

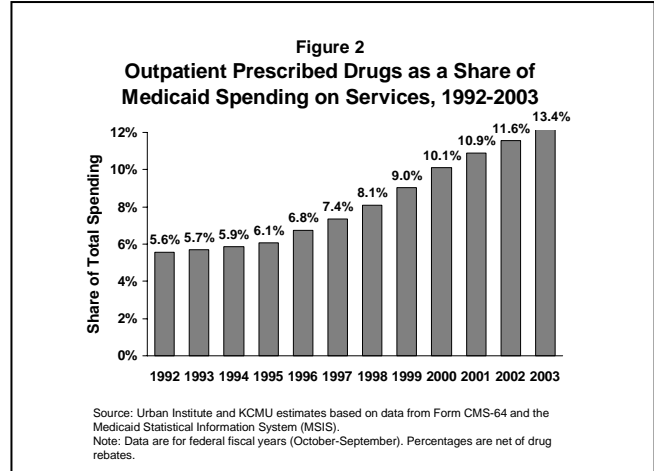
Medicaid and Outpatient Prescription Drugs

Medicaid is the major source of outpatient pharmacy services to the low-income population, particularly for those enrollees with chronic physical or mental illnesses that require drug therapy. In recent years, the aged and disabled eligibility groups made up roughly a quarter of beneficiaries but accounted for some 85% of Medicaid prescription drug spending. High prescription drug costs mean that low-income people who do not qualify for Medicaid coverage face considerable financial barriers to obtaining needed medications.

Medicaid's Coverage of Prescription Drugs

Medicaid is financed by federal and state funds and is administered by the states according to federal guidelines. Outpatient prescription drug coverage is an optional benefit that all Medicaid programs currently provide. Most Medicaid enrollees are covered by prepaid managed care plans where drug payments are included in the payments plans receive from the state.

In 2003, Medicaid spent \$33.9 billion for prescription drugs, including estimates of managed care drug spending (Fig. 1). This amount represented 13.4 % of total Medicaid spending on services for that year (Fig. 2).

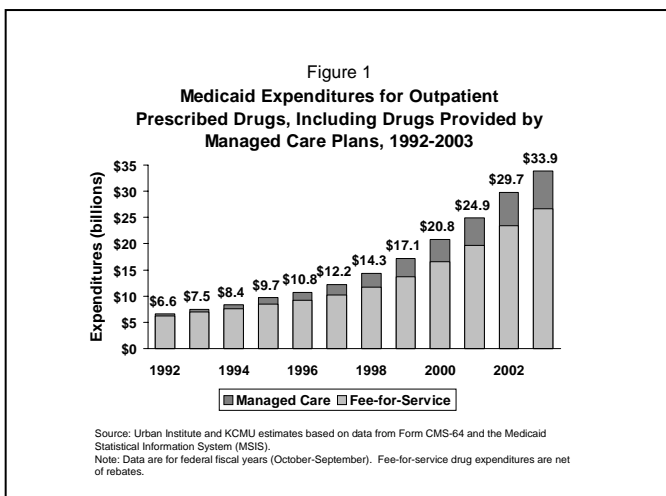


Managing Medicaid Drug Use and Costs

Rising prescription drug expenditures are a perennial challenge for all payers, including Medicaid programs. Higher drug costs and increased prescribing volume resulted in the fastest growth among Medicaid services between 2000 and 2003, spurring all states to implement various strategies to control drug expenditures.

Formularies. Most states maintain a Medicaid formulary or list of approved products. Formulary restrictions vary by state, but exclusions must be justified and excluded drugs must be available through prior authorization when necessary. Several states have preferred drug lists (PDLs), generally using prior authorization as an incentive both to prescribers to choose formulary drugs, and to manufacturers to offer discounts in order to ensure their products are on the list.

Prior Authorization. States have the option to require that prescribers or dispensers get permission before providing a Medicaid beneficiary a drug. States are required to make authorization decisions within 24 hours and to provide a 72-hour supply of a medication in emergencies. Many states exercised the prior authorization option in the past on a drug-by-drug basis. In recent years states have increasingly applied prior authorization systematically to their Medicaid drug formularies in order to create PDLs.



Drug Reimbursement. Medicaid payment for drugs includes three elements: ingredient costs, dispensing fees and manufacturer rebates. States typically reimburse ingredient costs at a discount off of a list price such as the average wholesale price (AWP). This has recently come under increased scrutiny amid charges that Medicaid is overpaying for drugs, even with increased discounts. Some states have also trimmed dispensing fees.

Drug Rebates. In order for a state to receive federal Medicaid matching funds for a drug, the manufacturer must have signed an agreement with the Secretary of HHS stating that it will rebate a portion of payments to the government. In return, Medicaid must cover almost all prescription drugs manufactured by a company that has signed an agreement. Some states require manufacturers to pay supplemental rebates in addition to the federal rebate.

Caps and Cost Sharing. Most states have limits on the number of concurrent prescriptions (as few as three in some states), amount of drug supplied at one time or number of refills allowed. States may also charge nominal copayments (\$.50-\$3.00). These strategies are permitted only for certain categories of beneficiaries as they may decrease both appropriate and inappropriate drug access. Reduced access to drug therapy has been linked to increased hospitalization and use of long term care.

Drug Utilization Review (DUR). States must perform prospective and retrospective DUR for Medicaid outpatient drugs. Prospective DUR, performed prior to dispensing a drug, is intended to reduce medication errors and adverse drug events such as drug interactions. Retrospective DUR reviews prescribing and dispensing history to identify safety and cost problems. Both strategies have been reported by some states as tools that can improve quality of care while controlling costs.

Generic Substitution. Most states now require that a generic version of a medication be substituted for the brand name drug when available. In some states, prescribers have the option to override the substitution by documenting that the branded version is medically necessary.

Purchasing Pools. A number of states have entered into pooling arrangements with other states, or have developed intrastate pools that purchase drugs for several state programs, such as state employee plans, education and corrections.

These arrangements are meant to increase bargaining power and administrative efficiency.

Disease Management. Several states are investigating or implementing programs to manage the care of high cost Medicaid beneficiaries. While not a drug cost or utilization control as it may actually increase drug spending by encouraging drug regimen adherence, disease management is an option states are exploring to control overall costs for targeted populations.

Medicaid Drug Coverage and Medicare

Medicaid provides important supplementary coverage for low-income Medicare beneficiaries. Medicare beneficiaries who receive cash assistance through the Supplemental Security Income (SSI) program (known as “dual eligibles”) generally qualify for Medicaid drug coverage. Medicaid currently pays for prescription drugs for over 6 million dual eligibles (representing 6% of overall Medicaid spending), but in 2006 their drug coverage will shift to Medicare Part D plans.

The implementation of the Medicare drug law has significant implications for Medicaid, in large part because drugs for dual eligibles will be purchased through Medicare. The mix and volume of drugs purchased by Medicaid will change, with implications for currently negotiated supplemental rebates. States will continue to finance a large share of drug expenditures for duals through payments to the federal government. Additionally, states may feel the need to wrap around Medicare formularies, which may not be as comprehensive as Medicaid's, spending that will not be eligible for federal matching funds.

Future Challenges for Medicaid's Drug Benefit

Spending growth for prescription drugs has been notable for all payers, including Medicaid, prompting proposed or implemented responses such as adjustments to the prices paid for drugs, increased cost sharing and greater use of limits or caps, and changes to eligibility. In addition, the Medicare drug law will affect Medicaid's drug purchasing and access to drugs for dual eligibles. As the program evolves, preserving beneficiary access to critical services, including drug therapy, and constraining drug costs will remain major challenges for Medicaid.

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