OREGON DUR BOARD NEWSLETTER©
AN EVIDENCE BASED DRUG THERAPY RESOURCE http://pharmacy.oregonstate.edu/drug_policy/newsletter

January 2010 Volume 12, Issue 1

The Oregon Health Plan Preferred Drug List: What is it, what's on it and why?

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The Oregon fee-for-service (FFS) Medicaid program (also called the Oregon Health Plan or OHP) was finally authorized by the 2009 Legislature to "enforce" its Preferred Drug List (PDL) for non-mental health drugs.[1] This means the OHP PDL will operate similar to commercial health insurances and require a prior authorization to use non-preferred drugs in 2010. This policy is expected to avoid approximately $4 million in OHP drug costs (total funds) for the current biennium and assumes 90% use of preferred products.

Additionally, the Medicaid program has identified and listed preferred drugs for two mental health drug classes (newer antidepressants and atypical antipsychotics). Use of preferred products in these classes remains voluntary. This policy is expected to avoid approximately $3 million in OHP drug costs and assumes 66% use of preferred products.

This article will provide a brief historical background of the OHP PDL, a summary of the how it is developed and tools to assist clinicians in knowing what is on it.

The long and winding road….

The OHP PDL (also called the Practitioner Managed Prescription Drug Plan) was initially authorized by the 2001 Legislature.[2] The legislation mandated that drugs be publicly evaluated first for their clinical evidence and second for their relative cost. This set up a landmark process for comparison of medical evidence for public decision-making that is now included in the current national health care debate.

Non-preferred drug exceptions were initially requested with a "dispense as written" note on the prescription during 2002. This exception method proved technically challenging to administer. Additionally, in January 2003, under the crunch of a collapsing state budget and imminent enrollment reductions, DMAP staff evaluated the impact of this passive approach and found it to be inadequate to meet the budget goals of the legislation. There was only 58% use of preferred products. The "dispense as written" exception process was abandoned for a traditional prior authorization requirement for non-preferred drugs. During this time DMAP realized ~$500,000 per month savings and 82% use of preferred products for the initial four drug classes where the policy was evaluated.[3] However, stakeholder pressure on the Legislature during a subsequent special session resulted in the PDL becoming entirely voluntary five months later and use of preferred products dropped to 68%.

Governor Kulongoski's recommended budget for 2007-2009 waived copays for preferred products thus providing additional patient incentive to use them. Use of preferred products has increased from 76.5% in March 2008 to 83.1% in September 2009.[4] This is an unprecedented use rate for a voluntary PDL and the Mediciad provider community should be commended. However, it is hoped the prior authorization of non-preferred physical health drugs will increase use of preferred products to 90%.

The copay will be waived for preferred mental health drugs and remains the only incentive to reach an 66% utilization target for the new voluntary mental health PDL.

Clinical Evidence and Transparency Paramount

The OHP PDL development process garnered national recognition early on for its reliance on comparative clinical evidence.[5] [6] [7] [8] The evidence is gathered and evaluated using peer-reviewed literature and applying established evidence-based methods. It is developed with the assistance of the Oregon[9] and North Carolina[10] Evidence-Based Practice Centers (EPC) contracted through the Drug Effectiveness Review Project (DERP).[11]

The DERP is a collaboration of public organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class. Initially established in 2003, it is contracted through June 2012.

Current DERP participating organizations include: Medicaid programs from Arkansas, Idaho, Oregon, Maryland, Missouri, Montana, New York, Washington, Wisconsin, and Wyoming and the Canadian Agency for Drugs and Technologies in Health. Oregon was the founding member, joined soon after by Washington and Idaho.

The DERP project produces systematic literature reviews of drug classes using only the highest quality evidence. Reviews are public and have the following components:

- Key Questions – to focus the review and which are posted for public comment and peer reviewed

- Evidence Tables – detailing what research was used in the review
- Draft Report – draft of review which is posted for public comment and peer reviewed
- Final Report – final version of systematic review that incorporates or considers public commentary

A collaborative governance process directs the work of the DERP. The process for gathering and determining the research evidence is designed to eliminate conflict of interest but still remain open and transparent to stakeholders. Industry, interest groups and the general pubic are encouraged to provide comment at several points in the process: dossier submission, draft key questions, draft reports.

Once a DERP report is made public, entities use it differently to support their programs. In Oregon, the Health Resources Commission (HRC)[12], through its subcommittees of volunteer health care providers and consumer representatives review and summarize the report and make recommendations to DMAP. The evaluations are done in a public forum and public testimony is taken. Once a drug or group of drugs is determined by the HRC to be of superior or comparable effectiveness and safety, DMAP determines which of those eligible drugs are least costly for the OHP.

The Benefits and the Drawbacks

The success of this rigorous review process has been the ability to see through the marketing blitz of new drugs. The most prominent example is the HRC's recommendation in 2002 that the COX2 inhibitors did indeed have better gastro-intestinal safety than other non-steroidal anti-inflammatory drugs, but they also came with a potential cardio-vascular risk. The process also identified the metabolic risks of atypical antipsychotics very early.

The drawback is that the comprehensiveness and transparency of the process demand considerable time and it routinely takes 12-18 months to complete. Thus it is only financially practical for the most prominent and expensive drug classes. New drugs often must wait a year to be reviewed with their class.

The DERP reports themselves can be more than 500 pages long and are difficult to digest for the front-line clinician. Thus the PDL is envisioned as a guide for OHP clinicians to identify cost-effective drug selections that have been through this extensive analysis and can be prescribed with confidence. Those that want to have more detail can find the complete reports at the DERP website[11] or the HRC summary at the HRC website.[12] There are now 27 classes of drugs that have been through the comparative review process in Oregon.

Helpful tools for clinicians

The OHP PDL is communicated to clinicians via Epocrates (http://www.epocrates.com/products/rx/). This software is available for free on several handheld platforms as well as for a personal computer. Select the Oregon Medicaid Open-Card formulary. This will communicate PDL status as well as other drug coverage information for individual drugs.

A printable Pocket Drug Guide is also available at www.orpdl.org. Prior authorization criteria for the OHP fee-for-service pharmaceutical program is also posted to: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/clinical.html .

Conclusion

The OHP PDL was created and is maintained using a rigorous and transparent comparative process. The preferred drugs are first evaluated to be clinically superior or equivalent to non-preferred drugs for initial use in the majority of patients. Preferred drugs are thus a good value for the State Medicaid program and their increased use is good stewardship of tax dollars.

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