Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
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DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

TO: Medicaid Drug Product Selection Committee

FROM: Iowa Department of Human Services

RE: Recommendations from the Iowa Pharmacy Association (IPA)

DATE: December 19, 2008

It was requested by Medicaid Drug Product Selection Committee that the Department respond to the five recommendations from the Iowa Pharmacy Association (IPA).

1. Resist change to Iowa's Drug Product Selection Law.

   Response: IME agrees and has recommended no change be made to this Legislation in the past.

2. Preclude the inclusion of brand name drugs on the PDL where there exists a generic equivalent for such drugs.

   Response: The Department acknowledges this is a burden for pharmacies and the Department strives to reduce the number of brands on the list. As the brand goes to nonpreferred the Department allows a transition time where stores can use up the brand they have in stock, as well as an override process if they have additional product in stock beyond the transition time.

   The cost benefits of generic use are not as black and white as commonly perceived and portrayed in the media, especially for Medicaid programs. State Medicaid programs participate in a federally negotiated rebate program with drug manufacturers. This means they receive a varying percentage of the cost of every drug back from the manufacturer. Due to such disproportionately large brand rebates, the net prices of certain brand drugs are significantly less than their generic counterparts.

   The program has cost-avoided millions of dollars by selectively favoring these more cost-effective brands and shunning the more expensive generic. The lesson for state Medicaid programs is that they must follow their final net prices after all rebates and not the pre-rebate prices of drugs paid at the time of picking up the drugs at the pharmacy.

   State Medicaid programs are allowed to set price caps on certain generic products. Each state can adopt their own approach and formula for setting these caps called SMACs (state maximum allowable cost). States vary in how aggressively they lower these generic prices. The lower these prices are set, the less likely it is that the brand version will cost less in comparison. Iowa does not currently have low enough generic price caps to undercut the net price of many brand drugs. The program could address this issue and minimize the preference of brand products if the process to set price caps was altered to remove the brand prices in setting the rates.

   If the State had allowed the more costly generic versions to be dispensed instead, the Medicaid Program would have incurred an additional expense of just under $7.5 million, of which the State share would have been $2.87 million.

3. Explore ways of increasing transparency in the PDL process, both as it relates to administrative and financial activity.

Response: There are two issues with regard to transparency, contract and rebate transparency and PDL meeting process transparency.

1). Contract and Rebate Transparency: Pursuant to Section 1927 of the Social Security Act, terms of the rebate agreements must be held confidential except in limited circumstances. This includes the terms of the state supplemental rebate agreements. One hundred percent of all rebates come to the State, however the state must return the Federal government's share of the rebates.

2). PDL Meeting Process Transparency: The following is the current process of communication regarding the PDL to stakeholders, with the enhancements in italics. All P&T meetings are public meetings and only a small portion of the meeting is closed to discuss confidential pricing information as required by Federal law.

A. The PDL Agenda is posted to the website www.iowamedicaidpdl.com under P&T Committee and at the Hoover State Office Building bulletin board 30 days in advance of the meeting. *[The Department will develop a list serve anyone can be part of to receive notification by e-mail when the agenda is posted.]*

B. The same website above has an e-mail address info@iowamedicaidpdl.com where questions can be submitted. A response is provided within 24 hours. *[The Department can reiterate to those that sign up for the list serve that this option is available.]*

C. Public comment can be submitted in writing through the e-mail listed above and anyone can sign up on the website to provide oral public comment in person at the P&T meetings. Comment received by e-mail is also posted on the website. Written public comment is shared with P&T Committee members at each meeting. *[The Department can reiterate to those that sign up for the list serve that these options for public comments are available.]*

D. Informational Letters follow each P&T meeting to discuss all changes to the PDL implemented as a result of the meeting. These are posted to the website www.iowamedicaidpdl.com. All Medicaid providers also receive these by mail and the IME disseminates an electronic version to all provider organizations through the MAAC Committee list serve. Each Informational Letter has a contact e-mail and phone number at the end of the letter for any questions related to the letter.

E. The Department encourages all organizations to be active participants in all open meetings including the P&T and DUR.

4. Separate contract vendors for the DUR and P&T processes.

Response: Many states have one committee and one vendor perform both DUR and PDL functions. The Department does not think this is a problem.

5. Expand MTM (Medication Therapy Management or Pharmaceutical Case Management) and implement chronic care disease management programs within the Medicaid program.

Response: The IME agrees with the benefits of MTM and Pharmaceutical Case Management (PCM). PCM is an Iowa Medicaid service provided by physicians and pharmacists working together to closely manage the total medication regimens of their most complex patients. The services are provided to Medicaid members who are identified as being at high risk for medication-related problems. Eligible patients are those who take four or more regularly scheduled non-topical medications, are not nursing home residents, and who have at least one of twelve specified disease states. The innovative care delivered through this program is based on a model of care known to improve medication safety in hospital and clinic settings where pharmacists and physicians practice under the same roof and have access to patient care records.

The Iowa PCM program began in 2000 with funds appropriated by the Iowa legislature. The program, designed by an advisory committee of physicians and pharmacists, seeks to improve the quality of medication use in Medicaid eligible patients who are at high risk for experiencing adverse effects from their medications.

Pharmacists providing this service must have an Iowa license in good standing and have completed professional training regarding patient-oriented medication-related problem prevention and resolution. This training can be obtained by completion of a Doctorate of Pharmacy or completing a course from the Iowa Center for Pharmaceutical Care. The pharmacy or office where PCM services will be provided must have an area that allows private consultation.

The following page reflects the reimbursement trend from 2002-2008 for physicians and pharmacies. While reimbursement has remained relatively stable for physicians in this program, the amount of reimbursement, and thus program utilization, has gradually increased for pharmacies. The Department has been working on incorporating the beneficial aspects of this program with other IME initiatives including Chronic Disease Management and Complex Care Management.

The IME operates four care management programs including three Chronic Disease Management programs and Complex Care Management. The Chronic Disease Management programs include:

- Diabetes Mellitus, which was implemented 3.5 years ago and has served 433 Medicaid members.
- Congestive Heart Failure, which was implemented 2.5 years ago and has served 804 Medicaid members.
- Asthma, which was implemented 1.5 years ago and has served 284 Medicaid members.

Complex Care Management was implemented 3.5 years ago and has served 123 Medicaid members.

The IME has found these programs to be very effective at improving the quality of care and patient outcomes for Medicaid members.

Pharmaceutical Case Management (PCM) Reimbursement

		State Fiscal Years							
		2002	2003	2004	2005	2006	2007	2008	Total
Physician									
W3100	Initial	$2,355.49	$945.75	$1,442.75	$1,284.00	$4,756.28	$3,739.67	$375.00	$14,898.94
W3200	Preventative	$73.50	$0.00	$24.25	$24.25	$74.94	$724.70	$0.00	$921.64
W3300	New Problem	$196.40	$0.00	$426.80	$232.80	$552.48	$3,360.08	$480.00	$5,248.56
W3400	Follow-up	$742.00	$659.60	$2,444.40	$2,161.16	$3,747.48	$7,959.08	$2,097.96	$19,811.68
		$3,367.39	$1,605.35	$4,338.20	$3,702.21	$9,131.18	$15,783.53	$2,952.96	$40,880.82
Pharmacist									
W4100	Initial	$28,537.50	$20,022.50	$13,990.00	$18,675.00	$24,777.34	$28,899.23	$16,616.03	$151,517.60
W4200	Preventative	$1,850.00	$1,825.00	$1,825.00	$1,875.00	$4,709.40	$3,397.78	$4,849.04	$20,331.22
W4300	New Problem	$6,276.00	$10,160.00	$10,800.00	$13,880.00	$16,586.20	$28,664.77	$20,795.16	$107,162.13
W4400	Follow-up	$15,440.00	$24,080.00	$29,068.15	$43,480.00	$42,723.60	$66,470.96	$52,630.12	$273,892.83
		$52,103.50	$56,087.50	$55,683.15	$77,910.00	$88,796.54	$127,432.74	$94,890.35	$552,903.78
Grand Total		$55,470.89	$57,692.85	$60,021.35	$81,612.21	$97,927.72	$143,216.27	$97,843.31	$593,784.60