Alabama Medicaid Pharmacist

Published Quarterly by Health Information Designs, Inc., Summer 2010 — A Service of Alabama Medicaid

PDL Update

Effective July 1, 2010, the Alabama Medicaid Agency updated the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions
Besivance—EENT Preparations/ Antibactericals	Pramox—Skin and Mucous Membrane Agent
	Optivar—EENT Preparations/ Antiallergic Agents

**denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

Also effective July 1, the Alabama Medicaid Agency will add the First Generation Antihistamines to the Preferred Drug List (PDL). Non-preferred brands in this class require prior authorization (PA) for payment. The Preferred Drug List (PDL) will be updated to reflect these changes. The criteria for the First Generation Antihistamines can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA.

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Reminder

Please fax all prior authorization and override requests *directly* to Health Information Designs at 800-748-0116. If you have questions, please call 800-748-0130 to speak with a call center representative.

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HID Help Desk

Monday—Friday

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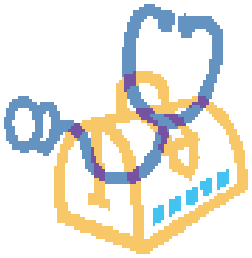
Healthcare Reform



On March 23, 2010, the Patient Protection and Affordable Care Act and subsequent Reconciliation Act (collectively termed Affordable Care Act or ACA) was signed into law. Healthcare providers will see many changes with this new healthcare reform bill.

How will this affect Alabama Medicaid?

First, the healthcare legislation opens up coverage to more people, including those non-Medicare eligible individuals under the age of 65 with incomes up to 133% of the federal poverty level (FPL). This will greatly increase the number of recipients covered.

There will be services called 'essential health benefits' that must be offered to recipients – these benefits will have no lifetime dollar limit, and beginning January 2014, there will be no annual dollar limits. The essential health benefits are listed below.

- Hospitalizations
- Emergency services
- Maternity and newborn care
- Mental health/substance abuse disorder services
- Prescription drugs
- Chronic disease management

By October 1, 2010, all Medicaid programs will be required to cover smoking cessation treatments (including both prescription and OTC products) for pregnant women. Beginning January 2014, Medicaid programs will be required to cover smoking cessation medications for all patients. Alabama Medicaid currently provides smoking cessation coverage for pregnant women.

There are many changes to the Medicaid Federal drug rebate program, retrospectively effective back to January 2010, including a federal rebate increase for most brand drugs from 15.1% to 23.1% of average manufacturer price (AMP), and an increase of federal rebate for non-innovator, multiple source drugs from 11% to 13%, with several exceptions for line extensions, drugs approved by the FDA for only pediatric use, and blood clotting factors. 100% of all new/increased rebate amounts will be recaptured by the federal government, while the new rebate provisions are expected to negatively affect States with supplemental state rebates (usually related to PDLs). New rebate requirements related to States with Managed Care Organizations (MCOs) were effective upon signing of ACA, March 23, 2010. States continue to coordinate with CMS as guidance dissemination on the new rebate provisions is ongoing.

Medicaid programs will have to create a new state plan option to permit patients with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home.

There are many changes that affect Medicare Part D, as well. By 2020 the donut hole (the coverage gap when recipients have to pay for their own medications) will be phased out. Also, beginning in 2011, all Part D plans must include coverage for all drugs in the following categories: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressant agents for treating transplant rejections.

References:

1. Kaiser Family Foundation. Focus on Health Reform: Summary of New Health Reform Law. Publication #8061. Accessed 05/17/2010 at www.kff.org.
2. Kaiser Family Foundation. Focus on Health Reform: Medicaid and Children's Health Insurance Program Provisions in the New Health Reform Law. Publication #7952-03. Accessed 05/17/10 at www.kff.org.
3. Healthcare reform highlights. Pharmacist's Letter/Prescriber's Letter 2010;26(5):260511.

Alabama Medicaid Receives Performance Bonus

In December 2009, Governor Bob Riley announced that the Alabama Medicaid Agency has received a $39.1 million federal performance bonus for the effectiveness of its innovative and user-friendly methods to enroll more low-income children in Medicaid during the 2009 Fiscal Year. Alabama is one of only nine states receiving a performance bonus from the U.S. Department of Health and Human Services.

Governor Riley said, "Ensuring the health of our children is essential to the future of our state. By taking advantage of this opportunity, Alabama Medicaid has made it possible for more children who qualify for Medicaid to access basic health services. The fact that Alabama is one of only nine states receiving a performance bonus, and we are receiving the largest bonus, demonstrates the effectiveness of our innovative program."

While nine states qualified for a performance bonus, Alabama received over half of the $72.6 million awarded. Other states receiving bonuses included Alaska, Illinois, Louisiana, Michigan, New Jersey, New Mexico, Oregon and Washington.

The bonus, awarded by the U.S. Department of Health and Human Services, is one of nine awarded nationally to recognize states which had implemented at least five of eight program features known to promote enrollment and retention in children's health insurance coverage and had increased state Medicaid enrollment above a target set by federal law. The bonus payments were part of the 2009 Children's Health Insurance Program Reauthorization (CHIPRA) legislation signed into law in February 2009.

"One of the primary goals of the CHIPRA legislation was to boost enrollment among eligible, uninsured children, especially those who were qualified for Medicaid," said Alabama Medicaid Commissioner Carol H. Steckel. "Thanks to the many efforts of our eligibility staff and a strong partnership between ALL Kids and the Alabama Child Caring Program, more Alabama children will benefit from Medicaid-covered health care services."

The amount of the payment was calculated based on the level of enrollment success and per capita State Medicaid expenditures for children. States were also eligible for an enhanced payment once they exceeded a certain percentage enrollment increase. Alabama was the only state to reach this threshold, increasing enrollment by 39 percent. To qualify, the changes had to be implemented by both Medicaid and ALL Kids, the states' CHIP program.

Program features implemented in Alabama included providing 12 months of continuous enrollment, removing the requirement for an in-person interview in order to qualify for coverage, streamlining the eligibility renewal process, removal of asset limits for pregnant women and children, and use of a joint application between Medicaid, ALL Kids and Blue Cross Blue Shields' Caring Foundation.

Clostridium Difficile Treatment Guidelines

C. difficile is a gram positive, spore forming, toxin-producing anaerobic bacteria. It is the most common cause of infectious diarrhea in North America. *C. difficile* infections have been on the rise, and a recent study found that rates of *C. difficile* infections have surpassed methicillin-resistant *Staphylococcus aureus* (MRSA) infections in some community hospitals.

Symptoms of a *C. difficile* infection include: watery diarrhea, fever, loss of appetite, nausea, and abdominal pain/tenderness. The clinical definition of a *C. difficile* infection is the occurrence of three or more unformed stools in 24 hours or less with a positive stool test for the presence of *C. difficile* toxins. Most patients who contract a *C. difficile* infection have had antibiotics, antineoplastic agents, or a long stay in a healthcare facility. Antibiotic use is most strongly associated with development of a *C. difficile* infection, because antibiotic agents suppress normal bowel flora, allowing *C. difficile* to flourish. Antibiotics most commonly implicated include clindamycin, penicillins, second- and third-generation cephalosporins, and fluoroquinolones. Patients taking multiple antibiotics are also at higher risk for developing a *C. difficile* infection.

Updated Guidelines for treatment of C. difficile released by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA).

C. difficile is shed in feces and any surface, device or material that becomes contaminated with the spores may transmit the infection. Prevention of transmission is vitally important in keeping this type of infection under control. Surfaces should be kept clean (with a mixture of one part bleach to ten parts water) and hands should be washed with soap and water (alcohol-based hand sanitizers are not effective for removing *C. difficile* spores). Barrier precautions (masks, gloves, etc.) should be used when treating patients known to be infected with *C. difficile*.

Treatment of *C. difficile* should begin with discontinuation of any antibiotic that the patient is taking. In cases of mild *C. difficile* in otherwise healthy patients, discontinuation of the antibiotic results in resolution of diarrhea in 25% of patients. For patients with an initial episode of *C. difficile* of mild to moderate severity (WBC 15,000 or lower and SrCr less than 1.5 times baseline) metronidazole 500mg PO 3 times a day for 10 to 14 days is the preferred regimen. For patients with a severe initial episode (WBC 15,000 or greater and SrCr 1.5 times or greater versus baseline) vancomycin 125mg PO 4 times a day for 10 to 14 days is preferred. In patients with a severe, complicated initial episode (WBC 15,000 or greater and SrCr 1.5 times or greater versus baseline with hypotension/shock, ileus, or megacolon), the recommended treatment is vancomycin 500mg PO/NG 4 times a day for 10 to 14 days with or without metronidazole 500mg IV every 8 hours. Use of antimotility agents (such as loperamide) should be avoided because they prevent toxin elimination and can cause toxic megacolon.

Unfortunately, recurrence of *C. difficile* infections is common and can occur in up to 25% of patients. For the first recurrence, the same treatment regimens should be followed. For the second recurrence, it is recommended that patients follow a regimen of tapered and/or pulsed oral vancomycin. It is thought that by giving vancomycin in gradually reduced dosages, or in pulses, the pathogenic forms of *C. difficile* will be inhibited while the normal gastrointestinal flora is restored.

Although administration of probiotics as been advocated as a way to prevent patients on antibiotics from developing *C. difficile* infection, there have been few studies to support that theory. Recently, a randomized trial showed that ingestion of a specific type of probiotic reduced the risk of *C. difficile* infection in patients more than 50 years of age who were prescribed antibiotics and who were able to take food and drink orally. However, this conclusion was based on a small number of patients in a highly selected population and more studies will be needed before this practice can be recommended.

References:

1. Cohen SH, Gerding DN, Johnson S, et al. Clinical practice guidelines for *Clostridium difficile* infections in adults: 2010 update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA). Infect Control Hosp Epidemiol 2010:31. Available at www.journals.uchicago.edu. Accessed May 24, 2010.
2. Prevention and treatment of *Clostridium difficile*. Pharmacist's Letter/Prescriber's Letter 2010;26(5):260509.
3. Centers for Disease Control and Prevention Information for Healthcare Providers: *Clostridium difficile*. Available at www.cdc.gov. Accessed May 24, 2010.

E-prescribing and Controlled Substances

In March 2010, the Drug Enforcement Agency (DEA) issued an interim final rule with request for comment on the issue of prescribing controlled substances electronically. This rule will become effective during the summer of 2010.

This rule gives prescribers the option of issuing controlled substance prescriptions electronically and allows pharmacists to receive, dispense, and archive them.

Listed below are the steps that providers will need to take before using e-prescribing for controlled substances:

For Prescribers:

- Your electronic health record software will need to comply with the DEA's requirements. The software vendor will verify this and issue a report saying that the software is compliant.
- Two forms of identification will be required to sign e-prescriptions for controlled substances. This is to provide extra security, to prevent hacking and unauthorized use of the application. Providers must use two out of the three authentication devices listed:
    - Something you have, like a USB key.
    - Something you know, like a pin or a password.
    - Physiologic identifier, like a fingerprint.

At the time the rule becomes effective, only the prescriber's identity will be verified, and not the DEA number.

For Pharmacists:

- Your e-prescribing software has to be compliant with the DEA's new requirements. The software vendor will verify this and issue a report saying that the software is compliant.
- Pharmacy application service providers must back up files daily. Also, although it is not required, the DEA recommends as a best practice that pharmacies store their back-up copies at another location to prevent the loss of the records in the event of natural disasters, fires, or system failures.
- Once a prescription is created electronically, all records of the prescription must be retained electronically. As is the case with paper prescription records, electronic controlled substance prescription records must be kept for a minimum period of two years.

References:

1. U.S. Departments of Justice Drug Enforcement Administration Office of Diversion Control. Electronic Prescriptions for Controlled Substances. Accessed May 17, 2010 at www.deadiversion.usdoj.gov/ecomm/e_rx/faq/faq.htm.

2. E-prescribing controlled substances. Pharmacist's Letter/Prescriber's Letter 2010;26(5):260501.

Governor Riley signs General Fund budget, FMAP extension pending

State lawmakers wrapped up the 2010 regular session by passing a General Fund budget totaling $345 million toward Medicaid's $5.2 billion budget for FY 2011. Gov. Bob Riley signed the budget into law on April 21, a day before legislators adjourned the annual session.

In addition to passage of the General Fund and education budgets, legislators approved a one-year Nursing Home Privilege Tax to provide funds needed by the state's Medicaid program. The newly-approved General Fund budget, which takes effect Oct. 1, 2010, effectively maintains the Alabama Medicaid program for another year, although $196 million in the budget's revenue stream is contingent on approval of a federal matching rate extension now pending before Congress.

The $1.6 billion General Fund budget includes a $37 million increase in state funding for Medicaid along with a $35 million allocation to Medicaid for FY 2011 from the Children First Trust Fund.

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