

An Evaluation of Iowa's Medicaid Managed Care Program

Julie M Urmie, Ph.D. and William R. Doucette, Ph.D.

University of Iowa College of Pharmacy

Iowa City, Iowa

Funded by the Community Pharmacy Foundation

October 29, 2018

Introduction

States have the choice of serving as the insurer for their state Medicaid programs and directly paying providers for their services or contracting with private insurance companies to cover health care services for Medicaid beneficiaries. Most state-run programs are fee for service programs while states that contract with private companies usually choose managed care plans. In the last ten years many states have chosen to switch their Medicaid programs from state-run fee for service programs to private managed care plans. This switch has implications for pharmacies because under a state-run program, the state sets the formulary, chooses which drug benefit management tools to use and determines pharmacy reimbursement. Under private Medicaid managed care plans, these decisions typically are left up to the private plans. Transitioning Medicaid programs from state-run fee for service to private managed care plans in other states has resulted in decreased pharmacy reimbursement (Balick 2018, Olsen 2018).

In Iowa, the Medicaid program transitioned from a state-run fee for service program to three private managed care companies on April 1, 2016. Iowa's transition was somewhat larger in scope than other states because it included people dually eligible for Medicare and Medicaid plus almost all health care services, including long term care. The objectives for this grant were to: 1) describe Iowa community pharmacy experience and satisfaction with the transition to the Medicaid managed care program and 2) conduct an in depth case study of the financial impact and other effects of Iowa Medicaid managed care on three independent Iowa community pharmacies. The study took place in two separate phases; the first phase occurred approximately 6 months following the switch to Medicaid managed care and the second phase occurred in the 6-18 month period after the switch.

Background information on Iowa Medicaid reimbursement rates and formulary management

Although states typically allow Medicaid managed care plans to set their own pharmacy reimbursement rates, as a result of negotiation between the Iowa Pharmacy Association and the Iowa governor's office the Iowa Medicaid managed care plans were required to maintain the same reimbursement system that was established for the state run Medicaid program in the Iowa 2012 legislative session. This system included an average acquisition cost payment for drug products that is determined by pharmacy survey and a dispensing fee that is based on an average cost of dispensing as determined by a biennial cost of dispensing survey. Both surveys are specific to Iowa pharmacies. More details on these methodologies can be found at <http://www.mslc.com/Iowa/AACLlist.aspx> and <http://www.mslc.com/Iowa/CostofDispensingSurvey.aspx>. In August 2016, the Iowa Medicaid dispensing fee was lowered from \$11.73 to \$10.02 as a result of the most recent cost of dispensing survey (<http://www.iowamedicaidpos.com/sites/default/files/ghs-files/informational-letters-attachments/2016-08-02/1705-mcpharmacy-dispensing-fee-change.pdf>).

The Iowa Medicaid formulary also supposed to stay the same following the managed care transition, although plans were allowed to establish their own prior authorization processes.

Phase 1 Objective: Describe Iowa community pharmacy experiences and satisfaction with the transition to the Iowa Medicaid managed care program.

Methods – Phase I

Phase I of the study was a cross-sectional descriptive study using a census of Iowa community pharmacies. A four page survey was developed to examine effects of the Medicaid managed care transition and pharmacy satisfaction with the managed care plans. The survey was pilot tested using a random sample of 50 Iowa community pharmacies. Results from the pilot survey were used to modify the survey. One key change was that pilot survey results showed that pharmacists had very similar views of all three Medicaid managed care plans so the final survey questions were for the Medicaid managed care program in general, rather than for the individual Medicaid managed care plans specifically. The final survey had thirteen questions on pharmacy experiences with the Medicaid managed care transition that were measured using 5 point Likert scales anchored by 1 = strongly disagree and 5 = strongly agree. There were thirteen satisfaction items that were measured using 7 point semantic differential scales anchored by 1 = extremely dissatisfied and 7 = extremely satisfied. Respondents were given a “don’t know” option for all the experiences and satisfaction items. The survey also asked pharmacists to rank the Medicaid managed care program, the previous state-run Medicaid program, Wellmark (the largest private insurer in the state) and the pharmacy’s largest Medicare Part D plan in terms of their overall satisfaction with the plan. Additional items measured the timeliness of Medicaid managed care plans’ claims payments and the effect of the Medicaid managed care program on their patients’ access to prescriptions. The final set of items collected descriptive information about the pharmacies. Open ended items asking respondents to describe aspects of the Medicaid managed care program that had been particularly good or particularly bad and any general comments also were included.

The revised survey was mailed in fall 2016 to all remaining community pharmacies with an Iowa zip code (n = 1,436). The pharmacy names and addresses were obtained from the Iowa Board of Pharmacy website and the survey was addressed to the pharmacy manager. Reminder postcards sent to all pharmacies and a second survey mailing to non-respondents were used to increase response rate.

Descriptive statistics were calculated for all items. “Don’t Know” responses were coded as missing data. Student t-tests and Chi-square tests were used to compare satisfaction levels by pharmacy type. Open-ended items were independently coded by two researchers to determine key themes and then the researchers met to finalize the themes and reconcile any differences in coding.

Results – Phase I

After the initial mailing, we discovered that the mailing list from the Iowa Board of Pharmacy contained many duplicate pharmacy listings and listing for closed pharmacies. These pharmacies were removed prior to the follow-up mailings, leaving a sample size of 1,235 pharmacies. From this list of pharmacies we had 266 undeliverable surveys and 265 returned surveys, yielding a 27.3% response rate. The respondents reported working at independent or

small chain pharmacies (41.6%), large chain pharmacies (24.0%), mass merchandiser or supermarket pharmacies (21.8%) and other pharmacies (12.6%). The vast majority (97%) of the pharmacies had accepted the previous state run Medicaid program and filled an average of 25% of their prescriptions through Medicaid. The respondents had the following mean percentages of prescriptions at their pharmacies reimbursed under each Medicaid managed care plan: UnitedHealthCare (12.4%), Amerigroup (15.0%), and Amerihealth Caritas (19.4%). The weekly prescription volume varied from 15 to 4,440 with a mean of 1,349 (S.D. = 882) and a median of 1,200 prescriptions per week.

Respondents were most likely to agree with the statements “My staff had extra work due to the managed care transition,” “My patients faced barriers to getting their prescriptions during the transition” and “It has been difficult to get prior authorization approvals under Medicaid managed care.” Respondents were most likely to disagree with the statements “My patients were well informed about the Medicaid managed care transition,” “Coverage of OTC medications has been the same as in the state-run Medicaid program,” and “The prescription drug formularies for the managed care plans are the same as in the state-run Medicaid program.”

Respondents reported the most satisfaction with the “ease of joining plans’ pharmacy networks” and “determining patients’ plan eligibility.” They reported the most dissatisfaction with “plans’ communication with patients” and “availability of payment for non-dispensing related services.” The last item may have been due to pharmacies losing the opportunity to bill for pharmaceutical case management, which was allowed under the previous state-run Medicaid program. Overall mean satisfaction with the Medicaid managed care program was 3.1 on a scale of 1 to 7 with 1 being extremely dissatisfied and 7 being extremely satisfied. Independent pharmacies had significantly lower levels of overall satisfaction with the Medicaid managed care program compared to other types of pharmacies ($p < 0.05$).

When asked to rank the four major types of third party plans, the previous state run Medicaid program ranked the highest in satisfaction, the largest private payer in the state ranked second, the pharmacy’s largest Medicare part D plan ranked third and the Medicaid managed care plans ranked last. Although this study did not directly measure patient effects of the Medicaid managed care transition, we did ask pharmacists to report how many of their patients were unable to get a medication prescribed by their physicians since the start of Medicaid managed care. There appeared to be some patient access problems as 54% of respondents said that more than 10 of their patients had been unable to get a medication prescribed by their physician. When asked about the timeliness of reimbursement from the private Medicaid managed care plans, 63% of respondents did not know, while 16% of respondents reported that 0 to 50% of claims were being paid within the 14 day standard required by state law.

The responses to the open-ended items were crucial in helping understand pharmacy experiences with the Medicaid managed care transition. There were 176 comments yielding 283 ideas and the comments were primarily negative. Five main themes were identified: 1) formulary management, 2) transition confusion, 3) reimbursement issues, 4) durable medical equipment (DME) issues and 5) eligibility complications. The themes definitions and representative comments for each theme are in Table 1.

Table 1: Themes Identified from the Survey Open-Ended Items

Theme	Description	Representative Quotes
Formulary management	Observations about formulary changes, ease of formulary access, and OTC medication coverage.	<ul style="list-style-type: none"> - <i>“The amount of OTC items seems to have decreased considerably.”</i> - <i>“Changes in formulary have caused problems, no online easy to follow list, has taken a lot of time.”</i> - <i>“Not following [Title] XIX guidelines for formulary as they [MCOs] were supposed to.”</i>
Transition Confusion	Comments regarding patient understanding of Medicaid transition and help desk satisfaction during transition.	<ul style="list-style-type: none"> - <i>“Many patients were ill-informed, misinformed or were very confused with the transition process.”</i> - <i>“Pharmacy help desks are grossly inadequate in both knowledge and helpfulness.”</i> - <i>Help desk personnel are not as easy to work with.”</i>
Reimbursement Issues	Comments concerning the amount and speed of Medicaid managed care plan payments to pharmacies.	<ul style="list-style-type: none"> - <i>“Medicaid reimbursement takes much longer. We are being reimbursement less.”</i> - <i>“Payment delays are horrible.”</i> - <i>“Payment is slow and the reimbursement is too low.”</i>
Durable Medical Equipment (DME) Issues	Comments about DME coverage, obtaining DME contracts, and reimbursement for DME products.	<ul style="list-style-type: none"> - <i>“Having to file paper claims for products (DME) is tedious, slow and not at all transparent.”</i> - <i>“Billing for DME services is cumbersome, we are still working to get payment on claims.”</i> - <i>“DME [reimbursement] is bad/non-existent.”</i>
Eligibility Concerns	Issues with patient Medicaid managed care plan eligibility.	<ul style="list-style-type: none"> - <i>“Many recipient’s managed care plans reject because they show the member is enrolled in another policy. In every instance this reject has come up, the enrollee does not [have] other coverage.”</i> - <i>“It takes too long for the MCOs to activate a member after Medicaid grants their eligibility.”</i>

Phase I – Discussion

Respondents generally were very dissatisfied with the Iowa Medicaid managed care program. The only item where the mean reported satisfaction was above the neutral level was the ease of joining plans' pharmacy networks. Especially high levels of dissatisfaction were reported with plan communication. Plan communication with patients and with pharmacies had among the lowest satisfaction ratings and there were many comments about poor communication in the open ended items. The lowest level of satisfaction was with the availability of payment for non-dispensing related services. The previous state-run Medicaid program had a long-standing program that paid pharmacists for doing pharmaceutical case management and this program was not continued after the Medicaid managed care transition. To the best of our knowledge, at this time none of the Medicaid managed care plans have any program that pays pharmacists for non-dispensing related services.

It was interesting that respondents were slightly dissatisfied with the amount of payment for brand name and generic drugs, plus respondents slightly agreed that reimbursement for both types of prescriptions had decreased. Under the previous state-run Medicaid program, Medicaid was one of the best third party payers in the state (Murry et al 2018) and the payment formula was not supposed to change. The formulary also was supposed to stay consistent following the transition to managed care, but respondents also reported issues with the formulary coverage in the comments and disagreed with the statement that the formularies had stayed the same. Respondents were particularly dissatisfied with the coverage of OTC products. Phase II gave us the opportunity to follow-up on these concerns about payment and the formulary. Although we did not specifically ask about reimbursement for durable medical equipment (DME), problems with DME coverage and contract were frequently mentioned in the open-ended items so we also followed up with questions about DME coverage in Phase II of the study.

It is important to note that there were high percentages of “don't know” responses for some of the satisfaction and experience items, particularly the items on plan audits, timeliness of product cost updates, timeliness of payment and payment for non-dispensing related services. It's likely that 6 months post-implementation was too soon for respondents to be familiar with these issues, however it also is possible that although the survey was addressed to the pharmacy manager, some respondents were not managers and thus not as familiar with these topics.

Direct measurement of patient experiences with the Medicaid managed care transition were beyond the scope of this study, but we did ask pharmacy respondents about their perceptions of patient experiences. Respondents reported many issues with plan communication to patients, resulting in considerable patient confusion about the transition and their particular plan. Also, 54% of respondents reported that more than 10 of their patients had been unable to get a medication prescribed by their physicians since the Medicaid managed care transition. This indicates that patients were having some problems accessing medications following the Medicaid managed care transition.

Phase II Objective: To conduct an in depth case study of the effects of the financial impact and other effects of the Medicaid managed care program on three independent Iowa community pharmacies.

Phase II – Participating Pharmacies

A convenience sample of pharmacies was selected for the in depth case study. Four independent pharmacies initially agreed to participate in the study, but one pharmacy failed to complete the initial data requests and was dropped from the study. Pharmacy A was located in a rural area in central Iowa with a population of approximately 5,000 people. Pharmacy B was located in an urban area in northern Iowa with a population of approximately 70,000 people. Pharmacy C was located in an urban area in southeastern Iowa with a population of approximately 76,000 people. The pharmacies were selected to achieve some geographic diversity and because of previous research connections with some of the pharmacists. To participate in the study, pharmacies were required to have at least 10% of their prescriptions reimbursed through the Iowa Medicaid program.

Phase II Methods – Interviews

Face-to-face interviews were conducted with staff from the three participating community pharmacies. Once the three pharmacies were recruited, a visit day was scheduled for each, during which the staff interviews were conducted. Pharmacy staff targeted for interviews included pharmacy owner, staff pharmacist, pharmacy technician, and durable medical equipment (DME) staff. The number of interviews at each pharmacy varied due to variations in staff availability during the visit. The interview guide was informed by the results of the Phase 1 survey results. Topics addressed in the interviews included: how the transition of Iowa Medicaid to managed care was affecting the pharmacy in various areas (dispensing, DME, payment reconciliation, calling the payer, signing Medicaid contracts), comparing managed care Medicaid to the previous Iowa Medicaid program, variability in experiences across the three managed care organizations, how patients were being affected by the transition, and how their experience with the Iowa Medicaid managed care program had changed since start-up. The interviews were audiotaped, and then transcribed verbatim. Two people independently coded the transcripts. After reconciling any differences in the initial coding, the coders identified themes raised during the interviews, noting quotes for each.

Phase II Results – Interviews

A total of eight interviews were conducted, with at least two at each pharmacy. Overall the interviewees included two pharmacy owners, three staff pharmacists and three technicians/DME staff. The interviews lasted on average about 25 minutes, with a range of 11-40 minutes. A total of five themes were identified: 1) Multiple MCOs cause confusion, 2) Plan communication with pharmacies, 3) Product coverage challenges, 4) DME problems, and 5) Payment challenges for medications.

One theme that was clear across the interviews was that having three managed care organizations running the Iowa Medicaid program created confusion for patients and providers. While various issues were mentioned, a common complaint was that the three MCOs had

different rules for operating their version of the Iowa Medicaid. The following comment by a pharmacy owner represents the concerns about having too many rules across the three MCOs.

So the first thing I will say is, by having three different MCO's creates three sets of formularies and three sets of rules and we don't always know from week to week and month to month which one a patient is on because they end up getting moved from time to time. [Pharmacy owner]

Another comment that was made by multiple interviewees stated a strong preference to return to the consistent approach used by the previous state-run Iowa Medicaid program. The following quote illustrates this sentiment.

I personally liked the old way better..... You could call the one, the Iowa Medicaid and that was it. It wasn't the three different ones trying to figure out what everybody wanted. The PDL for the old Medicaid was more, not more specific, but was more up to date. And it was, you could go, you could look, you could figure it out. And pretty much always you could get stuff to work that way. [Pharmacist]

Patient confusion also was identified as a problem from having three MCOs running Iowa Medicaid. Many interviewees mentioned that patients often did not know which MCO was providing them with coverage, but only could state that they had Medicaid coverage. This confusion could have resulted from limited communications from the MCOs to patients and to providers.

It's confusing for them, but it's been more difficult for us because there's just that much more to do for that many more agencies, per se, compared to just straight Iowa Medicaid. [Pharmacy technician]

The eligibility confusion could result in delayed care, as the pharmacies have to determine which MCO was covering a particular patient. Also, the extra time required to determine eligibility added to the pharmacies' costs of serving Iowa Medicaid beneficiaries. The following quotes refer to the added burden.

Even today we'll have patients who will be on one MCO one month and then we'll find out the next month that they're not. [Pharmacy owner]

A second theme was “plan communication with pharmacies,” which encompassed the helpfulness of the MCO staff when called and ambiguity of claims rejections. A concern was the variability in who the pharmacy staff actually talked with when they called one of the MCOs. They were not able to consistently talk to the same person, which would have been helpful in resolving drawn out problems. A pharmacy owner had the next comment.

I would call the old Medicaid system, I feel like I could call a Des Moines number and I feel like I could have spoken to three people the whole year. And right now, you know, I don't think you could ever get the same person twice. And I think that creates more subjectivity into the system where this person may be subjective is going to help more; their personality may or may not help you. [Pharmacy owner]

In addition to difficulties from support staff, the interviewees raised concerns about the usefulness of the MCOs' web sites. Sometimes the pharmacy staff member had to call the MCO to be able to locate a form or other needed information on their web site. Such calls added to the time and cost the pharmacies had when caring for Iowa Medicaid beneficiaries.

I just find their websites are really not easy to maneuver. It's like this morning; I'm trying to find a copy of a form for (Plan1). I cannot get it to come up, so you have to call them and say, "Okay," and they walk you through it. Their web sites aren't real easy to get through. And I have another website that you can go to and you have to have a sign in, the password and all that. It just takes a lot of time to get what you want. [DME staff member]

The feedback provided by the MCOs to pharmacies about rejected claims was another area of concern about communications. Some drug rejections occurred as the MCOs tweaked the formularies to suit their needs. Unfortunately the acceptable NDC numbers were not always readily available to pharmacy staff. At times, the MCO support staff could not readily resolve such issues.

... a lot of times it just says not covered it, which could mean it's not the right NDC, it's just not covered. It's, they want a different strength. It's very vague. [Pharmacy owner]

Product coverage challenges represented a third, though related, theme. For Iowa Medicaid an up-to-date preferred drug list (PDL) is supposed to be available so providers can readily determine which products are covered. There was variability in how well the PDLs were kept updated across the MCOs, as the following quotes illustrate.

I think it's not as user friendly. Because of the, basically the guessing game on what's covered, what's not. [Pharmacist]

The concerns about product coverage extended to over-the-counter (OTC) medications which can be covered for patients with Medicaid, especially those in a nursing home. The MCOs varied in their OTC coverage decisions, which created some challenges for the pharmacies, patients, and nursing homes.

We find that the things that originally were on the list, the over the counter products, with Senna, Tylenols, aspirins, those things are commonly used within the facility are no longer being paid by that group. [Pharmacy owner]

A third issue related to the product coverage theme is use of prior authorizations (PAs) in getting coverage extended to a product that is not first line or has other reasons for limited access. A common statement was about negative patient reactions to having to wait for the prior authorization process to be completed before they could get the processed medication. In addition, providers could have difficulties in getting the PAs processed. Pharmacy staff expressed a concern that the number of PAs seemed to have increased with the switch to MCOs running Iowa Medicaid (see comments).

It seems like there's an increase in amounts of needing to do that (PA). [Pharmacist]

The fourth theme dealt with problems involving durable medical equipment (DME). One issue described by interviewees at two different pharmacies was problems with getting signed contracts as DME providers with all of the MCOs. Two owners mentioned problems with applications or apparently completed contracts being lost. These problems caused delays in coverage for patients who had need of DME services and goods. The following quotes refer to these contractual issues.

In the case of the durable medical equipment contracts, each individual plan had to be contracted manually. Each had their own set of criteria and credentialing and they would lose information and lose applications. [Pharmacy owner]

Another problem with DME related to questions of product coverage. Similar to medications, the rules of the MCOs made it difficult for the pharmacy staffs to determine coverage of DME products for their patients (see quotes).

You have a diagnosis code. It tells them exactly what the diagnosis is, but they want chart notes, so that's another glitch in it all of a sudden. "We want chart notes to verify the diagnosis and why the patient needs it." [DME staff member]

The third issue for DME dealt with payment levels and claims processing. Sometimes payment levels were so low that a lesser quality product was covered, regardless of the patient situation/need. In addition, claims were slow to be processed; sometimes requiring multiple claims submissions to be able to get paid. Again, these approaches by the MCOs added costs to the pharmacies to serve their Iowa Medicaid patients' DME needs. The following quotes illustrate this concept.

They pay next to nothing. I think [owner] said it ends up being 50 cents a brief or something, which limits us to the cheaper ones, which is hard when you have patients that are, have seizures in the day or aren't able to get themselves up at night. [Pharmacist]

The fifth theme was about payment challenges for medications. One component of this theme is that Iowa Medicaid will accept brand name products as preferred drugs, when a substantial discount is provided to Iowa Medicaid by the brand name manufacturer. A second issue here is that the MCOs can use a drug cost basis that is below what the pharmacy can actually pay for the drug product. These issues are shown in the next two quotes.

I think it's unacceptable for any prescription to be paid under cost. So 5% of my Medicaid claims are paid under cost. To me, that's unacceptable. [Pharmacy owner]

Phase II Discussion – Interviews

Having three MCOs created confusion for patients and providers. Each MCO has developed its own operating rules, which creates a burden for pharmacy staff to know rules for all three MCOs. Having to deal with multiple MCOs also can result in mistakes or extra costs,

when the rules of one MCO are inadvertently applied to a beneficiary covered under a different MCO. A question that arises is whether we need to have three MCOs in the Iowa Medicaid program. Having multiple MCOs does create some competition and allows some choice by MA beneficiaries. Perhaps two MCOs would be sufficient to meet these goals without the additional burden on providers.

Patient confusion was another aspect of having three MCOs. Patients at times did not know which MCO was actually covering them. Such confusion could relate to changes made in coverage, where MCOs are changed for patients. Another potential cause could of patient confusion be low effectiveness of MCO communication with beneficiaries. Patient confusion has been identified as a problem or concern in other states converting Medicaid to managed care, including Illinois, Arkansas, Michigan, Indiana, and Massachusetts (Ramsey 2015, Kennedy 2017, Musumeci et al 2017, McCluskey 2018). We were not able to evaluate patient experiences directly with these data. Future research could be conducted to collect opinions and experiences directly from Medicaid beneficiaries experiencing care under managed care organizations.

A companion issue to the greater burden of rules due to three MCOs was concerns about poor communication with pharmacies. One component of this issue was the difficulty of calling the service support personnel of the MCOs. It could take a lot of time to get someone on the phone. In addition there was variability in who the pharmacy staff would reach, which limited continuity of services and establishing rapport between the MCO and pharmacy personnel – which was in contrast to working under the former Iowa Medicaid program. At times the MCO personnel appeared to be lacking information they needed to resolve a pharmacy question, such as a billable NDC number. Such situations could reduce the ability of pharmacy staff to solve problems that could affect patient care.

The web sites of the MCOs also were identified as posing problems for pharmacy staff seeking needed information (e.g. forms). This was somewhat surprising since these are experienced MCOs that should have smooth operations, including user friendly web sites. The more obstacles providers encounter due to poor communication by the MCOs, the greater the likelihood for gaps in patient care to emerge.

Product coverage questions were raised for prescription drugs and OTC drugs. One key aspect of this theme was unreliability of preferred drug lists (PDLs). A common mechanism for Medicaid, PDLs were used by 45 states in 2015 (Young and Garfield 2018). The PDLs are supposed to provide accurate and up-to-date information about covered products. However, such has not always been the case with these MCOs, resulting in unnecessary phone calls and delays in care. Given the importance of the PDL, efforts should be made by the MCOs to eliminate problems inaccurate of delayed information.

Durable medical equipment (DME) was a thematic area, with complaints about problems with initial contracts and concern with coverage of DME products. Such concerns have been voiced for physician practices as well as pharmacies (Huff 2014, Clayworth 2018). Reflecting on the transition to MCOs, two pharmacy owners stated that there were considerable delays (i.e. several months) and poor communication with their DME contracts with one MCO. Regarding DME product coverage, the MCOs tended to keep raising the bar on requirements for documenting need for DME products, including requiring two ICD10 codes and chart notes. These rules added cost to the pharmacy for them to provide DME products for Iowa Medicaid beneficiaries.

A fifth theme area was payment challenges for prescription drugs, including having brand name products as preferred products. Under this approach, the community pharmacy needs to

carry the expensive brand name plus the generic version in its inventory. This can add to inventory costs, especially if only one patient is taking that particular product. In addition, for some products the MCOs use a drug cost basis that is below the best pharmacy purchase price. These cases result in the pharmacy being paid below their costs, despite following the rules and reasonable purchasing practices (Olsen 2018). It is important to note that having some brand name products preferred over generic products was a carryover from the previous state-run Medicaid program and not something initiated by the Medicaid managed care plans.

Phase II Methods – Financial Data

The three participating pharmacies were asked to submit deidentified dispensing data from October to December 2015 and October to December 2016. The same three months were used in each year in order to account for seasonal differences in prescribing. The first step in the process was to determine the accuracy of the actual acquisition cost (AAC) was listed in the dispensing data. A random sample of 50 prescriptions was selected for each pharmacy and the dispensing data AAC was compared to the same product's AAC listed in the pharmacy's wholesaler invoices. The AAC was obtained from the most recent purchase of the product that occurred prior to the dispensing date. Pharmacy A's AAC from the dispensing data was identical to the cost listed in the wholesaler invoices so the computer cost was used. Pharmacy B's AAC from the dispensing data was mostly accurate, so the computer AAC was used with some spot checking. For Pharmacy A and Pharmacy B, we analyzed all Medicaid prescriptions from the two periods plus all prescription dispensed under their largest private third party payer and their largest Medicaid Part D plan. Pharmacy C's dispensing data AAC was very inaccurate, so wholesale invoice costs were used for that pharmacy's analysis. We were not able to obtain wholesaler invoice data from 2015 for this pharmacy, so gross margins only were calculated for October to December 2016. Rather than using just a sample of the Medicaid prescriptions as originally planned, we included all 2016 Medicaid prescriptions for that pharmacy. For each Medicaid prescription the most wholesaler invoice cost for the most recent purchase of that drug product prior to the dispensing date was used.

Wholesaler rebates and any 340B pricing were not factored into the AACs for any of the three pharmacies. Durable medical prescriptions and vaccines were not included in the prescription gross margin analysis. Reimbursement for DME was anecdotally reported to be problematic, but due to the lack of availability of accurate cost data, examining DME gross margin was beyond the scope of this study.

To calculate gross margin, AAC was subtracted from total reimbursement (patient out of pocket plus third party payment) for each prescription. Outlier prescriptions with a gross margin of less than -\$100 or more than \$100 were excluded. This methodology is consistent with past research (Urlick et al. 2014, Murry et al. 2018). Gross margins were compared for Medicaid prescriptions across period 1 (Oct-Dec 2015) and Period 2 (Oct-Dec 2016) and across the three Medicaid managed care plans in period 2. T-tests and one-way ANOVA were used to determine the statistical significance of differences in mean gross margin. Mean gross margins also were calculated for the largest private payer and Medicare Part D plan at each of the first two pharmacies in order to compare the Medicaid reimbursement to other third party payer

reimbursement. Private plan data from Pharmacy 3 was not included due to the lack of accurate cost data in the computer.

Phase II Results – Financial Data

Table 2 shows the average Medicaid gross margins before and after the Medicaid managed care transition. In spite of the decrease in the Medicaid dispensing fee that occurred in August 2016, the mean gross margin for Medicaid prescriptions at the three pharmacies stayed almost the same under the Medicaid managed care plans (\$12.11 for the state-run Medicaid vs \$12.15 for the Medicaid managed care plans). The slight increase in mean gross margin was not statistically significant when tested using a t-test ($p < 0.05$). The average gross margins across the three Medicaid managed care plans, were similar, but the difference was statistically significant when tested using one way ANOVA ($F = 3.17, p < 0.05$).

Table 2 Average Gross Margin for Medicaid Prescriptions

Third Party Plan	Period 1 (Oct-Dec 2015) Gross Margin Mean (S.D.)	Period 2 (Oct-Dec 2016) Gross Margin Mean (S.D.)
State run Medicaid	\$12.11 ¹ (\$9.46), N = 10,659	NA
Medicaid Managed Care Plan 1	NA	\$11.76 ² (\$10.14), N = 3,205
Medicaid Managed Care Plan 2	NA	\$12.49 ² (\$10.41), N = 3,039
Medicaid Managed Care Plan 3	NA	\$12.20 ² (\$13.51), N = 3,807
Combined Medicaid MC plans	NA	\$12.15 ¹ (\$11.60), N = 10,051

1. The average Medicaid mean gross margins for the state-run Medicaid program and the combined Medicaid managed care plans were not significantly different ($p < 0.05$).
2. The average gross margins for each of the Medicaid managed care plans were significantly different ($p < 0.05$).

Results for each of the three pharmacies are displayed in Tables 2-4. Pharmacy A had slightly lower gross margins under the Medicaid managed care plans compared to the state-run Medicaid program while Pharmacy B had slightly higher gross margins under Medicaid managed care. Pharmacy C generally had the lowest average gross margins for the three managed care plans. The Medicare Part D plan gross margins do not factor in any direct or indirect remuneration (DIR) fees charged retrospectively by the Part D plans.

Table 3 Average Prescription Gross Margins for Pharmacy B

Third Party Plan	Period 1 (Oct-Dec 2015) Gross Margin Mean (S.D.)	Period 2 (Oct-Dec 2016) Gross Margin Mean (S.D.)
IA Medicaid	\$12.51 (\$8.94), N = 6,025	NA
Medicaid Managed Care Plan 1	NA	\$12.76 (\$9.34), N = 2,024
Medicaid Managed Care Plan 2	NA	\$13.24 (\$9.28), N = 2,138
Medicaid Managed Care Plan 3	NA	\$13.41 (\$8.88), N = 1,973
Largest Private Plan*	\$9.24 (\$13.49), N = 7,623	\$12.51 (\$14.66), N = 6,224
Largest Medicare Part D Plan*	\$8.17 (\$12.02), N = 2,237	\$8.42 (\$13.61), N = 1,990

*Pharmacy B's largest private plan and largest Medicare Part D plan were not the same plans as Pharmacy A's largest private plan and largest Medicare Part D plan.

Table 4 Average Medicaid Prescription Gross Margins for Pharmacy C

Third Party Plan	Period 2 (Oct-Dec 2016) Gross Margin Mean (S.D.)
Medicaid Managed Care Plan 1	\$9.62 (\$15.53), N = 288
Medicaid Managed Care Plan 2	\$10.97 (\$20.97), N = 212
Medicaid Managed Care Plan 3	\$10.49 (\$22.28), N = 939

Phase II Discussion – Financial Data

In the Phase I survey and the Phase II interviews, participants reported some concerns about the Medicaid managed care plan prescription reimbursement. However, the payment formula did not change except for a slight decrease in dispensing fee in August 2016 as a result of a lower cost of dispensing based on the biennial cost of dispensing survey. We found that the average gross margin for prescriptions under the Medicaid managed care program was not significantly different from the average prescription gross margin under the state-run Medicaid program. The Medicaid gross margins also were larger than the average gross margins for the largest private payer and largest Medicare Part D plan at the two pharmacies where we calculated other third party payer gross margins. Although examining the cost of dispensing specifically for Medicaid prescriptions was beyond the scope of this study, it’s possible that the financial concerns expressed by the study participants were related to an awareness of the extra time and hassle needed to process Medicaid prescriptions through the managed care plans. In the surveys and Phase II interviews, many respondents reported problems with the plans’ help desk support and much staff time spent resolving problems. Even though average gross margin didn’t change, the net profit for Medicaid prescriptions would decrease if costs associated with dispensing the prescriptions increased.

The average gross margins for each of the individual Medicaid managed care plans were similar, but the small differences were statistically significant. All of the plans were required to use the same payment formula, so it’s likely that these differences were due to a different product mix of dispensed prescriptions across the three plans. It is interesting the same Medicaid managed care plan had the lowest gross margin at all three of the pharmacies. Patients were allowed to choose the plan they wanted, but patients who did not choose a plan were randomly assigned across the three plans. The plans paid the average acquisition cost for the product, so theoretically the gross margin should have been equal to the dispensing fee, but since the average acquisition cost did not perfectly match the pharmacy actual acquisition cost there was quite a bit of variation in gross margin as evidenced by the high standard deviations. This ingredient cost “spread” means that product mix differences would affect gross margin.

There were some differences in average Medicaid gross margins across the three pharmacies. However, the relative order of average gross margins was generally consistent across plans, with Medicaid plan 1 having the lowest average gross margin at all three pharmacies. Medicaid plan 3 had the highest average gross margin at two of the three pharmacies. As discussed above, these differences across pharmacies likely were due to differences in the product mix of dispensed prescriptions, although different wholesaler purchasing terms for the pharmacies also could have been a factor.

Limitations

The Phase I survey was mailed to all Iowa community pharmacies, but only 27% responded so results can't be generalized to all Iowa community pharmacies. We received a good mix of responses from different types of community pharmacies, but it is possible that respondents had stronger opinions about the managed care program than pharmacy managers who did not respond. Due to the intensive nature of the data collection for Phase II, only three independent pharmacies were included. Results from Phase II shouldn't be generalized to chain pharmacies or even other independent pharmacies.

Difficulties with accessing financial data from the pharmacies created some challenges for Phase II. Inaccurate cost data in one pharmacy's computer system meant that considerable effort had to be exerted to obtain accurate product cost data by looking up individual product costs from past wholesaler invoices. As a result of this challenge and limited access to older wholesaler invoices we could not do as extensive a gross margin analysis at one of the study pharmacies. Fortunately this pharmacy had the smallest number of Medicaid prescriptions of the three study pharmacies. We also had planned to calculate the average time to payment for Medicaid prescription claims before and after the managed care transition, but were unable to do these analysis since the date of payment for each claim was not readily available from the pharmacies. It would have put considerable data collection burden on the pharmacies to provide us with these data, plus the timeliness of payment problem seemed to be limited to the transition period as it did not come up during phase II of the study.

A final limitation is that we did not factor wholesaler rebates or 340B pricing into our product costs. Both of these factors would lower pharmacy product costs, so the average gross margins likely would have been somewhat higher if information on these discounts were available and factored into the analyses.

Conclusions

The Iowa Medicaid transition to a privately run managed care program has been a negative experience for pharmacies. The early transition period was particularly problematic, but many issues remained over a year after the transition. Respondents reported many communication and logistics problems with the managed care plans and these problems are exacerbated by having multiple managed care plans. Under the previous state-run system, pharmacies had one organization to contact with any problems whereas now they have multiple organizations. After we completed the main data collection for our study, one of the managed care plans decided to suddenly exit the program due to a lack of profitability. Immediately following the plan's exit, the remaining two plans did not have sufficient capacity to take on all the plan's members, so some members were temporarily returned to the state-run program, likely creating additional confusion. The state has chosen an additional managed care plan that will begin enrolling patients next year, so there likely will always be multiple plans.

The formulary was not supposed to change following the Medicaid managed care transition and all plans were supposed to use the same formulary, although each was allowed to establish their own prior authorization processes. However, we found that pharmacies reported many formulary issues and had difficulty determining what was covered, particularly for OTC products. Some of the formulary issues reported in the interviews were problems that also occurred in the previous state-run Medicaid program (e.g. some brand name products preferred over generic products) but there did seem to be new challenges with determining which products were covered under the managed care plans.

Problems with managed care plan coverage of durable medical equipment (DME) was a consistent theme in our results. Pharmacies reported problems getting DME contracts and many problems with DME reimbursement. Non-pharmacy suppliers of DME also have reported problems with DME reimbursement (Clayworth 2018) so this is an important topic for future research.

Prescription gross margins under the Medicaid managed care plans were remarkably stable, due in large part to efforts by the Iowa Pharmacy Association (IPA) to maintain the same reimbursement formula. However, there is likely to be ongoing pressure by the managed care plans to allow them to reduce pharmacy reimbursement. Study participants reported that the Medicaid managed care program has created additional costs for pharmacies, so it is important to maintain the existing reimbursement rates.

References

- Balick R (2018). Pharmacists fume over slashed Medicaid reimbursement rates. *Pharmacy Today*. 24(7):40-14.
- Clayworth (2018, April 8). How privatized Medicaid is systematically denying hundreds of disabled Iowans the medical equipment doctors say they need. *Des Moines Register*.
<https://www.desmoinesregister.com/story/news/investigations/2018/04/08/privatized-medicaid-denying-hundreds-disabled-iowans-medical-equipment/1069296001/> Accessed August 1, 2018.
- Huff C. (July/August 2014). DME requests pose practice problems. *ACP Internist*.
<https://acpinternist.org/archives/2014/07/dme.htm>. Accessed July 30, 2018.
- Kennedy K. (2017, February 9). Illinois Issues: Has the managed care option helped Medicaid patients? *National Public Radio Illinois*. <http://www.nprillinois.org/post/illinois-issues-has-managed-care-option-helped-medicaid-patients#stream/0>. Accessed July 27, 2018.
- McCluskey PD. (2018, February 28). Health care providers brace for confusion as new Mass. Medicaid rules are rolled out. *Boston Globe*.
<https://www.bostonglobe.com/business/2018/02/28/masshealth/SUZzc5Hjcn17891Zfah4GN/story.html>. Accessed July 27, 2018.
- Murry L et al. (2018). Third-party reimbursement for generic drugs: The prevalence of below-cost reimbursement in an environment of maximum allowable cost-based reimbursement. *Journal of the American Pharmacists Association*. 58:421-425
- Musumeci MB, Rudowitz R, Ubri P, Hinton E. (2017, January 31). An early look at Medicaid expansion waiver implementation in Michigan and Indiana. *The Henry J. Kaiser Family Foundation*.
<https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/> Accessed July 27, 2018.
- Olsen D. (2018, April 29). Medicaid managed-care reboot pinching pharmacies, advocates say. *The State Journal-Register*. <http://www.sj-r.com/news/20180429/medicaid-managed-care-reboot-pinching-pharmacies-advocates-say>. Accessed July 30, 2018.
- Ramsey D. (2015, August 16). DHS letters to Medicaid beneficiaries were vague, confusing and poorly marked; almost 50,000 lost coverage. *Arkansas Times*.
<https://www.arktimes.com/ArkansasBlog/archives/2015/08/16/dhs-letters-to-medicaid-beneficiaries-were-vague-confusing-and-poorly-marked-almost-50000-lost-coverage>. Accessed July 27, 2018.
- Urick B et al. (2014). Assessing changes in third-party gross margin for a single community pharmacy. *Journal of the American Pharmacists Association*. 54:27-34.
- Young K, Garfield R. (2018 February). Issue Brief: Snapshots of recent state initiatives in Medicaid prescription drug cost control. *The Henry J Kaiser Family Foundation*.
<http://files.kff.org/attachment/Issue-Brief-Snapshots-of-Recent-State-Initiatives-in-Medicaid-Prescription-Drug-Cost-Control>. Accessed July 30, 2018.