform allows capitated plans to vary the amount, duration, and scope of 10 services of which 4, including prescribed drugs, must meet the projected needs of at least 98.5% of a plan's beneficiaries (plans can vary 6 services without limits). Reform plans can also charge beneficiaries co-payments for prescription drugs. However, as of July 2008, no Reform HMOs had elected to charge co-payments.

[27] Two of the 11 unique Reform HMOs place limits on the number of prescriptions that beneficiaries can receive each month and 4 place limits on the amount that beneficiaries can spend each year. These plans' limits vary based on whether beneficiaries are in the aged and disabled or the children and families category. One Reform

AHCA has taken steps to address these challenges. For example, within a few months after implementing Reform, AHCA established a special needs unit to assist beneficiaries who need help determining which Reform plans cover all or most of their needed prescription drugs.[28] In addition, in March 2008, AHCA contracted with Affiliated Computer Systems to develop an electronic tool, called the Navigator, that choice counselors can use to assist beneficiaries who want specific information on prescribed drugs. This tool will include the PDLs for all Reform plans as well as prescription drug history for beneficiaries who are not new to Medicaid. Choice counselors will be able to use this information to help beneficiaries identify Reform HMOs that cover the prescription drugs they are currently taking, including any generic equivalents that a plan may offer. AHCA anticipates that the Navigator will be operational in October 2008. As of November 2008, AHCA also will require all Reform plans to provide any drug limits they may impose in terms of maximum prescriptions per month which should also help beneficiaries compare plans.

While these steps address assisting beneficiaries who call choice counselors, they do not address all the difficulties that beneficiaries' experience in comparing information from plans' websites. To better assist beneficiaries, AHCA should develop guidelines for Medicaid Reform plans to ensure that drug coverage information is easy to find on their websites. For example, AHCA could require plans to link directly to a Medicaid Reform plan homepage and include a visible link from the homepage to prescription drug information. AHCA should also require plans to display information related to prior authorization, step therapy, and other restrictions using common symbols or abbreviations.

Agency Response

In accordance with the provision s. 11.51(5), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration for her review and response.

The Secretary's written response has been reproduced in Appendix C.

HMO limits the number of prescriptions that beneficiaries can receive each month for the aged and disabled beneficiaries while limiting annual spending for beneficiaries in the children and families category.

[28] Although established since early Reform implementation, the unit has experienced difficulty focusing its efforts to assist beneficiaries due to periodic staffing problems.

Appendix A

Some Drugs Commonly Used by Medicaid Fee-for-Service Beneficiaries Are Not Included on Medicaid Reform HMO Preferred Drug Lists

As part of our review of Medicaid Reform plans' preferred drug lists (PDLs), we identified the number of plans that included the 50 most expensive and/or most prescribed drugs provided to beneficiaries served by Medicaid fee-for-service delivery systems. We compared these drugs to the PDLs of 10 of the 11 unique HMO plans serving Medicaid Reform beneficiaries in the pilot counties. Table A-1 shows the number of plans that include each of the 66 drugs that make up the 50 most expensive and/or prescribed brand name drugs provided to Medicaid fee-for-service beneficiaries from January through March 2008. Of these drugs, only 19, or 29%, are included in all 10 of the Reform HMO plans' prescribed drug lists that we reviewed, although for the most part, these plans included at least one drug in the therapeutic classes that contain these drugs. However, some Medicaid Reform HMO plans' PDLs did not include any drugs in the therapeutic drug classes for 15 of these 66 drugs. As indicated by the shaded areas in the exhibit, these drugs are Synagis, Abilify, Singulair, Truvada, Enbrel, Genotropin, Saizen, Lovenox, Vytorin, Pulmozyne, Exjade, Strattera, Spiriva, Lotrel, and Synthroid.

Table A-1
Of the Top 66 Drugs That Make Up the 50 Most Expensive and/or Most Prescribed Drugs Provided to Medicaid Fee-for-Service Beneficiaries, 47 Are Not Included on All Reform HMO Plans' PDLs

Brand Name Drug	Common Use	Ranking for Dollars Spent	Ranking for Number of Prescriptions	Number of Plans that Include the Brand Name Drug on PDL	Number of Plans that Include a Drug in the Therapeutic Class
PREVACID	Stomach acid	1	1	4	10
SEROQUEL	Antipsychotic	2	4	9	10
SYNAGIS	Antiviral	3	42	5	5
RISPERDAL	Antipsychotic	4	5	10	10
ABILIFY	Antipsychotic	5	12	6	6
SINGULAIR	Asthma	6	2	8	8
NEXIUM	Stomach acid	7	3	3	10
ZYPREXA	Antipsychotic	8	30	4	10
TRUVADA	HIV/AIDS	9	48	9	9
PULMICORT	Asthma	10	14	10	10
ADVAIR	Asthma	11	9	10	10
LAMICTAL	Anticonvulsant	12	19	10	10
ATRIPLA	HIV/AIDS	13	91	10	10
XOPENEX	Asthma	14	8	5	10
KALETRA	HIV/AIDS	15	56	10	10
REYATAZ	HIV/AIDS	16	71	10	10
ADDERALL XR [1]	Attention deficit disorder	17	11	9	10
GEODON	Antipsychotic	18	36	5	10
KEPPRA	Anticonvulsant	19	26	9	10
TOPAMAX	Anticonvulsant	20	32	9	10
PLAVIX	Blood clots	21	15	10	10

Brand Name Drug	Common Use	Ranking for Dollars Spent	Ranking for Number of Prescriptions	Number of Plans that Include the Brand Name Drug on PDL	Number of Plans that Include a Drug in the Therapeutic Class
LEXAPRO	Depression/Anxiety	22	6	3	10
DEPAKOTE	Anticonvulsant	23	20	10	10
NORVIR	HIV/AIDS	24	53	10	10
LIDODERM	Topical painkiller	25	39	6	10
WELLBUTRIN XL [1]	Depression	26	23	5	10
COMBIVIR	HIV/AIDS	27	94	10	10
NASONEX	Nasal allergies	28	10	6	10
CRESTOR	Cholesterol	29	16	6	10
CONCERTA [1]	Attention deficit disorder	30	21	7	10
LIPITOR	Cholesterol	31	17	3	10
DEPAKOTE ER	Anticonvulsant	32	25	10	10
ENBREL	Arthritis	33	176	6	6
ACTOS	Diabetes	33	28	9	10
PROGRAF	Immunosuppressive	35	81	10	10
GENOTROPIN	Growth hormone	36	235	5	5
EPZICOM	HIV/AIDS	37	114	10	10
SAIZEN	Growth hormone	38	254	5	5
FOCALIN XR [1]	Attention deficit disorder	39	24	4	10
LOVENOX	Blood clots	40	115	9	9
VYTORIN	Cholesterol	41	18	6	6
PULMOZYNE	Cystic Fibrosis	42	193	7	9
LANTUS	Diabetes	43	27	10	10
LYRICA	Anticonvulsant	44	29	4	10
OMNICEF [1]	Antibiotic	45	22	3	10
EFFEXOR XR [1]	Depression/Anxiety	46	35	6	10
DURAGESIC [1]	Painkiller	47	69	4	10
VIREAD	HIV/AIDS	48	102	10	10
TRIZIVIR	HIV/AIDS	49	175	10	10
EXJADE	Iron Chelation	50	284	2	6
PROAIR HFA [1]	Asthma	51	7	8	10
STRATTERA	Attention deficit disorder	52	43	6	6
VYVANSE	Attention deficit disorder	53	34	1	10
LEVAQUIN	Antibiotic	54	31	6	10
FLOVENT HFA [1]	Asthma	55	33	8	10
HUMALOG	Diabetes	56	45	6	10
METADATE CD [1]	Attention deficit disorder	57	41	6	10
ARICEPT	Dementia	58	50	10	10
SPIRIVA	Asthma	59	47	5	9
TRICOR	Cholesterol	60	37	5	10
COMBIVENT INHALER	Lung disease	61	40	10	10
LOTREL[1]	High blood pressure	62	46	5	8
DIOVAN	High blood pressure	63	38	6	10
HUMULIN [1]	Diabetes	64	44	7	10
VIGAMOX	Ophthalmic antibiotic	65	49	5	10
SYNTHROID [1]	Thyroid hormone	66	13	4	5

[1] While not all Medicaid HMOs include this brand name drug on their PDLs, some of these plans instead include an equivalent drug on their PDL.
Source: OPPAGA analysis of Medicaid prescription drug data and Reform HMO plans' PDLs.

Appendix B

Some Medicaid Reform HMO Plans Restrict the Use of Drugs That Are Commonly Provided to Medicaid Fee-for-Service Beneficiaries

As part of our review of Medicaid Reform plans' preferred drug lists (PDLs), we identified the types of restrictions that Reform HMO plans sometimes impose on the 15 most expensive and/or most prescribed brand name drugs that were provided to Medicaid fee-for-service beneficiaries from January 2008 through March 2008. These restrictions include requiring a physician to obtain prior authorization before prescribing the drug, requiring that beneficiaries go through step therapy before the physician prescribes the drug, and/or imposing quantity limits. [29] To identify which plans imposed restrictions on these 15 drugs, we reviewed the on-line PDLs for 8 of the 11 unique Reform HMO plans. [30] The information in Table B-1 which displays the number of plans that impose such restrictions is not additive because plans can impose one or more of these restrictions on a drug.

Table B-1
According to Their On-Line PDLs, Some Reform HMO Plans Require Prior Authorization or Step Therapy and/or Impose Quantity Limits Before Beneficiaries Can Receive Some Drugs

Brand Name Drug	Common Use	Number of Plans That Require Prior Authorization for the Drug	Number of Plans That Require Step Therapy	Number of Plans That Impose Quantity Limits
PREVACID	Stomach acid	2	4	4
SEROQUEL	Antipsychotic	0	0	4
SYNAGIS	Antiviral	3	0	2
RISPERDAL	Antipsychotic	1	2	3
ABILIFY	Antipsychotic	0	0	3
SINGULAIR	Asthma	1	2	3
NEXIUM	Stomach acid	1	3	3
ZYPREXA	Antipsychotic	1	0	3
TRUVADA	HIV/AIDS	0	0	4
PULMICORT	Asthma	0	0	5
ADVAIR	Asthma	0	1	5
XOPENEX	Asthma	1	0	2
LEXAPRO	Depression/Anxiety	0	1	2
NASONEX	Nasal allergies	0	0	1
PROAIR HFA	Asthma	0	0	4

Source: OPPAGA analysis of Medicaid fee-for-service prescription drug claims for January through March 2008 and of information provided by Medicaid Reform plans' on-line PDLs.

[29] Quantity limits also exist for Medicaid fee-for-system beneficiaries for some of the drugs listed in Table B-1.

[30] We reviewed the drug restriction status for 8 out of 11 plans based on availability of PDLs on plans' websites.

Appendix C

CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

September 26, 2008

Gary R. VanLandingham, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, FL 32399-1475

Dear Mr. VanLandingham:

Thank you for the opportunity to review the draft report entitled: *"Medicaid Reform: Oversight to Ensure Beneficiaries Receive Needed Prescription Drugs Can Be Improved; Information Difficult for Beneficiaries to Locate and Compare."*

The Agency would like to thank OPPAGA for their diligent efforts to understand the Agency's oversight process of capitated health plans in the pilot regarding prescription drugs. As always, we appreciate the opportunity to respond and look forward to working with OPPAGA again in the future.

Sincerely,

Holly Benson
Secretary

HB/co

2727 Mahan Drive, MS #1
Tallahassee, FL 32308

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Office of Program Policy Analysis and Government Accountability

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