REPORT OF THE JOINT COMMISSION ON HEALTH CARE

Benefits of Public-Private Partnerships to Medicaid Recipients (SJR 58, 2004)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA



SENATE DOCUMENT NO. 13

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COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

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March 15, 2005

TO:

The Honorable Mark R. Warner, Governor of Virginia and Members of the General Assembly

The 2004 General Assembly, in Senate Joint Resolution 58, directed the Joint Commission on Health Care to study how other states improved services and reduced their Medicaid health care and prescription drug costs through public-private partnerships, in order to develop recommendations for Virginia's Medicaid program.

An executive summary of the requested report was submitted prior to the 2005 General Assembly Session. The final report is enclosed for your consideration.

Respectfully submitted,

Harvey B. Morgan

Chairman

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PREFACE

Senate Joint Resolution 58 of the 2004 Session of the General Assembly directed the Joint Commission on Health Care (JCHC) to study how other states have succeeded in improving services and lowering health care and prescription drug costs to Medicaid recipients through public-private partnerships.

The JCHC study determined that the Virginia Department of Medical Assistance Services (DMAS) has implemented nearly all of the cost-savings initiatives employed by other states. A budget amendment was introduced on behalf of JCHC directing DMAS to report prior to October 1, 2005, on the evaluation of its Healthy Returns Disease Management Program.

On behalf of the Joint Commission and its staff, I would like to thank the numerous individuals, including staff of the Virginia Department of Medical Assistance Services, the Florida Agency for Health Care Administration, the Florida Office of Program Policy Analysis and Government Accountability, and representatives of various pharmaceutical manufacturers who assisted in the completion of this report.

Kim Snead Executive Director

March 2005

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BENEFITS OF PUBLIC-PRIVATE PARTNERSHIPS TO MEDICAID RECIPIENTS

EXECUTIVE SUMMARY

Authority for Study

Senate Joint Resolution (SJ) 58 of the 2004 Session of the General Assembly directed the Joint Commission on Health Care to study how other states have succeeded in improving services and lowering health care and prescription drug costs to Medicaid recipients through public-private partnerships. Specific areas the study addresses include:

- Other states' programs for reducing the costs of healthcare and prescription drugs through agreements with the private sector which should specifically address disease management programs;
- Florida's Medicaid Initiative and Disease Management Initiative; and
- Options for implementing Medicaid disease management programs as a cost-containment strategy in Virginia.

This report is being submitted to the Governor and the General Assembly.

State Strategies to Control Medicaid Pharmaceutical Costs

In response to the increasing burden of Medicaid pharmaceutical costs on State budgets, the majority of states are considering or have enacted changes to control rising drug expenditures. Most of the strategies employed center on new or expanded application of management tools that the federal government allows under existing law. A multitude of strategies are used by states including:

- Prior authorization:
- Preferred drug lists (PDL);
- Supplemental rebates from manufacturers;
- Multi-state pharmaceutical purchasing pools;
- Generic substitution;
- Drug utilization review (DUR); and
- Pricing strategies.

The Department of Medical Assistance Services currently applies all of the strategies listed above, with the exception of multi-state pharmaceutical purchasing pools. In addition to the previously listed strategies, some states also employ disease management programs as a cost-containment measure.

Medicaid Disease Management Programs

According to the Centers for Medicare and Medicaid Services, 20 states operate Medicaid disease management programs. There is a great deal of variation in the type and scope of these programs. States have implemented disease management programs as a state plan service, under waiver authority, and with the use of supplemental drug rebates.

One of the methods used by Florida to provide disease management consists of using value-added programs provided through supplemental rebates from drug manufacturers. Pharmaceutical manufacturers participating in this program include Pfizer, Bristol-Myers Squibb, AstraZeneca, and GlaxoSmithCline. Under these contracts, pharmaceutical manufacturers provide disease management services instead of monetary supplemental rebates. Original calculations estimated that the four pharmaceutical companies combined programs would save Florida \$108.4 million from July 2002 through September of 2005. A report issued by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) in April of 2003, estimated that the state could save \$64.2 million in 2003 and 2004 by requiring the four drug companies to provide traditional supplemental rebates instead of disease management programs. An additional report issued in May 2004 by OPPAGA, estimated that Florida's disease management initiative had only saved \$13.4 million, far below the original estimate of \$108.4 million. The Florida Agency for Health Care Administration (AHCA), the state entity administering the Medicaid program, disagreed with the analysis conducted by OPPAGA in 2003 and 2004. AHCA questioned the methodology and assumptions used by OPPAGA to reach their final conclusions. However, on May 28, 2004, the Governor signed House Bill 1843, which prohibits value-added programs, such as disease-management from being used as a substitute for cash supplemental rebates.

The Virginia Department of Medical Assistance Services has also been involved in several initiatives to provide disease management to both the fee-for service and managed care populations. Programs outlined in this report specifically address fee-for-service Medicaid disease management initiatives.

The Virginia Health Outcomes Project (VHOP), a pilot project in the Richmond area, began serving recipients in DMAS' primary care case management program, MEDALLION, in 1993. With the participation of six pediatricians in the Richmond area, the program sought to educate these physicians treating recipients with asthma, on clinically sound and evidence-based treatments. Initial cost-savings calculations concluded that for every \$1 spent \$3 in treatment costs were saved. However, questions were raised about the methods used to calculate cost-savings and DMAS reported significant administrative costs associated with the program.

In 1997, Heritage Information Systems, Inc. was awarded a contract to design, implement, and evaluate disease management services in the fee-for-service Medicaid program. In June 1999, the disease management program was implemented. An analysis by Heritage Information Systems, Inc. showed a rate of return on investment of \$1.75 for every \$1 spent.

During the 2002-2004 biennium, DMAS was directed to create a statewide disease management program. DMAS was expected to produce \$22 million in savings from initial funding of \$1.4 million. Several difficulties in implementing the program were reported by DMAS, including:

- Funds budgeted for the program were limited;
- Growing evidence that significant savings from disease management programs are not usually seen in the two-year budget cycle DMAS was working under;
- Lack of vendors who were willing to guarantee savings.

DMAS has entered into a contract with the Anthem subsidiary Health Management Corporation, Inc. (HMC) to implement and evaluate the pilot Healthy Returns Disease Management Program. From June 1, 2004 to May 30, 2005, the program will target fee-for-service recipients with a diagnosis of coronary heart disease or congestive heart failure. The program will be evaluated by Health Management Corporation, Inc.

In addition to these disease management programs for the fee-for-service Medicaid population, all of DMAS' managed care programs have disease management programs. Currently more than half of the Medicaid population is served through managed care.

Actions Taken by JCHC

Three policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. The Commission voted to support Option III to introduce a budget amendment directing DMAS to report to JCHC by October 1, 2005 on the results of the Healthy Returns Disease Management Program and the feasibility of expanding the program.

I. Authority for the Study/Organization of Report

Senate Joint Resolution (SJ) 58 of the 2004 Session of the General Assembly directs the Joint Commission on Health Care to study how other states have succeeded in improving services and lowering health care and prescription drug costs to Medicaid recipients through public-private partnerships. (Appendix A)

SJ 58 requires the Department of Medical Assistance Services and any other appropriate agency of the Commonwealth, to provide technical assistance to the Joint Commission on Health Care while conducting the study. Specific areas the study will address include:

- (i) other states' programs for reducing the costs of health care and prescription drugs through agreements with the private sector which should specifically address disease management programs;
- (ii) Florida's Medicaid Initiative and Disease Management Initiative; and
- (iii) options regarding the feasibility of implementing Medicaid disease management programs as a cost-containment strategy in Virginia.

ORGANIZATION OF THE REPORT

This report includes five separate sections. The initial section, which was just discussed, covers the authority for this study. Section II will provide greater detail on health care and prescription drug costs, followed by overviews of state initiatives to control pharmaceutical costs and disease management in Sections III and IV respectively. Policy options available to the Joint Commission on Health Care will be covered in the final section of the report.

II. Background on Health Care and Prescription Drug Costs

The cost of health care has continued to rise in the United States. As one of the fastest growing components of health care, rising prescription drug costs have been a major contributor to this phenomenon. According to the Kaiser Family Foundation, the following three main factors have contributed to the increase in prescription drug spending:

- 1) Increased utilization;
- 2) Change in the type of drugs used; and
- 3) Price increases for drugs currently in the market.

Other studies disagree with the extent that the factors listed above have increased spending in various pharmaceutical markets. However, it is generally agreed that all three factors do have a role in the increase of prescription drug spending.

Between the years of 1992 and 2002 the average number of prescriptions per person increased from 7.3 to 11.6. The number of prescriptions purchased increased from 1.9 billion to 3.3 billion, a 74 percent increase, compared to the 12 percent growth in the United States population. Many factors are attributed to this increase in utilization including improved insurance coverage, population aging, increased diagnosis of chronic conditions, new drugs that treat a wide range of diagnoses, new markets opened by these new drugs, greater emphasis on pharmaceuticals in medical practice, and growth of direct-to-consumer advertising.

The Kaiser Family Foundation estimates that the use of newer, more expensive drugs instead of older, less costly pharmaceuticals has accounted for 27 percent of the increase in prescription drug spending. Based on their calculations, the Kaiser Family Foundation also estimates that manufacturer price increases for existing drugs account for 26 percent of the increase in spending on pharmaceuticals. On average, retail prescription prices have increased 7.3 percent a year between 1992 and 2002. The average inflation rate during this time period was 2.5 percent, less than half the rate of retail prescription drug price increases. Some of the factors contributing to this change include demonstrated or asserted advantages of new medications, the effect of

advertising on consumer awareness and demand, and a lack of sensitivity to drug prices through low insurance co-payments.

Figure 1 outlines spending for retail prescription drugs, in the United States, for selected years over a span of 42 years.

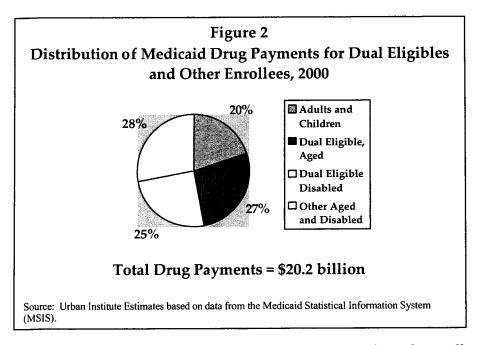
Growth From Prior Year, Selected Years 1960 – 2002								
Spending	1960	1980	1982	1992	1994	1999	2000	2002
Prescription drugs (billions)	\$2.7	\$12.0	\$15.0	\$48.2	\$54.6	\$104.4	\$121.5	\$162.4
Out-of-pocket	2.6	8.4	10.0	26.4	26.3	34.4	38.3	48.6
Third-party	0.1	3.7	5.0	21.8	28.3	70.1	83.2	113.8
Private health insurance	0	2.0	3.0	13.1	17.5	47.9	56.6	77.6
Medicaid		1.4	1.7	6.9	8.7	17.3	20.9	28.6
Other public support	0.1	0.3	0.3	1.8	2.1	4.9	5.8	7.6
Per capita (dollars)	\$14	\$52	\$64	\$186	\$206	\$376	\$433	\$569
Average annual growth from prior period		7.8%	11.7%	12.4%	6.4%	13.8%	16.4%	15.6%

Medicaid, as a major payer of prescription drug costs, has experienced the rising costs of pharmaceuticals. Although it is an optional benefit for states to include outpatient prescription drug coverage in their Medicaid state plans, all states have chosen to include this benefit for categorically needy recipients in their state. Many states have expanded this benefit to include other Medicaid recipients such as individuals who qualify as medically needy.

Despite the economic difficulties that the majority of states have recently faced, states have maintained their commitment to preserving this optional Medicaid benefit, realizing the importance of prescription drug coverage particularly to the specialized populations that the program serves. However, as a result of decreased state revenues, many states are implementing or planning cost-control measures for their pharmacy programs.

III. State Initiatives to Control Medicaid Pharmaceutical Costs

States across the country have seen aggressive growth in Medicaid outpatient prescription drug expenditures. Although all individuals who qualify for full Medicaid benefits receive outpatient prescription drug coverage, there is a significant difference in prescription drug use and payments among Medicaid enrollees. The Kaiser Commission on Medicaid and the Uninsured calculated that in 2000, 80 percent of payments for prescription drugs were attributable to Medicaid recipients age 65 and older and individuals with disabilities, despite the fact that they were only 34 percent of all Medicaid drug recipients. In 2002, the Joint Legislative Audit and Review Commission (JLARC) of the Virginia General Assembly issued a special report, *State Spending on Medical Supplies and Pharmaceuticals*, that reported the Virginia Medicaid "blind and disabled category accounts for only 19 percent of recipients, but 45 percent of total annual Medicaid spending."



Many of the elderly and disabled, who comprise a relatively small percentage of the Medicaid population yet generate a large portion of the pharmaceutical benefit costs, may be excluded from Medicaid managed care which is designed to control Medicaid costs. Dually eligible recipients, those who are Medicare beneficiaries and Medicaid recipients, as well as Medicaid

recipients who receive long-term care services are excluded from Medicaid managed care. In addition, dually eligible recipients, will begin receiving their outpatient prescription drug coverage from Medicare in 2006. Virginia like other states will be responsible for providing a "clawback" payment to the federal government for these dual eligibles. The amount of the "clawback" payment will be based on state pharmaceutical expenditures in 2003 for the dually eligible population. The "clawback" methodology relies on a formula using per capita prescription drug expenditures in 2003 for the dually eligible population. Thus for Virginia, many of the programs designed to control Medicaid fee-for-service pharmaceutical costs were not fully implemented in 2003. The "clawback" payment for Virginia will not recognize the cost savings the state has recently achieved through a variety of cost-containment measures. The full impact of the federal "clawback" has yet to be determined.

Medicaid recipients who do not participate in Medicaid managed care typically receive their outpatient pharmacy benefits through fee-for-service arrangements. According to the JLARC study *State Spending on Medical Supplies and Pharmaceuticals*, in FY 2002, DMAS incurred \$443 million in general and nongeneral fund costs before drug rebates on fee-for-service pharmaceutical services. (Approximately 50 percent of the \$443 million was covered with federal Medicaid matching funds, in addition to the approximately 20 percent drug rebate DMAS was receiving at that time.) Between FY 1998 and FY 2001, Medicaid fee-for-service pharmacy costs increased 61 percent. It was estimated that if Medicaid pharmacy fee-for-service costs continued to increase at a similar rate of 13 percent a year, over \$1 billion annually in state and federal funds would be spent to cover prescription drugs by 2009.

MEDICAID PHARMACEUTICAL COST CONTAINMENT STRATEGIES

In response to the increasing burden of Medicaid pharmaceutical costs on state budgets, the majority of states are considering or have enacted changes to control rising drug expenditures. Most of the strategies employed center on new or expanded applications of management tools that the federal government allows under existing law. Most states have focused on the following strategies:

- (1) prior authorization;
- (2) preferred drug lists (PDL) or formularies;
- (3) supplemental rebates from manufacturers;
- (4) multi-state pharmaceutical purchasing pools;
- (5) generic substitution;

- (6) drug utilization review (DUR); and
- (7) pricing strategies.

Many states have implemented a multi-pronged approach, using several of the strategies listed above simultaneously to help control Medicaid costs.

Prior Authorization

Managing prescription drug utilization is one strategy to controlling the cost of Medicaid covered pharmaceuticals. Prior authorization is one tool that has been used by states for several years to assist in the management of prescription drug utilization. Prior authorization programs typically require physicians to request and receive approval before a particular medication can be dispensed to a Medicaid recipient. This process has usually been reserved for the disbursement of specialized or high cost drugs.

The National Pharmaceutical Council reports that over 80 percent of states have implemented prior authorization in their Medicaid pharmacy programs. According to the National Council of State Legislatures, common reasons for implementing prior authorization requirements include:

- (1) the availability of alternative therapies;
- (2) the presence of less expensive brand name or generic equivalents; or
- (3) highly advertised drugs.

Prior Authorization Produces a Cost-Savings by Possibly Altering the Prescribing Patterns of Physicians. The premise is that physicians will initially prescribe drugs that are cheaper, therapeutically effective, and do not require prior authorization before they prescribe a more expensive drug that requires prior authorization.

The federal government has established safeguards to protect patient access and health. For example, a state with a prior authorization program must have a process in place for responding within 24 hours to authorization requests. In addition, they must provide a 72-hour emergency supply of any drug on the prior authorization list.

In establishing their prior authorization programs, states may elect to include individual or entire classes of drugs. Just as they may include or exclude

different pharmaceuticals, states may also choose to exclude certain vulnerable populations from participation in the prior authorization process.

Prior Authorization Requirements Have Been Built into Virginia Medicaid's Preferred Drug List (PDL) Program. Before a recipient may receive a medication that is not on the PDL, prior authorization must be attained. Further detail on this program will be provided under the next section.

Preferred Drug List

The scrutiny of pharmaceutical costs under state prior authorization programs and the desire of states to control growing Medicaid pharmaceutical expenditures led to the creation of Medicaid preferred drug lists (PDL). As of October 1, 2004, at least 33 states operate or are in the process of implementing a PDL. The purpose of a PDL is to assist states in reducing pharmacy program expenditures through the establishment of cost-effective utilization criteria that are based on nationally accepted standards. A state creates a Pharmaceutical and Therapeutics Committee or Drug Utilization Review Board to assess the therapeutic indications and clinical effectiveness of a drug, to determine if it should be considered for placement on the state's PDL. Members of the review committee or board are typically physicians and pharmacists.

Prescription Medications on a State's PDL Are Divided Into Two Categories: "Preferred" and "Non-Preferred." Preferred drugs are typically listed within the "drug class" under which they fall. Simply stated, a drug class is a group of drugs that are used to treat the same condition. An example would be a class that treats high blood pressure or gastrointestinal disorders. From each class, several drugs are selected by the Pharmaceutical and Therapeutics Committee or Drug Utilization Review Board, based on the drug's therapeutic action, safety, clinical outcome data, and cost. Normally, a preferred drug is more effective than others in the same class. The cost of the drug does not automatically preclude the item from inclusion on the PDL. For example, if a less expensive drug within a class is available but it is not as effective as other drugs in its class, it will probably be excluded. However, if several drugs within the same class have the same level of effectiveness, then typically the less expensive drug will receive preferred status.

Once the PDL is finalized, the state or its representative, who is typically a Pharmacy Benefits Manager (PBM), may negotiate with drug manufacturers or wholesalers for the best purchase price for the medications. The state is at an

advantage when negotiating lower drug purchasing prices since they can provide an almost guaranteed source of high volume sales to the drug manufacturer or wholesaler through the PDL.

The Majority of States that Have Implemented PDLs Have Excluded Drugs for the Treatment of Certain Conditions Standard Prior Authorization Requirements. Excluding conditions such as mental illness, HIV and AIDS from a PDL provides greater access to the range of medications available for the treatment of those conditions. CMS, in a September 9, 2004 letter from Dennis Smith, to state Medicaid directors, urged:

States to consider including in their PDLs drugs that are needed by some of Medicaid's most vulnerable population, such as individuals with HIV/AIDS, mental health condition, cancer, and other conditions for which clinical effectiveness or individual tolerance and responsiveness to drugs frequently vary.

Most states who have implemented PDLs have done so in conjunction with prior authorization programs and supplemental rebates in order to create maximum cost savings.

Item 325 (ZZ.1) of the 2003 Appropriations Act directed the Virginia Department of Medical Assistance Services to Establish a PDL by January 1, 2004. The budget language also required drugs that are included on the PDL to have their safety and clinical effectiveness reviewed before considering their cost-effectiveness. In addition, budget language also specified that the Pharmacy and Therapeutics Committee should recommend appropriate medication exclusions from the PDL.

In July of 2004, DMAS reported that preliminary results indicate that the PDL program is meeting its goals. The rate at which physicians chose to switch their patients to medications on the preferred drug list, or the PDL compliance rate, is 89 percent. The majority of the prescription changes have been voluntary.

DMAS has not finalized its fiscal analysis of the PDL's program savings. However, preliminary estimates appear to show that the program will meet its targeted savings. For example, it was estimated that DMAS would need to attain a minimum PDL compliance rate of 85 percent and as noted, the current compliance rate is 89 percent. However, DMAS stresses that further analysis of cost data is needed before a final report is released.

Supplemental Rebates

Drug rebates, received by a state Medicaid program in excess of rebates required under federal law, are classified as supplemental rebates. Sections 1927(a)(1) and 1927(a)(4) of the Social Security Act and a September 18, 2002 State Medicaid Director letter from CMS outline how the Secretary of Health and Human Services may allow a state to enter into their own separate or supplemental drug rebate program with manufacturers. An agreement between a state and a manufacturer must provide rebates that are at least the amount of rebates provided in the Health and Human Services Secretary's rebate agreement with manufacturers. A September 9, 2004 letter to State Medicaid Directors from CMS states:

In an effort to gain additional rebates, a state can submit to CMS for its approval a SPA (state plan amendment) to allow the state to implement a prior authorization program to negotiate drug discounts for Medicaid populations.

Supplemental rebates that a state may receive are not limited to cash, but may include other services such as disease management. This topic is discussed in further detail in Section IV of this report.

Virginia, like Several Other States, Has Used Supplemental Rebates in Conjunction with Prior Authorization and PDL Programs. The combination of these three programs often gives states additional bargaining power and leverage when negotiating with drug manufacturers. (Appendix B provides a listing of methods used by various states to control Medicaid pharmaceutical costs.) However, the creation of these cost-savings initiatives has not gone unchallenged.

The Pharmaceutical Research and Manufacturers of America (PhRMA) Opposes the Use of PDLs and Supplemental Rebates by States Trying to Control Medicaid Pharmaceutical Expenditures. PhRMA filed lawsuits in Florida and Michigan claiming that by not covering drugs that have a rebate agreement with the U.S. Department of Health and Human Services the two states are in violation of the federal Medicaid statute. In the Michigan case, PhRMA and various advocates for Medicaid beneficiaries claim that the program is unconstitutional because the full state legislature never considered the program. On April 2, 2004, the U.S. Court of Appeals for the District of Columbia ruled

that Michigan could continue its Medicaid prescription drug cost-containment measures. The U.S. 11th Circuit Court of Appeals in Atlanta ruled on September 6, 2002 that Florida's prior authorization, PDL, supplemental rebate, and other drug cost-containment measures were within the scope of law. On May 28, 2003, the U.S. Supreme Court denied a petition by PhRMA seeking the Supreme Court's review of Florida's program. If the courts had overturned either Michigan or Florida's Medicaid prescription drug cost-savings measures, other states with similar programs would have been affected.

Multi-State Pharmaceutical Purchasing Pools

By forming drug purchasing pools, states are typically able to achieve cost-savings by increasing the customer purchase pool and thereby elevating the state's price or rebate negotiating power with drug manufacturers. In April 2004, CMS approved the first multi-state Medicaid prescription drug purchasing pool. The original proposal was submitted by Michigan and Vermont. Five states, including Alaska, Michigan, Nevada, New Hampshire, and Vermont, received approval for their State Plan Amendments (SPA) to allow them to pool their purchasing power and create the National Medicaid Pooling Initiative (NMPI). Three other states, Montana, Hawaii, and Minnesota, have also submitted SPAs to join the NMPI.

First Health Services Corporation will serve as NMPI's pharmacy benefits manager and will be responsible for negotiating discounts with pharmaceutical manufacturers. As of October 4, 2004, nearly 30 pharmaceutical companies had agreed to participate in the pool and provide drug rebates. States participating in purchasing pools are also allowed to maintain their own list of preferred drugs.

In response to the recent approval of this purchasing pool, CMS issued a State Medicaid Director Letter to clarify issues surrounding this new initiative. In the letter, CMS officials stressed the importance of competition among various purchasing pools. CMS officials do not expect a large number of additional states to join the NMPI. States may create pools that use another vendor (pharmacy benefits manager) or they have the option of joining together to procure rebates without using a vendor. The current availability of already approved state purchasing pools should not preclude states from creating their own purchasing pool initiatives.

Although Virginia Did Not Participate in the NMPI, Medicaid Multi-State Purchasing Pools Are Still an Option. Given the stated preference of CMS to form new purchasing coalitions instead of joining NMPI, the Department of Medical Assistance Services could explore the feasibility of creating a new purchasing pool consisting of states not already approved and active in the NMPI.

Generic Drug Substitutions

States may create generic substitution programs that require a pharmacist to dispense a generic substitute if it is available and the physician has not provided a justification for brand use. States employ several different methods to promote generic drug usage including the "fail-first" approach which requires physicians to ensure that older, less expensive therapies are not effective before prescribing costlier treatments. Some states require the pharmacists to make the generic substitution while others will only provide reimbursement based on the generic price. Several states require prior authorization before a recipient may receive a brand name drug.

States are also employing Medicaid recipient co-payments to encourage the use of generic medications. These co-payments must be kept to a nominal fee. For example, the co-payment for a generic medication may be \$1 but increase to \$3 for brand drugs. However, Medicaid recipients cannot be denied a prescription medication because they do not pay the co-payment. In addition, certain Medicaid recipients including children, pregnant women, people in institutions and individuals receiving emergency or family planning services, cannot be required to pay a co-payment.

In September of 2004, DMAS implemented the Mandatory Generic Edit. This computer system edit helps to ensure that generics are maximized to the greatest extent appropriate. The program prevents the approval of brand name pharmacy claims unless the prescriber indicates that the brand name form is necessary. In addition, Medicaid recipients are responsible for \$3 co-payments for brand name drugs and \$1 co-payments for generic drugs (except for the recipients who are not required to make co-payments).

Many states have enacted legislation or created regulations regarding the use of generic drugs. However, less emphasis has been placed on generic drugs as a cost-savings measure as states have increasingly focused on PDLs and the additional, anticipated savings.

Drug Utilization Review

The federal government requires states to have drug utilization review (DUR) programs in place for outpatient prescription drugs in order to ensure that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes. There are two primary forms of DUR, prospective and retrospective.

Prospective DUR targets inappropriate drug use at the point-of-sale. In the Kaiser Commission on Medicaid and the Uninsured's 2000 survey, 40 state Medicaid programs evaluated duplicative drug therapies and drug interactions. Another 35 programs examined dosage levels and 33 reviewed prescription duration. Of the states that responded to the survey, fewer than half reported that their prospective DUR programs address the appropriateness of the beneficiaries' medication to their diagnosis.

States' retrospective DUR programs typically track an individual provider's prescription writing practices as well as overall use of and expenditures for drugs. In addition, some states may track the use of specific pharmaceuticals. In response to the 2000 survey by the Kaiser Commission, less than half of the states who responded tracked prescription drug use by disease or focused on high cost Medicaid beneficiaries.

States may choose to use their DUR program to create innovative methods to help contain pharmaceutical costs. Additional benefit management activities, such as managing the drug regimens for high cost recipients, identifying physician prescribing patterns, and analyzing physician compliance with typical diagnostic treatment protocol may help states attain Medicaid pharmaceutical cost-savings.

The Department of Medical Assistance Services recently implemented changes to its prospective drug utilization review (ProDUR) process. The anticipated effect of these changes is to improve patient care by requiring the dispensing pharmacists to provide more clinical information on a patient before an edit can be overriden. To attain this clinical information, increased communication between pharmacists and patients will have to occur, which may lead to more appropriate decisions regarding drug therapy. DMAS estimates that the ProDUR edits could save the state approximately \$2 to 3 million a year.

Pricing Strategies

In addition to supplemental rebates, states are also looking to other pricing strategies to help control the growing cost of Medicaid outpatient prescription drug coverage. Specifically they are examining prescription payment rates and pharmacy dispensing fees.

Reimbursement Provided for Medicaid Prescriptions May Be Adjusted to Reduce Costs. Federal Medicaid regulations require states to reimburse pharmacies for the cost of each prescription filled based on the lower of the usual and customary charge to the public or the prescription's estimated acquisition cost (EAC) plus a reasonable dispensing fee. States typically seek to meet the federal EAC requirement by paying the average wholesale price (AWP) of the prescription minus a fixed percentage or discount of that cost. (The AWP is a published list price that the manufacturer suggests wholesalers charge pharmacies.) According to National Pharmaceutical Council records, the discount amounts applied by states range from 5 to 15 percent of the prescription's AWP. In August 2001, the Office of the Inspector General of the U.S. Department of Health and Human Services reported an average discount amount of 10.3 percent for state Medicaid programs. The Office of the Inspector General indicated that 10.3 percent was too low a discount considering that the average pharmacy acquisition cost was AWP minus 21.8 percent in 2001.

DMAS reimburses pharmacies for brand-name and generic drug prescriptions based on AWP minus 10.25 percent. However, DMAS is in the process of implementing a new method for reimbursing pharmacies for filling generic drug prescriptions. The new method, known as Maximum Allowable Cost (MAC) pricing, establishes a "maximum" reimbursement amount that is based on the cost that the drug can be purchased by pharmacies in the marketplace plus an allowance for profit. Because pharmacies are able to purchase generic drugs less expensively from a number of different sources, MAC pricing is frequently less than the reimbursement paid under the AWP minus discount approach. The Medicaid programs in at least 35 other states use a MAC approach to reimbursing pharmacies for generic drug prescriptions. DMAS has estimated that the use of MAC pricing will generate general fund savings of \$5.15 million for each year of the 2004-2006 biennium.

Pharmacy Dispensing Fees May Be Adjusted to Contain Costs.

Comparing dispensing fees paid to pharmacists by Medicaid to private sector payments and adjusting Medicaid payments downwards if they exceed market

rates is another method used to control costs. The National Pharmaceutical Council reports that Medicaid pharmacy dispensing fees range from \$3 to \$6 per prescription. Tiered fee schedules that encourage the use of generic medications can also be created.

As of October 2004, DMAS reimburses pharmacists a \$3.75 drug dispensing fee. This rate went into effect on July 1, 2003 and is a decrease from the previous rate of \$4.25. However, in July 2005, the dispensing fee for generic drugs will increase to \$4.00 while the dispensing fee for brand name drugs will remain at \$3.75.

IV. Overview of Disease Management Initiatives

Disease management typically focuses on individuals with chronic conditions, with the goal of improving health through targeted interventions. According to the Center for Medicaid and State Operations at CMS, Medicaid disease management programs include:

- identification of patients and matching the intervention with need;
- support for adherence to evidence-based medical practice guidelines, including providing medical treatment guidelines to physicians and other providers, and providing support services to assist in monitoring the patients;
- services designed to enhance patient management, and adherence to an individualized treatment plan (e.g., patient education, monitoring and reminders, and behavior modification programs aimed at encouraging lifestyle changes);
- routine reporting and feedback loops (may include communication with patient, physician, health plan and ancillary providers, and practice profiling); and
- collection and analysis of process and outcome measures.

Disease management is frequently confused with case management, a similar yet unique service. Disease management programs tend to focus on treating patients with a specific disease or condition, whereas case management programs typically enroll individuals with complex combinations of medical problems. These complex combinations tend to place patients at high risk for adverse medical events. Case Management interventions are tailored to meet the individual needs of each participant, whereas disease management programs rely on the similar needs of enrollees with identical conditions to provide standardized approaches and interventions. Figure 3 provides a comparative outline of the two programs.

Figure 3

Broad Differences Between Case Management and Disease Management

	Case Management	Disease Management
Characteristics of Patient Population	People at high risk for costly, adverse medical events and poor health outcomes	People diagnosed with a specific disease
Methods for Identifying Patient	Mailed questionnaires; data on use of hospitals and emergency rooms; referrals by physicians using criteria to identify "high-risk" patients	Data on presence of a particular diagnosis; prescription for certain drugs used to treat a disease; referrals by physicians who treat many patients with that disease
Patient Education	No standardization of curriculum or educational materials; highly individualized	Standardized curriculum and educational materials for a specific disease
Reliance on Evidence- Based Treatment Guidelines	Low	High
Reliance on Protocols and Standardization	Low	High

Source: Corgressional Office Testimony on Disease Management in Medicare, September 19, 2002

DISEASE MANAGEMENT INITIATIVES

In initiatives across the country, states have sought to control Medicaid health care costs and improve fee-for-service patient outcomes by implementing disease management programs. States have typically covered disease management as a medical service or as an administrative function of their Medicaid programs. The use of funding from outside sources, typically pharmaceutical manufacturers, has garnered increased interest from states.

Disease management may be covered under Medicaid as a medical service if direct services are provided by a licensed practitioner, such as a nurse, pharmacist, or physician in order to improve or maintain a patient's health. Three examples of direct services include medical assessments, disease and dietary education, and instruction in health self-management. As medical state plan services, the state will receive federal financial participation at the state's regular Federal Medical Assistance Percentage (FMAP) rate. (For Virginia, the current FMAP is 50 percent.)

There are many ways for a state to create a disease management program. Three prominent models include: disease management through contracting with a disease management organization; disease management through an enhanced primary care case management program; and disease management through individual providers.

When a state contracts with a disease management organization (DMO), the contracted entity is responsible for managing the overall care of the Medicaid recipient. However, the DMO does not perform prior authorization or restrict access to other Medicaid services. In order to achieve the desired cost-savings, states will frequently require performance guarantees of the DMO. This can be accomplished in a number of ways including using a capitated payment methodology and placing the DMO at risk for reducing overall expenditures.

In the enhancement of a primary care case management (PCCM) model, the focus is on enhancing the care received by individuals with selected chronic conditions. Providers of PCCM are frequently paid an enhanced case management fee for providing disease management. Ongoing monitoring reports of patient utilization of care are typically used.

The provision of disease management through individual providers in the community, such as physicians or dieticians, is typically reimbursed on a fee-for-service basis. States have the option of offering participation in the program to any qualified provider or they may build a comprehensive system that provides additional support and oversight.

Any of the models mentioned may be implemented either through a state plan amendment or a waiver. Waivers provide the opportunity to create more flexible and focused programs than what would be possible under a state plan amendment. If disease management is provided through a state's Medicaid program as an administrative function, it will not constitute medical assistance and is therefore ineligible for the FMAP rate for medical services. However, as an administrative function of the state plan, disease management would be eligible for the standard administrative matching rate of 50 percent from the federal government. As an administrative function, disease management would not be subject to such requirements as statewideness and comparability that apply to state plan services. An example of disease management as an administrative function includes such activities as contracting with a Quality Improvement Organization to promote adherence by health care providers to evidence-based guidelines.

CMS allows pharmaceutical manufacturers to provide funding for disease management programs for Medicaid recipients. Under federal guidelines, this source of funding is considered a supplemental rebate under Section 1927 of the Social Security Act.

DISEASE MANAGEMENT PROGRAMS IN OTHER STATES

According to information provided by CMS, 20 states currently operate Medicaid disease management programs. There is a great deal of variation in the type and scope of these programs. The focus of these programs covers a number of different chronic conditions. States have implemented disease management programs as a state plan service, under waiver authority, and with the use of supplemental drug rebates. The chronic conditions of diabetes, asthma, and congestive heart failure appear to be an overriding theme as states seek to address high cost health care users. Appendix C provides an outline of disease management programs in the different states.

Disease Management as a State Plan Service: Mississippi

Mississippi has chosen to offer disease management as a state plan service. The program was launched in April of 2003 and targets Medicaid recipients with asthma, diabetes, or hypertension. Recipients may decide to opt out of the program. If they chose to participate, several services may be provided including:

- beneficiary education;
- care coordination;
- clinical protocols founded on evidence-based guidelines;

- home visits from field-based nurses;
- provider education and outreach; and
- optional home delivery of medicines and medical supplies.

The disease management program is managed by a contractor, McKesson Health Solutions, who was chosen through a request for proposals process. McKesson Health Solutions receives a monthly capitated payment for active disease management beneficiaries.

When evaluating the program, Mississippi will examine the utilization of health care services, changes in beneficiaries' self-management practices, the use of preventative measures and beneficiary satisfaction surveys. Mississippi is requiring a minimum five percent net savings. Based on budget estimates, they are expecting \$8 million in savings

Disease Management Under Waiver and State Plan Authority: South Carolina

South Carolina receives the authority for its disease management program from approved Medicaid waivers and its state plan. In 2004, state Medicaid officials issued a revised RFP for a disease management vendor, in response to concerns over unrealistic cost-savings expectations in the original proposal.

The goals of the disease management program include:

- improve the health outcomes of Medicaid beneficiaries with asthma, diabetes, and hypertension; and
- control expenditures by reducing avoidable emergency room visits and inpatient hospitalizations.

South Carolina plans on achieving these goals through emphasizing prevention and disease self-management, promoting continuity of care, using evidence-based protocols, and employing effective data management and feedback tools.

Contractors who agree to provide services must guarantee a minimum cost savings of five percent for the target population. These savings will be calculated by comparing the expected health care costs with the actual costs of the population. Services that will be provided in order to attain this cost savings include:

risk-assessment (including intensive outreach and risk-assessment);

- access to telephonic nurse consultation and screening;
- assistance in accessing appropriate care;
- culturally appropriate patient education regarding preventative services, overall wellness, and disease self-management; and
- creation of individualized plans of care.

Disease Management Provided through Supplemental Rebates from Drug Manufacturers: Florida

In June 2001, Governor Jeb Bush announced an agreement between Pfizer and the Florida state Medicaid agency that combined the cost-savings initiatives of disease management and supplemental rebates. Additional contracts would follow with Bristol-Myers Squibb, AstraZeneca, and GlaxoSmithCline.

Under these contracts, pharmaceutical manufacturers provide disease management services instead of monetary supplemental rebates. In 2001, Florida passed legislation which established a preferred drug list and supplemental rebate program. The Pfizer program alone was to provide a rebate of \$33 million over a two-year period, in return for having 23 Pfizer products included on the state's Medicaid PDL. Instead of providing a monetary rebate, Pfizer implemented a disease management program. The disease management services that Pfizer agreed to provide include:

- fund the development of hospital-based disease management programs in at least 10 major hospitals in Florida;
- hire at least 60 full time care mangers for beneficiaries with asthma, congestive heart failure, diabetes and hypertension;
- provide Pfizer Health Solutions disease management software and train providers;
- implement a program designed to assist beneficiaries in understanding their conditions, treatment, and benefits; and
- provide free Pfizer products to an estimated 50,000 Medicaid beneficiaries through 30 community health centers.

Florida's agreement with Bristol-Myers Squibb specifically targeted African-American and Hispanic populations with breast cancer, cervical cancer, lung cancer, depression, and HIV/AIDS through community-based health management programs. An additional component of the agreement included the establishment of a Promatora program within community health centers that would seek to improve the quality of care, medication compliance, and healthy

lifestyle decisions for Hispanic Medicaid patients with a diagnosis of diabetes and cardiovascular disease, and depression. The Promatora program was designed to help remove cultural and language barriers by using community health advisors and lay health workers.

The four pharmaceutical companies' combined programs were originally estimated to save the state \$108.4 million from July 2002 through September of 2005. However, after reports on the lack of cost-savings achieved, the Florida legislature passed and the Governor signed House Bill 1843 into law. This piece of legislation eliminates supplemental rebate programs that do not provide cash rebates after the program contracts expire in 2005. A report, issued by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) in April of 2003, estimated that the state could save \$64.2 million in 2003 and 2004 by requiring the four drug companies to provide traditional supplemental rebates instead of disease management programs. In May 2004, OPPAGA reported that Pfizer overstated its program savings by at least \$5.1 million due to errors in its reporting system. OPPAGA also cited such problems as slow implementation, overstated cost savings due to faulty baseline cost estimates, lack of coverage for all disease states specified by the legislature, and the provision of disease management services to only a small portion of the eligible population. The OPPAGA report, estimated that Florida's disease management initiative had only saved \$13.4 million, far below the original estimate of \$108.4 million.

MEDICAID DISEASE MANAGEMENT INITIATIVES IN VIRGINIA

Virginia like other states has struggled with growing Medicaid expenditures. Reviews of Medicaid expenditure data have shown that a disproportionate share of spending can be attributed to individuals with particular chronic conditions. As a result, Virginia launched the pilot program Virginia Health Outcomes Project (VHOP).

VHOP began serving recipients in DMAS' primary care case management program, MEDALLION, in 1993. The program, sponsored by the National Pharmaceutical Council, sought to educate primary care physicians in the MEDALLION program who treated individuals with asthma. Cost-savings were sought by helping to defer less effective medical treatments and prevent expensive care settings such as inpatient hospitalizations and emergency room visits.

DMAS reports that the initial outcomes of the report on VHOP were favorable. However, questions were raised about the methods used to calculate the cost-savings and return on investment. Original figures were for every \$1 spent, \$3 dollars were saved. In addition to questions on the accuracy of actual cost-savings, DMAS reported significant administrative costs associated with the program. The program was expanded in 1997 to include the entire state and cover additional chronic conditions. An evaluation conducted by Heritage Information Systems, Inc. following this expansion showed a rate of return on investment of \$1.75 for every dollar spent.

DMAS was directed to create a statewide disease management program during the 2002-2004 biennium for \$1.4 million and produce \$22 million in savings during Governor Gilmore's administration. Governor Warner included this program in his amended budget and the program was included in the final budget approved by the General Assembly in 2002.

DMAS reported several difficulties in implementing this disease management program. Most notable was the difficulty they experienced in recruiting vendors for this initiative. DMAS attributes three issues to this problem:

- 1. funds budgeted for the program were limited;
- 2. growing evidence that significant savings from disease management programs are not usually seen in the two year budget cycle DMAS was working under; and
- 3. lack of vendors who were willing to guarantee savings.

In a change in strategy, DMAS has contracted with Anthem to implement and evaluate a disease management pilot program. This program is to be provided at no cost to Virginia. The program has been named the Healthy Returns Disease Management Program. It will be implemented through Health Management Corporation Inc. (HMC), a subsidiary of Anthem. Fee-for-service Medicaid recipients who have a diagnosis of coronary artery disease or congestive heart failure will be targeted. Key components of the program include:

- patient contact and assessment;
- patient counseling, on-going assessment, and development of a treatment plan;
- patient call service; and

patient mailings.

On September 28, 2004, there were 1,581 Medicaid recipients enrolled in the disease management program. As part of the contract, HMC's timeline for conducting this program is from June 1, 2004 to May 30, 2005. During this time period, DMAS may not create or implement a disease management program specifically targeted to individuals with coronary artery disease or congestive heart failure. Other provisions of the contract require that HMC provide an evaluation of the efficacy of the program in reducing costs for this particular population based on a comparison with baseline clinical data obtained from claims, health assessments, and medical expenditures.

IV. Policy Options

The following Policy Options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted in support of an amended Option III.

Option I:

Take no action.

No comments were received addressing Option I.

Option II:

Introduce a joint resolution and accompanying budget amendment (language only), requesting the Virginia Department of Medical Assistance Services to explore the advisability of establishing or joining a multi-state pharmaceutical purchasing pool, specifically designed for

state Medicaid programs.

One comment was received addressing Option II.

The Virginia Quality Health Care Network noted that multistate purchasing pools may "not have the flexibility in procedures as single-state solutions to pharmaceutical costs." Other concerns were raised about the administrative overhead and the cost of such a program outweighing the

benefits.

Option III:

Introduce a budget amendment (language only) directing the Virginia Department of Medical Assistance Services to report to the JCHC by December October 1, 2005 on the outcomes of the Healthy Returns Disease Management Program and the feasibility of continuing or expanding this program.

One comment was received in support of Option III. Virginia Quality Health Care Network.

General Public Comments

One comment was received that addresses the report in general as opposed to the proposed options.

Mr. Gary Bolick submitted comments on behalf of Pfizer, Inc. Mr. Bolick questioned the findings of OPPAGA regarding the value added supplemental rebate program in Florida. The comments noted in part:

"Florida: A Healthy State reports savings and investments of \$61.1 million over a 27-month period (beginning in July 2001 and ending in September 2003), as validated by an independent third-party evaluator, Medical Scientists, Inc. For each dollar invested in the program, \$2.18 were saved through medical cost reductions (which totaled \$41.9 million). The \$61 million far exceeds our guarantee of \$33 million."

It should be noted that the \$61 million quoted by Pfizer consists of \$41.9 million in medical cost savings, \$16.8 million in program operating expenses and investment on Florida health care services, as well as \$2.4 million in the Health Literacy Study and product donations.

Pfizer issued a press release on November 9, 2004 reporting the findings of the assessment conducted by Medical Scientists, Inc., which contradicts many of the findings of the previous OPPAGA studies.

Appendix A:

Senate Joint Resolution 58 (2004 General Assembly Session)

SENATE JOINT RESOLUTION NO. 58

Directing the Joint Commission on Health Care to study the success of other states in improving services and lowering costs of health care and prescription drugs to Medicaid recipients through public-private partnerships, including other states' disease management programs, and to recommend whether Virginia should adopt similar programs. Report.

> Agreed to by the Senate, February 17, 2004 Agreed to by the House of Delegates, March 9, 2004

WHEREAS, national average annual health care costs have increased by 59.4 percent since 1999 from \$3,907 to \$6,227 per employee and are projected to increase by another 12.6 percent in 2004 to \$7,009 per employee; and

WHEREAS, prescription drug costs have been and continue to be a major component of these cost increases, having experienced double-digit increases in per capita spending during the 1998-2002 period ranging from 12.4 to 19.5 percent, and with projected health plan costs for prescription drugs increasing

by 18.1 percent for retail costs and 17.4 percent for mail order costs in 2004; and WHEREAS, the Joint Legislative Audit and Review Commission, in a 2002 update on state spending, identified state medical assistance services (Medicaid) as the highest-growth program from Fiscal Year 1981 through Fiscal Year 2001, during which it grew by \$2.5 billion, accounting for 14.6 percent of total budget growth, and during that same period, the numbers of people served by Medicaid increased by 131 percent, while the state's population grew by only 32 percent; and

WHEREAS, projected baseline growth in the Medicaid program during the 2004-2006 biennium will result in \$800 million of additional costs to the state and federal governments for the health care needs

of Medicaid recipients; and

WHEREAS, in June 2001, Florida enacted a Medicaid initiative allowing it to negotiate directly with drug companies for rebates in addition to those provided by the federal Medicaid Drug Rebate Program;

WHEREAS, Florida expects to save \$214 million per year, or about 15 percent of its Medicaid drug budget through its own negotiations with drug manufacturers and through implementation of a preferred drug list with prior authorization; and

WHEREAS, the Florida law also allows the Florida Agency for Health Care Administration to negotiate supplemental rebates from pharmaceutical manufacturers that are in addition to those required

under the federal Medicaid Drug Rebate Program; and

WHEREAS, Florida is the first state since federal Medicaid laws were overhauled in 1990 to overcome drug company opposition and create a mandatory, preferred drug list that would require additional discounts from manufacturers for steering Medicaid recipients toward products on the list; and

WHEREAS, the law also allows a company to provide value added services, such as disease

management, instead of offering a rebate; and

WHEREAS, results of disease management studies conducted around the country indicate that closely managing patients with chronic diseases can reduce the higher costs of services the patients often require and at the same time improve quality of care for the patient; and

WHEREAS, disease management also can prevent or delay the onset of the more severe stages of a

disease; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the success of other states in improving services and lowering costs of health care and prescription drugs to Medicaid recipients through public-private partnerships, including other states' disease management programs, and to recommend whether Virginia should adopt similar programs.

In conducting its study, the Commission shall examine the other states' programs for improving services and lowering costs of health care and prescription drugs through agreements with the private

sector, including Florida's Medicaid Initiative and its Medicaid Disease Management Initiative.

Technical assistance shall be provided to the Commission by the Virginia Department of Medical Assistance Services. All agencies of the Commonwealth shall provide assistance to the Commission for

this study, upon request.

The Joint Commission on Health Care shall complete its meetings by November 30, 2004, and the Chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the 2005 Regular Session of the General Assembly. The executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations (for publication as a document). The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B: List of Methods Used by States to Control Medicaid Pharmaceutical Costs

Medicaid Pharmaceutical Cost Control Measures

State	Preferred Drug List	Supplemental Rebate
Alabama	X	-
Alaska	X	X
Arizona	_	
Arkansas		
California	X	X
Colorado		-
Connecticut	X	X
Delaware	-	
Florida	X	X
Georgia	X	X
Hawaii		
Idaho	_	-
Illinois	X	X
Indiana	X	
Iowa	X	X
Kansas	X	X
Kentucky	X	
Louisiana	X	X
Maine	X	X
Maryland	X	X
Massachusetts	X	
Michigan	X	X
Minnesota	X	X
Mississippi	X	
Missouri	X	-
Montana	X	X
Nebraska	<u>-</u>	-
Nevada	X	X
New Hampshire	-	<u></u>
New Jersey		
New Mexico	X	X
New York		
North Carolina		
North Dakota	-	
Ohio	X	X
Oklahoma	_	

Oregon	X	
Pennsylvania	-	
Rhode Island		
South Carolina	X	X
South Dakota	_	
Tennessee	X	X
Texas	X	X
Utah	_	
Vermont	X	X
Virginia	X	
Washington	X	
West Virginia	Y	Y
Wisconsin	Y	Y
Wyoming	Y	-
TOTALS	33	23

^{*}PDL states reflect those states with program operating, pending or have enacted legislation authorizing implementation through October 2004.

Source: Health Policy Tracking Service, October 4, 2004

Appendix C:

Outline of Medicaid Disease Management Programs

Medicaid Disease Management Programs

	FYOS	FMAP	70.80%	27.60%	67.50%	74.80%	20.00%	50.00%	20.00%	20.00%	70.00%	/600 00	28.90%	60.40%	2850%	70.60%	20.00%	63.60%	61 00%	%09 69	71 00%	64.90%		50.00%	50.00%	50.00%	77.10%	
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M		(E)(d)2161										ļ	×					×										
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	N	DATE OITATNEMEJAMI 40	03/01/03			2/11/03		7/01/02					5/01/97	1/01/03				7/01/03				00,40,4					0/01/08	4/01/03
Modern Disease Maingonicin i regimina	Noitaldoana	DESCRIPTION	2 Initiatives-both focus on asthma. One is operated through PBM and the second is being developed inhucus. Directed at providers. Designed to improve outcomes through education.			High Risk Obstehrics (as of 2/11/03) is a new DM program performed as a contract with the UAMS, Debt. of Obstehrics, Div of Maternal Fetal Medicine. Covers diseases and conditions in pregnant women that are considered high risk for poor outcomes.		Private donations from pharmaceutical manufacturers. Six pilots, phased in, started July 2002 and lasted 18 months each. 'Other Diseases' include schizophrenia, high-risk neonates, and breast and cervical cancer.					5 phased approach. Seven disease management organizations were awarded contracts for 5 disease states covered under the initial procurement process. Focus on care coordination, self-management, education, and physician education. Other Diseases' include ESRD, HIVARIDS, hemophilia, hypertension, and sixtle cell anemia.	Multi-plased approach to targeting primary care physicians (PCP) in educating them about asthma. Phase I – academic detailing of PCPs in rural areas. Phase II – platein education targeting academic professionals to education against about aethma	Dispersion of Colors of Co			Comprehensive, locally-based infrastructure developed by state. Uses call center in combination with nurse case managers. 'Other Diseases' include HIV/AIDS.					Program is mosity an incentive payment for duality activities. Not contracted with PBM, not formal disease management. Other Diseases' include pain management, cardiovascular disease, and immunityaling.				Communication of the communication	Contract with DMC on a risk basis. Prammacisis provide cognitive services, up to 8 visits per years for each beneficiary. Little activity. Other Diseases include hypertension.
		язнто											×					×										
		CONGESTIVE HEART FAILURE					L						×					×										
DICEACE	UISEASES	нен-кізк Ніен-кізк				×																						
		AMHT8A	×					×					×	×				×										×
		DIABETES						×					×					×					×		1			×
	1,110	A P	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	District of	Columbia	Florida	Georgia	Howell	Idaho	Illinois	Indiana	lowa	Kansas	Kentucky	Louisiana	Маіле	Maryland	Maccachicette	Michigan	Minnesota	Mississippi

Medicaid Disease Management Programs

	FY05 FMAP	61.20%	71.90%	29.60%	55.90% 50.00%	50.00%	74.30%	63.60%	67 50%	59.70%	70.20%	61.10%	53.50%	55.40% 69.90%	7000 33	64.80%	60.90%	72.10%	50.10%	33.33	20.00%	74.70%	58.30% 57.90%
-	OM YTIROHTUA										×												
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	DATE OF IMPLEMENTATION	7/01/02	1/01/04		1/01/04			11/01/98		6/01/04	9/01/02	10/01/02		4/01/04			12/01/02	9/01/98			4/01/02	7/01/01	
	DESCRIPTION	Physician/pharmacist team develops plan of care, does follow up (4 visits/year). Other Diseases include depression.	Contract with DMO on a risk basis. 'Other Diseases' include heart failure, chronic pain, and cancer.		Contract with DMO on a risk basis. 'Other Diseases'			Carolina ACCESS, NC's basic PCCM, focuses on CM for disbelse, asthma, CHF and ADHD. ACCESS IIIII, enhanced CM system, identifying asthmadiabetes and high costhigh risk for TCM. Physicians receive specialized training. 'Other Diseases' include ADHD.		Enhanced PCCM program in which states contract with local collaboratives. 'Other Diseases' include COPD.	State receives no federal funding for program. Asthma care improvement program is through the American Indian Health Facility. Very limited funding from tribal entities in the OK city Intertribal Health Board.	Contract with Disease Management Organization.		Contract with DMO on a risk basis. 'Other Diseases'	include hypertension.		The current disease management initiative is a Pediatric Ashman Management Plot for the Medicald/CHIP oppulation. The pilot was developed in-house by the state. Contract with DMO on a risk beasis. Other Diseases' include COPD and coronary artery disease.	Combination of selective contracting for factor replacement product and case management. 'Other Diseases' include hemophilia.	Come idention in a language discuss on the control of the	Considering implementing disease management by 2004.	Contracted with outside vendors for FFS clients with diabetes, asthma, CHF, and ESRD. Other Diseases include ESRD.	Delivered through individual physicians in conjunction with certified diabetes educators.	
	язнто	×			×			×		×		×					×				×		
	CONGESTIVE HEART FAILURE	×			×			×		×		×					×				×		
DISEASES	ЬИЕСИРИСА НІСН-ВІЗК																						
	AMHTSA	×	×		×			×		×	×	×		×			×				×		
	DIABETES	×	×		×	\prod		×		×		×		×	1		×				×	×	
	STATE	Missouri	Montana	Nevada	New Hampshire	New Jersey	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania Phodo Island	South Carolina	South Dakota	Tennessee	Техаѕ	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin Wyoming

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