kaiser commission on MEDICAID FACTS
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THE HENRY J. KAISER FAMILY FOUNDATION

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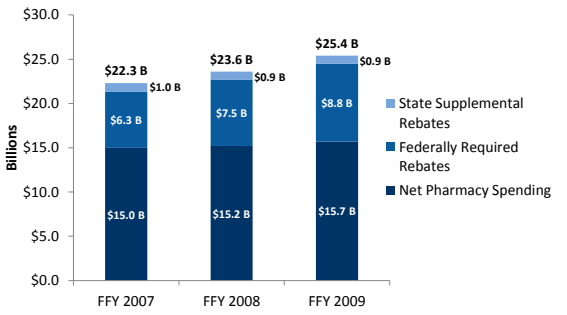
Medicaid Payment for Outpatient Prescription Drugs

Medicaid is the major source of outpatient prescription drugs for the low-income population. The program plays a critical role for enrollees with chronic physical or mental illnesses that require drug therapy and is the largest source of coverage for people with HIV/AIDS, a group with a particularly acute need for prescription medications.

Rising prescription drug expenditures are a perennial challenge for all payers, including state Medicaid programs. Outpatient prescription drug coverage is an optional benefit that all states currently provide. Both higher costs and increased prescribing volume have resulted in growth in spending. In 2009, Medicaid spent $25.4 billion in federal and state funds for prescription drugs (Fig. 1), excluding managed care spending and spending on specialty drugs, such as high-cost injectable therapies, covered under the program's medical benefit. This amount represented 6.6% of total Medicaid spending on all services for that year and 10% of total prescription drug spending in the United States.

FIGURE 1

U.S Medicaid Pharmacy Spending & Rebate Revenue Federal Fiscal Years 2007 - 2009



SOURCE: Financial Management Report for FY 2002 through FY 2009, CMS-64 Quarterly Expense Report, available at http://www.cms.gov/MedicaidBudgetExpendSystem/02_CMS64.asp

In 2006, Medicaid drug coverage for beneficiaries also eligible for Medicare ("dual eligibles") moved to Medicare Part D plans. States continue to finance a portion of drug coverage for dual eligibles through "clawback" payments to the federal government. Some states also wrap around Medicare coverage, which may not be as comprehensive as Medicaid's, and this spending is not eligible for federal matching funds.

Medicaid Reimbursement for Drugs

States' methods of setting pharmacy reimbursements for drugs vary a great deal and evolve over time. Many enrollees are covered by Medicaid managed care plans in which drug payments are included in the capitated payments that plans receive from states. However, some states carve out prescription drug benefits from managed care plans and pay for them on a fee-for-service basis.

Medicaid Reimbursement for Fee-for-Service Drugs

In states' fee-for-service programs, payments for drugs include three major elements: ingredient costs, dispensing fees, and manufacturer rebates.

Ingredient Costs. Most states reimburse ingredient costs based on list prices, such as a discount of the average wholesale price (AWP) or a markup of the wholesale acquisition cost (WAC). Exact discounts or markups vary across states. While a majority of states use AWP, its validity has come under scrutiny amid claims that it is arbitrarily inflated, and the vendor that most states use to set AWP rates will stop publishing these prices in 2011. Alabama and Oregon have begun to use a new benchmark, average acquisition cost (AAC), which bases payments on actual drug costs obtained from surveys of pharmacies. The Center for Medicare and Medicaid Services is developing a national database of pharmacies' acquisition costs for states' use. Regardless of pricing method, ingredient costs of brand name drugs are much higher than those of generic drugs. While brand name drugs represent less than 30% of prescriptions, they account for nearly 80% of ingredient costs of drugs that Medicaid pays for on a fee-for-service basis.[1]

Dispensing Fees. States pay pharmacies a dispensing fee for costs that are in excess of ingredient costs and are associated with dispensing drugs to beneficiaries. These fees also vary widely across states, and some states have trimmed dispensing fees as a cost-saving measure.

Manufacturer Rebates. For the costs of a drug to qualify for federal Medicaid matching funds, manufacturers must sign an agreement with the Secretary of HHS stating that they will rebate a specified portion of the Medicaid payment for drugs to the states, which in turn share the rebates with the federal government. In return, Medicaid must cover almost all FDA-approved drugs that those companies produce. Some states require manufacturers to pay supplemental rebates in addition to the federally required rebate. The Affordable Care Act (ACA) includes provisions that increase federal minimum drug rebates and that require manufacturers to pay rebates

[1] *State Drug Utilization Data*, CMS, CY 2009, available at: http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp and *Drug Product Data* available at: http://www.cms.gov/MedicaidDrugRebateProgram/09_DrugProdData.asp for drug type identifiers.

to states for drugs purchased for beneficiaries by managed care plans with capitated payment arrangements.

Managing Medicaid Drug Use and Costs
States have considerable flexibility when administering Medicaid prescription drug benefits. Their options include a variety of strategies to control expenditures; Figure 2 lists strategies that states have most commonly adopted.

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 brand version is medically necessary.

Prior Authorization. States can require that prescribers or dispensers get permission before providing a Medicaid beneficiary with a drug. States must make authorization decisions within 24 hours and provide a 72-hour supply of a medication in emergencies. States have increasingly and more systematically applied prior authorization to their formularies in order to create preferred drug lists (PDLs). PDLs include drugs that are covered without prior authorization. States use PDLs as an incentive to prescribers to choose formulary drugs because they can avoid having to seek prior authorization. States also use PDLs as an incentive to manufacturers to offer discounts in return for placing their products on the list.

Formularies. Most states also maintain a Medicaid formulary or list of approved products. Formulary restrictions vary by state, but exclusions must be justified and available through prior authorization when medically necessary. Medicaid managed care plans also use formularies to control utilization and obtain discounts from drug manufacturers. Managed care plans' formularies may differ from those of states' fee-for-service programs, typically covering fewer drugs, particularly brand name products, than states' PDLs.

Maximum Allowable Cost Programs. Nearly all states set Maximum Allowable Cost (MAC) rates that cap the prices that they will pay for drugs. States are allowed to set their own MAC rates, but they must fall within federal limits.

Purchasing Pools. A number of states have entered into purchasing pools 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.

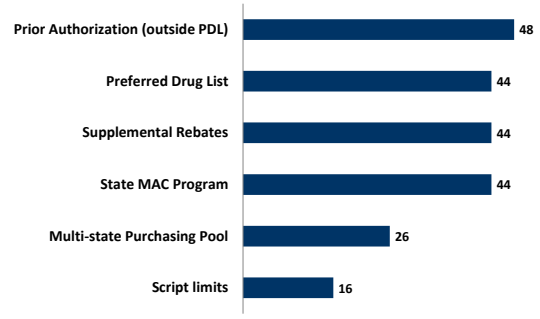
Disease Management. Disease management programs better coordinate care for enrollees with chronic conditions and improve adherence to evidence-based best practices through specialized treatment plans and enrollee support. While not a drug cost or utilization control, as it may actually increase drug spending by encouraging drug regimen adherence, disease management is an option states are exploring to control overall costs for high-cost populations.

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

Script Limits. 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.

Cost Sharing. States may establish nominal copayments ($.65-$3.65) for beneficiaries. Under the Deficit Reduction Act of 2005, states can also charge up to 20% coinsurance on non-preferred drugs for beneficiaries above 150% FPL, but very few states do so. These strategies are only permitted for certain categories of beneficiaries.

FIGURE 2
Medicaid Pharmacy Cost Containment Measures in Place in FY 2010



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

Future Challenges for Medicaid's Drug Benefit
To control costs, states are striving to increase generic dispensing rates and examining new methods of setting ingredient cost reimbursements, such as AAC, that reflect actual acquisition costs. States are also focused on controlling the cost of mental health drugs, such as atypical antipsychotics, and specialty drugs by improving care management and negotiating deeper discounts. Understanding the effects of differences between fee-for-service and managed care pharmacy benefits will also be important, especially as states enroll more complex and vulnerable groups in managed care. In sum, preserving beneficiaries' access to necessary prescription drugs while constraining costs will be an ongoing challenge.

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