Partnership for Medicaid

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National Hispanic Medical Association

National Rural Health Association

Controlling Pharmaceutical Costs through Greater Efficiencies and Better Administration of the Drug Rebate Program*

The current Medicaid drug pricing mechanism could be made more efficient to ensure that Medicaid is getting as low a price as possible given its buying volume.

Concern exists about the high levels of spending on drugs in Medicaid. Given that, proposals that would ensure that Medicaid pays a fair price for drugs given its extensive buying power are important.

It is also important that current reform proposals accurately reflect the costs incurred by pharmacists for the acquisition and dispensing of pharmaceuticals. These proposals could include initiatives to change reimbursement mechanisms and increase the level of rebates paid by manufacturers. Moreover, proposals to strengthen the administration of the drug rebate program and extend the Medicaid drug rebate to managed care plans are important and could yield additional savings. These efforts would help extend the rebate program to the 10 million Medicaid beneficiaries who receive their drugs through managed care.

*The ideas and opinions expressed in this document reflect the contributions of individual members of the Partnership. While every effort has been made to achieve consensus among all members, the ideas expressed in this document are not necessarily those of, nor are they endorsed by, any particular member organization(s) of the Partnership.

BACKGROUND

Medicaid fee-for-service and managed care spent an estimated $29.7 billion in FY 2002 on pharmaceuticals[1]. Prescription drugs are one of the fastest growing categories of Medicaid expenditures having quadrupled between 1992 and 2002. Between 2000 and 2002, spending on drugs increased by 18.8% per year, faster than any other major type of Medicaid service. In 1998, less than 8% of Medicaid expenditures were for drugs -- by 2002 drugs claimed over 11%. After 2006 drugs for Medicare beneficiaries will be paid for by Medicare. These recipients currently account for about half of all Medicaid drug spending. State Medicaid programs will still be responsible for the drug costs of children and families and other non-Medicare eligibles.

Drugs are paid for by Medicaid through three separate mechanisms. First, the state pays the pharmacists for the ingredient costs of the drug. Typically, states pay the pharmacists based on the average wholesale price (AWP) less some percentage. AWP is the average list price that a manufacturer suggests wholesalers charge pharmacies. The **Congressional Budget Office (CBO) estimated that Medicaid paid on average $60.90 per prescription while the actual acquisition costs to the pharmacists were only actually $47.10, leading to a difference of $13.80 per prescription[2]**.

Second, the states pay the pharmacists a dispensing fee which typically ranges from $3 to $5 per prescription. This fee is expected to cover a wide range of services associated with dispensing drugs to Medicaid patients. The need to adequately reimburse pharmacists for these services was recognized by Congress under the Medicare Modernization Act of 2003, which included a provision requiring Medicare Part D drug plans to reimburse pharmacists for "medication therapy management services" administered to patients with multiple chronic conditions.

Third, states receive a rebate directly from the manufacturers based on their utilization. The brand name rebate is the greater of a flat rebate amount of 15.1% of average manufacturers price (AMP) or the difference between AMP and the best price offered to any non-governmental buyer. Manufacturers have to pay an additional rebate if their drug prices have risen faster than the rate of general inflation. In addition, some states have entered into supplemental rebate agreements with manufacturers in return for putting their drugs on a preferred drug list. CBO estimates that the average rebate received by the states equaled 31.4% of AMP with the average basic rebate of 19.6% and the inflation adjustment rebate equal to 11.7%. States also receive a rebate on generic drugs of 11% of AMP. In return for the rebates, states must provide access to all FDA-approved drugs, although they may and do have extensive prior authorization programs, step therapy, limited prescriptions per month and copayments.

Medicaid managed care plans do not receive the statutory rebate levels, and instead must negotiate rebates on their own.

ISSUES TO CONSIDER

Administration of the Rebate Program is Inadequate – The Government Accountability Office had found significant shortcomings in the Centers for Medicare and Medicaid Services' (CMS) administration of the Medicaid drug rebate program, including lack of clear guidance to manufacturers for determining AMP, poor reporting of certain group purchase prices in setting "best price" levels, and limited audits of manufacturer price setting methods.[3] Moreover, the

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[1] Brian Bruen and Arunabh Ghosh, "Medicaid Prescription Drug Spending and Use," Kaiser Commission on Medicaid and the Uninsured, June 2004.
[2] Congressional Budget Office, "Medicaid's Reimbursement to Pharmacies for Prescription Drugs," December, 2004.
[3] *Medicaid Drug Rebate Program: Inadequate Oversight Raises Concerns about Rebates Paid to States* (GAO-05-102), February 2005.

Health and Human Services (HHS) Office of the Inspector General (OIG) recently found that CMS's failure to add qualified new drugs to the Federal upper limit list had resulted in state Medicaid programs paying more than they otherwise would have for these drugs.[4]

Reimbursement is not Reflective of the True Costs of Drugs and Pharmacy Services – As the CBO has recently pointed out, the states' use of AWP to set the average acquisition price allows for a markup in medication costs, especially for newer generic and brand name drugs which have a high AWP, while the actual acquisition price is often lower. The President's proposal would eliminate the AWP-based system. The dispensing fee is also considered by many to be inadequate for reimbursing pharmacists for the range of services they provide. These services may include managing inventory, counseling patients on proper medication use, and complying with federal and state regulations, in addition to storing, warehousing, and dispensing the drug. Without an adequate dispensing fee, some pharmacies may elect not to participate in Medicaid rather than assume financial loss.

Open Formularies – While Medicaid programs can use prior authorization and step therapy to drive utilization away from higher cost brand name drugs, almost all other large insurers can also use substantial copayments and closed formularies to control costs and utilization.

Exemption for Managed Care Plans Inefficient – Over 10 million Medicaid beneficiaries receive their drugs through Medicaid managed care plans which do not have access to the Medicaid drug rebate. Under the drug rebate, States receive between 18 and 20% discount on brand name drug prices and between 10 and 11% for generic drug prices. According to a study by the Lewin Group, Medicaid-focused managed care organizations (MCOs) typically only receive about a 6% discount on brand name drugs and no discount on generics. Because many MCOs (particularly smaller Medicaid-focused MCOs) do not have the capacity to negotiate deeper discounts with drug companies, Medicaid is overpaying for prescription drugs for enrollees in Medicaid health plans.

POTENTIAL SOLUTIONS

Tighten Administration of the Rebate Program – Inconsistent and inaccurate calculations of AMP, best price, and other components of the rebate formula have cost Medicaid millions of dollars. By improving CMS oversight over the program and increasing manufacturer accountability over proper calculation of rebates, Medicaid would reap the full benefits of the Medicaid drug rebate program.

Increase the Basic Level of Rebate – CBO has estimated that setting the basic rebate level at 23% would result in savings of $3.2 Billion over five years. Available information supports setting the rebate at a higher level than it is at today.

Payment for Pharmaceuticals and Pharmacist Services Should Be Realigned to Reflect True Costs – Both the Bush Administration and the National Governors Association have stated that the prices states pay for pharmaceuticals should be based on a price that is closer to actual acquisition costs. Likewise, reimbursement for pharmacists' services should be increased to reflect their increased role in managing medication-based therapies, counseling patients, and providing other critical pharmacy services to Medicaid patients.

Encourage Evidence-Based Formularies – Medicaid Pharmacy and Therapeutics Committees (P&T) should invite clinicians to participate in designing formularies. Effectiveness, not cost, should be the main objective when developing formularies. A lower cost drug will not necessarily result in a lower quality of care; and a higher cost drug may not necessarily result in greater effectiveness for an individual patient. Well-designed evidence-based formularies that take into

[4] *Addition of Qualified Drugs to the Medicaid Federal Upper Limit List* (OEI-03-04-00320), December 2004.

account comparative effectiveness data have the potential to provide access to high quality, cost-effective medications.

Allow Medicaid Managed Care Plans to have Access to the Drug Rebate for Non-340B Drugs – All Medicaid beneficiaries should have their drug costs reduced to the maximum extent possible, either by the Medicaid rebate or by the 340B program. While recognizing that managed care plans should have access to the Medicaid drug rebate, it is also important to be mindful of the need to protect the pharmaceutical industry and 340B-covered entities from the risk of creating a "duplicate discount" due to the overlap of the rebate and the 340B programs.

- RECOMMENDATIONS -

- Tighten Administration of the Rebate Program
- Increase the Basic Level of Rebate
- Payment for Pharmaceuticals and Pharmacist Services Should Be Realigned to Reflect True Costs
- Allow Medicaid Managed Care Plans to have Access to the Drug Rebate for Non-340B Drugs
- Encourage Evidence-Based Formularies