Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

December 27, 2006

Michael Marshall
Secretary of Senate
State Capitol
LOCAL

Margaret Thomson
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Marshall and Ms. Thomson:

Enclosed please find copies of reports to the General Assembly relative to an analysis of Medicaid pharmacy issues prompted by the federal 2005 Deficit Reduction Act.

These reports were prepared pursuant to directive contained in HF 2734. The report is attached. Please contact Susan Parker at 515-725-1126 if you have any questions.

Sincerely

Alisa Morris By AM

Alisa Morris
Legislative Liaison

Enclosure

cc: Dennis Prouty, Legislative Service Agency
Peter Matthes, Senate Minority Caucus
Dick Oshlo, Senate Majority Caucus
Brad Trow, House Minority Caucus
Ed Conlow, House Majority Caucus

The Iowa Department of Human Services Pharmacy Dispensing Fee Report, As Required by Iowa House File 2734 (2006) December 21, 2006

Iowa House File 2734 includes language that requires the Iowa Department of Human Services (the Department) to do the following:

> "...review the impact of the federal Deficit Reduction Act of 2005, Pub. L. No. 109-171, on the state's medical assistance program reimbursement policy for multiple source prescription drug products and the Act's impact on participating pharmacies. The department shall submit a report, including recommendations relating to adjustments to the medical assistance program pharmacy dispensing fee, to the governor and the general assembly no later than January 1, 2007."

The Department respectfully submits this report in response to this assignment.

Background

The Deficit Reduction Act of 2005 (DRA) includes a number of provisions that specifically address Medicaid pharmacy and are intended to extend additional policymaking flexibility to the states. These specifically include:

- An increase, from 150% of Average Wholesale Price (AWP) to 250% of Average Manufacturer's Price (AMP), in the federal upper payment limit (FUL) for drugs with two or more therapeutically and pharmaceutically equivalent drugs.
- Modification of the definition of Medicaid "best price" to include the lowest price for "authorized generics".
- Availability of monthly AMP.
- Exclusion of prompt-pay discounts to wholesalers from the definition of AMP.
- Mandated state collection of rebates on physician-administered drugs.
- Provision of optional state authority to enforce beneficiary cost-sharing and to increase the cost sharing for non-preferred drugs. Cost sharing amounts were previously limited to $3.00, and states can now increase that amount by the medical component of the consumer price index.

As required by the DRA, the Centers for Medicare and Medicaid Services (CMS) began providing the AMPs to State Medicaid Agencies on July 1, 2006 but determined that the AMPs were not reliable enough to use by states for setting new Medicaid payment rates.

On December 18, 2006, CMS issued a proposed rule that revises the definition of AMP, reduces the payments to pharmacists for prescription drugs for Medicaid beneficiaries, and limits the federal government's share of the cost of a prescription drug when at least three generic alternatives are available. The rule is expected to lower revenues for small pharmacies, particularly those in low-income areas where there are high concentrations of Medicaid beneficiaries."

The Iowa Department of Human Services has been evaluating the implications of these changes on the Iowa Medicaid Program since the DRA was enacted and since the Medicare Modernization Act of 2003 shifted responsibility for prescription drugs for dual Medicare/Medicaid eligible beneficiaries from the states to the federal government.

Despite CMS' announcement in late May that the initial AMP data was not reliable, the Department nevertheless performed two comparative analyses between Iowa's current Medicaid pharmacy rates and the estimated new AMP-based rates for multi-source drug groups subject to a State Maximum Allowable Cost (State MAC) rate. The first analysis was based on July 2006 data, and the second on October 2006 data. Findings for the two were essentially the same and are summarized as follows:

- For over half of the Iowa State MAC drug groups, the new AMP-based rates were *less* than the average acquisition cost that retail pharmacies pay for the drug. For over one-fourth of those, the estimated new rates are more than 300% lower than the average acquisition cost.
- In contrast, the new AMP-based rates for some of the other Iowa State MAC drug groups were *more than double* the average acquisition cost retail pharmacies pay for the drug.
- There is inconsistency in the relationship between the AMP-based rates and the average acquisition costs for the drugs.

In other words, our analysis confirmed the general conclusions made by CMS; that AMPs as currently defined are not reasonable or appropriate for setting reimbursement rates for drugs covered by Medicaid.

Comparison of Pharmacy Dispensing Fees

In order to meet the requirements specified by House File 2734, the Department evaluated the pharmacy dispensing fees for all State Medicaid Programs[1]. We specifically looked for trends in dispensing fee reimbursement, as well as for complementary policy issues that impact the findings.

We then performed a more in-depth review of Iowa's six contiguous states: Illinois, Missouri, Minnesota, Nebraska, South Dakota, and Wisconsin. The results of this review can be summarized as follows:

- Iowa's dispensing fee is lower than three of the contiguous states and higher than two. The dispensing fee for Nebraska is not directly comparable.
- Iowa's ingredient reimbursement formula for brand drugs is lower than five of the contiguous states and the same as one.
- Iowa is one of three states that impose a copayment of $1.00 for generic drugs. Only one state imposes a lower copayment for generic drugs.
- Iowa and all six contiguous states impose copayments for brand-name drugs.

[1]Source: CMS, "Medicaid Prescription Reimbursement Information by State – Qtr Ending September 2006". See http://www.cms.hhs.gov/MedicaidDrugRebateProgram/08_MdPresReimInfo.asp.

It is important to point out that an accurate evaluation of Iowa's Medicaid dispensing fee cannot be made without considering its relationship to a number of other reimbursement factors, such as reimbursement for ingredient costs, beneficiary copayments, distinctions between brand-name and generic, and generic substitution incentives. All are generally evaluated and combined in some manner to determine specific pharmacy reimbursement policy for each State Medicaid Program. As a result, separate evaluation of the dispensing fee or any of the other factors is generally inconclusive and is not a valid indicator of overall Medicaid reimbursement for drugs.

Please see Table 1 below for the specific reimbursement information for Iowa and its six contiguous states.

Table 1. Comparison Of Iowa Pharmacy Reimbursement With Contiguous States

State	Dispensing Fee	Ingredient Reimbursement	Co-Payments
Iowa	**$4.39**	**AWP – 12%**	**$1.00 - $3.00, for non-preferred brands only $1.00, for generic drugs and preferred brands**
Illinois	Brand: $3.40 Generic: $4.60	Brand: AWP – 12% Generic: AWP – 25%	Brand: $3.00 Generic: $0.00
Minnesota	$3.65 + $.50 for legend unit dose)	AWP – 11.5%	Brand: $3.00 Generic: $1.00
Missouri	$4.09	Lower of AWP – 10.43% or WAC + 10%	$.50 - $2.00, varies by prescription cost
Nebraska	$3.27 to $5.00 based on service delivery, unit dosage or 3rd party payors	AWP – 11%	$2.00
South Dakota	$4.75 ($5.55 for unit dose)	AWP – 10.5%	$2.00
Wisconsin	$4.88	AWP – 11.25%	Brand: $3.00 Generic: $1.00 Over-the-Counter: $.50

Source: CMS, "Medicaid Prescription Reimbursement Information by State – Qtr Ending September 2006". See http://www.cms.hhs.gov/MedicaidDrugRebateProgram/08_MdPresReimInfo.asp.

The Department also attempted to determine the average dispensing fees paid by other third party payors, such as Medicare, health insurers, managed care providers, and pharmacy benefit managers. With one exception, the information was largely unavailable. We found no analysis related to third party dispensing fees for generic drugs; what we did find was aggregated and somewhat dated information related to brand-name reimbursement. The results are, nevertheless, presented for your review in Table 2 on the following page.

Table 2. Pharmacy Reimbursement by Third Party Payors

Pharmacy Payor (Year)	Average Dispensing Fee	Ingredient Reimbursement
Employers and External Organizations (2004)	Brand: $1.95	Brand: AWP – 14.8%

Source: Takeda, "The Prescription Drug Benefit Cost and Plan Design Survey Report", 2005 Edition.

The report was developed from data collected from an annual survey performed by the Pharmacy Benefit Management Institute, Inc. (PBMI). The respondents consisted of employers and external organizations, which included HMOs, insurers, and third-party administrators.

The report addresses only brand-name and mail service drugs, neither of which is applicable for this report. We were unable to find a comparable analysis or study for generic drugs.

Although the report is somewhat dated (2004), the reimbursement findings identified in Table 2 reflect an average dispensing fee that is considerably lower than the fees paid by State Medicaid Agencies, and a formula for ingredient reimbursement that is lower than the formulae established by State Medicaid Agencies, which supports the point made previously. Namely, that neither factor can, in isolation, be considered a reliable predictor of overall reimbursement, since both are typically combined with a number of other factors such as beneficiary copayment requirements, to determine overall reimbursement for pharmacy.

Recommendations

Because of the significant impact of pharmacy provisions in both the Medicare Modernization Act of 2003 and the Deficit Reduction Act of 2005, the full effects on State Medicaid Programs cannot be readily predicted.

The proposed rule that implements the DRA pharmacy provisions for Medicaid was published only days ago. It includes a 60-day review period for State Medicaid Agencies and other stakeholders to fully evaluate the provisions and submit comments, questions, and concerns. Given normal timelines associated with administrative rule development, it is not likely that CMS will release the final rule until on, or shortly before, July 1, 2007.

In light of these substantial changes that are directed to Medicaid reimbursement for pharmacy, as well as the difficulty in assessing dispensing fees without also considering other payment factors, the Department recommends that no adjustments be made to the pharmacy dispensing fee at this time. If the General Assembly is in agreement, we propose to take the following action steps:

- The Iowa Department of Human Services will continue to perform a full evaluation of the proposed Federal AMP rule on Iowa Medicaid's pharmacy reimbursement. Included in that review will be an evaluation of the questions and concerns of other stakeholder groups, including but not limited to pharmacy associations, consumer groups, and other State Medicaid Agencies.
- The Department will evaluate the proposed rule and confer with others prior to submitting any comments, questions, or concerns within the 60-day period.
- The Department will continue to perform analysis as necessary to determine the anticipated impact of new federal changes on actual reimbursement.
- Once the implications are fully understood, the Department will report to the Iowa General Assembly on the anticipated impact of DRA provisions on Iowa Medicaid pharmacy providers. As applicable, the Department will develop recommendations.

If this approach is unsatisfactory to the General Assembly, it is also possible for the Department to move forward in performing a study of Iowa-specific dispensing costs. We would accomplish this through performance of a direct survey of Iowa Medicaid participating pharmacies, and/or performance of a similar survey of reimbursement rates paid by other third party payors and cash payors to Iowa Medicaid participating pharmacies. But while this approach would likely yield some valuable information, we recommend delaying engagement in such a study until we better understand the overall implications of the proposed and final rules on pharmacy reimbursement for the Iowa Medicaid Program and other states.

Conclusion

The Deficit Reduction Act of 2005 comes on the heels of massive changes made to both Medicaid and Medicare through the Medicare Modernization Act of 2003. Provisions in the two acts have had dramatic effects on both programs, the implications of which are not yet fully understood by states, consumers, and providers.

Both Acts contain a number of pharmacy provisions that target changes not only to reimbursement, but also to evaluation of acquisition cost, cost data reporting and integrity, policy incentives, and more. Consequently, these changing dynamics make it difficult to fully understand the implications of these changes on an isolated aspect of Iowa Medicaid pharmacy reimbursement, such as the dispensing fee, at this time.

The Department of Human Services will continue to monitor and evaluate federal changes that impact Medicaid pharmacy reimbursement and will report to the General Assembly significant issues as they arise.