The Florida Senate

Interim Project Report 2005-141 *November 2004*

Committee on Health Care Senator Durell Peaden, Jr., Chair

REVIEW OF MEDICAID PRESCRIPTION DRUG PRICING

SUMMARY

Prescription drug spending is estimated to be almost 20 percent of overall Medicaid spending in Florida in FY 2003-04. The Florida Medicaid program will spend an estimated $2.64 billion on prescription drugs in FY 2004-05. The way that prescription drugs are priced has become a central issue for state Medicaid programs. This report looks at prescription drug pricing, distribution, and reimbursement in the U.S., specifically for state Medicaid programs. Although it is an optional benefit under federal Medicaid law, all states currently provide coverage for outpatient prescription drugs to all categorically eligible individuals and most other enrollees within their Medicaid programs. The bulk of Medicaid prescription drug spending is for elderly and disabled enrollees, including many who are also eligible for Medicare. These populations are more likely to use prescription drugs and are also more likely to have a larger number of prescriptions filled each month.

When looking at the total amount a state Medicaid program pays for outpatient drugs, it is necessary to consider the payments made to providers for prescription drugs and the rebates received from manufacturers that offset what Medicaid pays. This report focuses primarily, however, on Medicaid drug reimbursement for outpatient drugs purchased by the fee-for-service component of Medicaid.

Staff reviewed Florida's current reimbursement methodology and the changes made to the methodology during the 2004 Legislative Session. The state expanded its use of the maximum allowable cost (MAC) component of the methodology. The state also implemented changes to the wholesaler acquisition cost (WAC) and average wholesale price (AWP) components of the methodology to more accurately reflect the estimated acquisition costs of prescription drugs for the Medicaid program. The state MAC expansion has not been fully implemented, therefore it is too early to tell whether the predicted savings will be fully realized. The state has already realized savings in response to the changes made to the WAC and AWP formulas.

The changes made during the last Legislative Session as well as numerous other Medicaid pharmacy cost control initiatives in the last five years have helped, and will continue to help, control the Medicaid program's prescription drug budget. However, utilization continues to increase. This will be an important area on which the state should focus its cost control efforts in the future.

The report recommends monitoring and studying the expansion of the state MAC program and focusing cost control efforts on prescription drug utilization, with an initial focus on those recipients who are the greatest cost to the Medicaid program.

BACKGROUND

Medicaid

Medicaid is a health care program that is jointly funded by the federal, state, and county governments to provide medical care to eligible individuals. Medicaid is the largest program providing medical and health-related services to the nation's poorest citizens. Within broad national guidelines, which the federal government establishes, each of the states establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

Drug Expenditures

U.S. purchasers spent approximately $162.4 billion on prescription drugs in 2002, more than four times what they spent in 1990. Prescription drug spending is a relatively small proportion of overall health care spending, yet it is one of the fastest growing components of health care spending. Nationally, prescription drug spending increased 15.3 percent from 2001 to 2002, compared to a 7.7 percent increase for physician and clinical services and a 9.5 percent increase for hospital care.[1] The Federal Centers for Medicare and Medicaid Services (CMS) projects that prescription drug spending will be the fastest-growing sector in health care, growing 12.4 percent between 2003 and 2004, and that prescription drug expenditures will account for 11.6 percent of U.S. health expenditures in 2004.[2]

Florida Medicaid drug expenditures grew at an average annual rate of 14.7 percent between FY 1999-00 and FY 2002-03, and drug spending is estimated to be almost 20 percent of overall Medicaid spending in Florida in FY 2003-04. The Florida Medicaid program will spend an estimated $2.64 billion on prescription drugs in FY 2004-05. It is expected that drug costs will continue to grow as a percentage of Medicaid expenditures, due to rising drug costs, greater utilization of higher-cost drugs, and changes in medical practice toward greater use of drug therapies.

Prescription Drug Pricing, Distribution, and Reimbursement

The way that prescription drugs are priced has become a central issue for state Medicaid programs, whose budgets continue to grow at a rapid pace. The "true" cost of prescription drugs has grown increasingly ambiguous due to the inclusion of new stakeholders, more diverse incentive systems, greater competition, and more complicated pharmacy benefit structures. Drug prices are affected by various types of discounts and rebates on both the public and private side. Each drug sold by a manufacturer, therefore, is subject to multiple prices, and little is known about this pricing information.

The difficulty in tracking prescription drug prices is that there is a complicated distribution system which includes differences in classes, doses, and forms of drugs and between brand-name and generic versions of these drugs. One pricing mechanism, the AWP, has come under increased scrutiny and has been the subject of investigations, litigation, and legislative proposals. The AWP has become the starting point for determining prescription drug reimbursement for both private and public payers, including most state Medicaid programs. Many argue that as the AWP has evolved, it has moved so far from the actual acquisition prices for prescription drugs that it fails to serve as a meaningful benchmark.

The prescription drug industry is multifaceted, with a variety of manufacturing, distribution, and retail sales arrangements that differ by product, purchaser, and geographic region. Manufacturers usually work with wholesalers to warehouse and distribute their products, although they occasionally distribute their products directly to hospitals, physicians, or other entities. Wholesalers purchase large quantities of drugs from manufacturers and distribute them to suppliers, including retail pharmacies, pharmacy benefit managers,[3] hospitals, and physicians who then sell them to the general public. Almost 80 percent of all prescription drugs are purchased through wholesalers.[4] Retailers negotiate lower prices through the inclusion of discounts from wholesalers or rebates and free merchandise from wholesalers.

Just as there are different kinds of providers and institutions that buy drugs from manufacturers or wholesalers, there are different governmental and private entities paying for these drugs. In the private-purchaser sector, prescription drugs are purchased and distributed in several ways: 1) individuals without health care coverage pay out of their pockets; 2) individuals carry indemnity insurance that reimburses them after they have purchased a drug or they have HMO coverage that reimburses the pharmacy directly; 3) pharmacy benefit managers manage drug benefits for large groups of individuals, such as enrollees in

[1] CMS. 2004. National Health Care Expenditures Aggregate Amounts and Average Annual Percentage Change by Type of Expenditures, Selected Years 1980-2002. CMS, Office of the Actuary: National Health Statistics Group. http://www.cms.hhs.gov/statistics/nhe/.

[2] CMS. 2004. National Health Care Expenditures Projections 2002-2012. CMS, Office of the Actuary: National Health Statistics Group. http://www.cms.hhs.gov/statistics/nhe/projections-2002/highlights.asp.

[3] Some pharmacy benefit managers do not distribute prescription drugs to the general public; focusing solely on negotiating contracts and prices.

[4] HHS, Office of the Inspector General. 2001. *Cost Containment of Medicaid HIV/AIDS Drug Expenditures*. (OEI-05-99-00611)

group health insurance plans or for self-insured companies, and individuals can purchase through the benefit manager or a retail pharmacy; and 4) institutional purchasers such as hospitals and group or staff model HMOs own and operate their own pharmacies.

Public sector pricing is similar to private sector pricing in that many federal, state, and local purchasers are institutions like hospitals, nursing homes, health departments, and prisons that have their own pharmacies and negotiate discounts using group purchasing arrangements. For example the Department of Health (DOH), Bureau of Statewide Pharmacy Services, operates a mail order pharmacy and a drug warehouse that supplies pharmaceuticals to county health departments. The bulk drug purchases made by these entities are primarily for patients of county health departments. DOH also purchases drugs for the general population for emergencies such as hurricane disasters or drugs to combat bioterrorism. DOH is also responsible for the statewide drug contracts that state agencies use to purchase drugs.

The purchase and distribution of prescription drugs in the public sector also has its differences. For example, the Medicaid program covers most outpatient drugs and receives rebates from drug manufacturers and discounts from participating retail pharmacies. Yet, Medicaid receives these lower prices as a matter of Federal law, and prices are typically lower for all government programs. Since passage of the Veteran's Health Care Act of 1992, manufacturers must make drugs available to specified public purchasers at the Federal Supply Schedule price to have their products covered by Medicaid. The schedule is based on market transactions reported by manufacturers and may not be higher than the lowest price provided to private payers for outpatient drugs in the domestic market. Medicaid places greater regulatory constraints on manufacturers, wholesalers, and retailers as well.[5]

The market for prescription drugs is very segmented by purchaser. Manufacturers typically offer different prices for different classes of trade. For example, hospitals generally pay less for drugs than retail pharmacies do. This is because hospitals are buying a limited number of and type of drug, so they can negotiate lower prices with manufactures and in return carry only that manufacturer's products. Community or retail pharmacies, on the other hand, must stock a wider variety of products to cover a more diverse group of consumers. Further, within each segment of the market, manufacturers negotiate individually with purchasers such as health plans, pharmacy benefit managers, and pharmacies. Pharmacy benefit managers also negotiate with pharmacies over the amount that they will reimburse pharmacies on behalf of their enrollees. Thus the actual price charged to any one customer is closely guarded and almost impossible to determine.

Medicaid Prescription Drug Program

All state Medicaid programs include outpatient prescription drug coverage for their categorically eligible recipients, even though prescription drugs are an optional benefit under Federal law. Each state's Medicaid expenditures for prescription drugs are matched by the federal government at between 50 and 77 percent depending on a state's per capita income. States provide Medicaid prescription drug coverage to eligible individuals on a fee-for-service basis or through managed care plans. Under the Medicaid program, drugs are tracked and identified by an 11-digit national drug code (NDC). NDCs identify unique formulations of drugs, including the manufacturer, strength, and package size.

Medicaid, as a third-party payer for drugs purchased by others, relies on payment formulas to determine reimbursement rates. Medicaid's payment system for drugs has two components: payments made at the point of sale and rebates returned to the program from pharmaceutical manufacturers. At the point of sale, each state determines its own reimbursement rates within certain federal guidelines created by CMS.

Unlike hospital or nursing home services, where Medicaid sets the fee-for-service prices it pays through a reimbursement formula or fee schedule, drug manufacturers set the prices for their products and report them to a private price reporting service or to the Medicaid program itself. Medicaid then reimburses providers for prescription drugs based on a formula that takes the manufacturer's reporting into account. Manufacturers who want Medicaid to cover their products must have a rebate agreement with the Secretary of the Federal Department of Health and Human Services (HHS) before they submit information to CMS on both the average manufacturer price (AMP) and the "best price" offered to private payers for their products. The AMP is a computed average price paid by wholesalers to manufacturers after accounting for

[5] Gencarelli, Dawn M. 2002. "Average Wholesale Price for Prescription Drugs: Is There a More Appropriate Pricing Mechanism?" *National Health Policy Forum*. Number 775.

discounts for a particular dosage, form, and strength of a drug distributed through retailers. The "best price" is the lowest price at which a manufacturer will supply the drug to any wholesaler, retailer, provider, HMO, or nonprofit organization. CMS has the authority to survey manufacturer's sales information to ensure that the AMP and best price computations are correct. However, the Social Security Act requires CMS to maintain the confidentiality of the pricing information and so it is not publicly available. Medicaid does not generally negotiate directly with manufacturers as do many private purchasers. Pharmacies keep the difference between the amount Medicaid pays and their actual cost of acquiring the drug from the manufacturer or wholesaler.

To receive rebates, states report to manufacturers the number of units of each drug they purchase and the payment totals for each national drug code. States then receive manufacturer rebates equal to the greater of 15.1 or 11.1 percent off the AMP for single source drugs and multiple source or generic drugs, respectively, or the difference between the AMP and the best price. The rebate formula also requires an additional payment if drug prices rise faster than the consumer price index, to limit the prescription drug industry's ability to improperly inflate prices. The federal rebate amount for each drug is established by CMS and is the same for all states.[6] Since the retail price paid by the states will be greater than the AMP, Medicaid prices do not equal the lowest price paid to any customer. In FY 2003-04, the Florida Medicaid program received $798,372,427 in Federal rebates.

In May 2000, Florida lawmakers approved legislation allowing the state to negotiate additional rebates with drug manufacturers and to create a preferred drug list (Ch. 2000-254, L.O.F.). The law requires manufacturers to offer the state a supplemental rebate before their drugs can appear on the preferred drug list. Manufacturers must provide a minimum rebate of 29 percent (Federal and Supplemental combined) in order to have products considered for the preferred drug list. In FY 2003-04, the Florida Medicaid program received $133,569,757 in supplemental rebates. Together with the Federal rebates, the state received $931,942,184 in total rebates to the Medicaid prescription drug program.

When looking at the total amount a state Medicaid program pays for outpatient drugs, it is necessary to consider the payments made to providers for prescription drugs and the rebates received from manufacturers, which offset what Medicaid pays. This project focuses primarily, however, on Medicaid drug reimbursement for outpatient drugs purchased by the fee-for-service component of Medicaid.

Reimbursement to Providers

Participating pharmacy providers receive reimbursement directly from the state for prescriptions that are dispensed to Medicaid recipients. State expenditures are matched at the state's federal financial participation (FFP) rate. Federal law places limits on the payment amounts the federal government will match for prescription drugs under state Medicaid programs. There are two payment ceilings: the Estimated Acquisition Cost (EAC)[7] and the Federal Upper Limit (FUL).[8] For single source drugs (brand-name drugs without generic equivalents), the cost limit is the drug's estimated acquisition cost.

The federal government does not establish a specific methodology that states must use in determining EAC. Each state establishes its own EAC formula in its Medicaid state plan. As a result, states usually use one of two methods. The "cost plus" method calculates the provider's cost based on the wholesaler acquisition cost[9] (WAC) plus a markup percent. The "list less" method uses the average wholesale price[10] (AWP) less a discount percentage.

The majority of state Medicaid programs (43) use AWP. Investigations into AWP by the HHS Office of the Inspector General show that data on which most states base pharmacy reimbursement for drug ingredient costs overstate pharmacy acquisition costs, particularly for multi-source drugs. The OIG report to the states showed that pharmacies purchase single source innovator drugs at approximately 82.8 percent of AWP (AWP minus 17.2 percent) and multisource drugs without FULs at 55.8 percent of AWP (AWP

[6] 42 U.S.C. § 1396r-8(a)

[7] The Estimated Acquisition Cost is a state Medicaid program's best current estimate of the price generally paid by providers for the drug. See 42 CFR 447.301.

[8] The Federal Upper Limit is the limit set by CMS on the amount that Medicaid can reimburse for drugs with three or more generic versions and at least three suppliers listed in the current edition of the published national compendia.

[9] The Wholesaler Acquisition Cost is the list price established by manufacturers for sales to wholesalers.

[10] The Average Wholesale Price is the average list price that a manufacturer suggests wholesalers charge providers. The AWP is reported by commercial publishers of drug pricing data which is purchased by government entities, private insurance companies, and others.

minus 44.2 percent). These findings were mirrored in a study by the consulting firm Meyers and Stauffer for HHS, which found that pharmacies purchase brand-name drugs at approximately 81.7 percent (AWP minus 18.3 percent) of AWP and generic drugs at 56.6 percent (AWP minus 43.4 percent) of AWP. In response to these investigations, CMS clarified that states who determine EAC using the AWP must include a significant discount to be considered an acceptable estimate of cost.[11]

Some states are making changes to their Medicaid EAC formulas in order to reign in costs. Seventeen states reported lowering their EAC formulas to reduce reimbursement and more accurately reflect actual pharmacy acquisition costs. Five of these states adopted a tiered system to account for differences in drug costs between brand names and generics.[12] The tiered reimbursement formulas incorporate larger discounts for generic drugs, consistent with previous OIG findings that the AWP overstates the cost of generic drugs to a greater extent than brand-name drugs.

To encourage states to promote the use of lower-cost generic drugs, federal regulations set special reimbursement limits on approximately 100 to 200 drugs that have generic substitutes. For these generic drugs and brand-name drugs with therapeutic equivalents the limit is based on the FUL. The FUL is set at 150 percent of the published price for the least costly therapeutic equivalent that can be purchased by pharmacies in the most popular package size (ex. 100 tablets or capsules), unless the physician specifies the use of a brand-name drug. In that case, the reimbursement formula for brand-name drugs may apply to multiple source products.

One limitation with the FUL methodology that the states have found is that FUL prices only address multiple source generic drugs for which there are at least three suppliers and do not address a large number of over the counter, topical, ophthalmic, and injectable products typically reimbursed by state Medicaid programs. In addition, the FUL pricing algorithm often overstates the cost for some products that are readily available at lower rates.

In response, some states have developed their own upper limits for prescription drugs, often known as the state MAC,[13] in lieu of FULs[14] and in some cases in place of reimbursing pharmacies the AWP or WAC. State MAC programs are designed to promote Medicaid prescription drug savings in three ways. First, they wield a mix effect by encouraging pharmacies to dispense generic rather than brand-name drugs, and second, they wield a price effect by directly limiting Medicaid reimbursements for listed generic products. Finally, they give the states leverage to control future costs. State Medicaid programs have greater autonomy and employ less stringent criteria in determining which drugs are eligible for inclusion on their MAC lists. Through enforcement of the state MAC pricing methodology for generics, in addition to other Medicaid requirements, states are equipped with the ability to drive utilization of generic product.

Many state MAC lists, including Florida's, also cover brand-name drugs. States establish MACs for hundreds of drug entities (different dosage forms of the same drug). Texas, for example, establishes MACs for over 800 different drug types.[15] In 2000, Florida added 400 NDCs for injectable drug products identified through whistle-blower litigation and many other products not identified in CMS's FUL listing to its state MAC pricing list.

States also have greater flexibility in setting drug prices than does the FUL program. States use several different methods to establish their MACs, including pharmacy surveys, review of pharmacy invoices, and surveys of other health plans and other state Medicaid programs. Six states contract with outside vendors to set their MAC prices. Florida Medicaid takes into account pharmacy invoices as well as changes in a drug's price in a given time span when establishing MAC prices for prescription drugs. States with MAC programs publish lists of selected generic and multi-source brand drugs

[11] HHS, Office of the Inspector General. 2002. *"Medicaid Pharmacy- Additional Analyses of the Actual Acquisition Cost of Prescription Drug Products."* (A-06-02-00041) State Medicaid Manual, Chapter 6, Section 6305.

[12] HHS, Office of the Inspector General. 2003. *"State Strategies to Contain Medicaid Drug Costs."* (OEI-05-02-00689)

[13] The state Maximum Allowable Cost is the upper limit price that a provider will be reimbursed for generically available or multiple source medications.

[14] States may set some MAC prices higher than the corresponding FUL prices as long as total Medicaid expenditures for all drugs with FUL prices do not exceed the total calculated reimbursement amount using FUL prices.

[15] HHS, Office of the Inspector General. 2003. *"State Strategies to Contain Medicaid Drug Costs."* (OEI-05-02-00689)

along with the maximum price at which Medicaid will reimburse for those drugs. In general, pharmacies will receive payment no higher than the MAC price when billing Medicaid for drugs on a state's MAC list.

According to an October 2003 report by the HHS Office of the Inspector General, 24 states use MACs as part of their drug pricing in their Medicaid programs and 17 of these states reported cost savings from use of the MACs from $575,000 up to $46 million per year. Between January and June 2004, Florida's MAC program saved the state approximately $12,068,600.

A study of five state MAC programs published in Spring 2004 also found that developing state MAC programs can be tedious and resource intensive. Maintenance costs can be high for state Medicaid programs because of the number of drugs that must be priced and monitored.[16]

The state MAC set for FUL and non-FUL drugs varies considerably across states. In a national comparison of Medicaid drug reimbursement costs, the HHS Office of the Inspector General found that for eight multiple source drugs, the highest reported state MAC was more than twice as expensive as the lowest state MAC for the drug.[17]

Dispensing Fees

State Medicaid agencies pay pharmacies a dispensing fee to cover the cost of filling each prescription in addition to the cost of the drug. CMS regulations provide that the fee must be "reasonable." States negotiate and set their own dispensing fees. As of June 2004, the average dispensing fee across all states was approximately $4.22.[18] The Florida Medicaid program reimburses pharmacies a dispensing fee of $4.23 per prescription. If a pharmacy prepares unit-dose packaging in-house, Medicaid allows an additional $0.015 per dose.

Medicaid Provider Reimbursement Process

Pharmacies represent 99 percent of Medicaid prescription drug billings. There were 3,832 active Medicaid pharmacies in the state (approximately 98 percent of all pharmacies) as of September 2004.

There are a number of types of pharmacies participating in the Florida Medicaid program. Pharmacy type is self reported to the Medicaid fiscal agent. Florida is a chain-dominated state. As of September 2004, 2,548 pharmacies reported being part of a chain of eleven or more stores, and 217 reported being part of a chain of 2-10 stores. Additionally, 910 pharmacies reported being a single entity and the remaining reported being hospital or nursing home-based or tax supported.

Most Medicaid pharmacy claims are on a point-of-service system, called the prescription drug claim system, to which more than 98 percent of pharmacies that are Medicaid providers are connected. Under the point-of-service system, a claim is electronically processed through the claims-processing cycle in real-time and a response indicating that the recipient is eligible or ineligible and that the claim is payable or rejected is returned to the pharmacy within seconds of submission.

Pharmacies using the point-of-service method can determine recipient eligibility and specific coverage limitations before dispensing a drug. In addition, the system reports information back to pharmacists that assists in correcting claim errors or billing third party sources. Examples of information reported back include: third party insurance coverage, HMO coverage, the number of prescriptions authorized and already used, and drug utilization review messages. Claims are processed daily and payments are made to the pharmacies on a weekly basis. A claim can usually be processed from receipt to payment within 3 to 7 days for point-of-service claims and 10 to 40 days for paper claims.

The Florida Medicaid program uses ingredient costs that are supplied and updated each week by First Data Bank's National Drug File Data File electronic service. Pharmacies have a sense of what reimbursement will be because they know the sate Medicaid policy and they know instantly what they are getting paid for a given prescription. Most pharmacies have access to the same data set that Medicaid uses to update their file from First Data Bank.

For hospices, intermediate care facilities for the developmentally disabled, and nursing homes, over the counter drugs such as aspirin are covered in the per diem rates paid to these providers by the Medicaid

---

[16] Abramson, Richard, et al. 2004. "Generic Cost Containment in Medicaid: Lessons from Five State MAC Programs." *Health Care Financing Review* 25(3):25-34.

[17] HHS Office of the Inspector General. 2004. "*Variations in State Medicaid Drug Prices."* (OEI-05-02-00681)

[18] CMS. 2004. *Medicaid Prescription Reimbursement Information by State, Quarter Ending June 2004*. http://www.cms.gov. Based on Medicaid state plans submitted by the states.

program. Any prescriptions for Medicaid beneficiaries in these facilities are filled and reimbursed through a community pharmacy.

METHODOLOGY

Health, Aging, and Long-Term Care Committee staff, with the assistance of staff of the Appropriations Subcommittee on Health and Human Services, reviewed the literature on the prescription drug market and prescription drug pricing and expenditures. Staff reviewed the different reimbursement methodologies used by the states to control prescription drug costs in their Medicaid programs. Staff collected and analyzed data on reimbursement of prescription drugs in Florida under the Medicaid program. Staff held meetings with the appropriate agency staff to discuss Medicaid prescription drug reimbursement as well as possible changes or improvements to the drug cost and reimbursement system. Staff also met with and collected information from representatives of the pharmaceutical industry and the retail pharmacies.

FINDINGS

Medicaid Prescription Drug Utilization

Between FY 1997-98 and FY 2002-03, the total number of Medicaid eligible recipients using prescription drugs increased from 987,990 to almost 1.6 million recipients. However, the percent of all Medicaid eligible individuals using prescription drugs decreased from 68 percent to 61 percent. AHCA estimates that there will be an increase in the percentage of Medicaid recipients using prescription drugs in FY 2003-04 and FY 2004-05 and specifies two key factors contributing to the increase. The first is the increase in the number of new drugs on the market to treat conditions that previously were treated with only a few drugs or in other ways than taking medication at home. The second factor is direct-to-consumer advertising, which encourages individuals to request treatment for specific symptoms. A study released by the Kaiser Family Foundation in June 2003 found that direct-to-consumer advertising is an important driver of growth in prescription drug spending, although it is not the primary factor.[19] Other explanations for increased utilization include improved insurance coverage, population aging, and increased diagnosis of chronic conditions.[20]

The average cost to Medicaid per Medicaid recipient using prescription drugs increased from $853.66 in FY 1997-98 to a projected $1982.57 in FY 2003-04, and is estimated to decrease to $1679.88 in FY 2004-05.[21] The average number of prescriptions per Medicaid user per year increased from 20.12 in FY 1997-98 to an estimated 30.73 in FY 2003-04, but is expected to decrease to 23.04 in FY 2004-05. The projected decreases in the cost per Medicaid recipient and the number of prescriptions per recipient are due largely to legislative and programmatic changes to the Medicaid pharmacy program. These include the reduction in pharmacy reimbursement through the changes to the AWP and WAC formulas and the expansion of the state MAC program, savings realized through the federal and state rebate programs, the drug benefit management program, and prescribed drug dosing limitations.

Consistent with national trends, as of the end of August 2004, individuals dually eligible for Medicare and Medicaid accounted for 33.6 percent of Medicaid prescription drug spending with an average of almost five prescriptions per month, followed by Supplemental Security Income (SSI) beneficiaries not receiving Medicare benefits who accounted for 24.7 percent of prescription drug spending with an average of 3.5 prescriptions per month. Medically needy individuals accounted for 8 percent of Medicaid prescription drug spending averaging 4 prescriptions per month. Those Medicaid beneficiaries for whom Medicaid is spending the most on prescription drugs are the elderly (mostly dual eligibles) and the disabled.

According to AHCA, approximately 80 percent of spending on prescription drugs is on brand-name drugs and approximately 20 percent of spending is on generics. Approximately 53 percent of all prescriptions written are for brand-name drugs and 46 percent are for generics. The numbers on brand-name drugs reflect a dramatic decrease due to the implementation of the four-brand limit on prescription drugs and the expansion of this limit to institutionalized adults. Medicaid providers are also required to dispense generic drugs if they are available at a lower cost than

[19] Kaiser Family Foundation. 2003. *"Impact of Direct-to-Consumer Advertising on Prescription Drug Spending."* (6084) www.kff.org.

[20] Employee Benefits Research Institute. 2004. "Prescription Drugs: Recent Trends in Utilization, Expenditures, and Coverage." Issue Brief #265

[21] These numbers do not include the rebates provided to the state from manufacturers.

branded products, and if the prescriber has not received prior approval to require the branded product. The brand-name drug numbers have increased recently due to the implementation of the preferred drug list and the supplemental rebate program. The cost of the increase was offset, however, because Medicaid is getting better prices for the drugs under the supplemental rebate program.

Medicaid Provider Reimbursement Methodologies

The state Medicaid program reimburses outpatient prescription drugs using a "lesser of" methodology that includes the lesser of WAC plus a percentage, AWP minus a percentage, the FUL, the state MAC, or the Usual and Customary[22] charge billed the provider. The system must check every methodology before assigning payment for a prescription drug in order to assure that Medicaid reimburses at the lowest cost to the state. Prior to the 2004 Legislative Session, most claims (85 percent) were reimbursed using the WAC methodology.

The reimbursement formula was revised during the 2004 Session to be **the lower of**: AWP minus 15.4 percent; WAC plus 5.75 percent; the FUL; the state MAC; or the Usual and Customary charge billed the provider. These changes were meant to more accurately reflect the estimated acquisition cost of the drug and to bring reimbursement using the AWP and WAC closer in line with each other. For example, if a drug does not have a WAC price, and is reimbursed using AWP, this amount would be almost identical to what would be paid using the WAC methodology. AHCA estimates that the WAC and AWP methods reimburse approximately 80 percent of prescription drugs at the same amount and that the other 20 percent are very close. The state hoped to achieve a one percent cost savings on ingredient costs from bringing the formulas into parity. Early data collected since the legislative changes to the reimbursement formulas in July show that the state has saved approximately $1,700,000 since the July 2004 changes.

As an even larger cost-saving measure, the 2004 Legislature expanded the state's MAC program. With the expansion, the state will cover approximately 200 drugs compared to the 20 covered previously and approximately 12,000 NDCs compared to 7,200 NDCs covered previously. AHCA will contract with Provider Synergies[23] who will be responsible for recommending the MAC prices for the drugs as well as performing market monitoring. AHCA will have the final authority over the drug pricing, however, and will work with pharmacies to assure that the new prices are feasible. The contract should be implemented in November 2004.

Florida's MAC program initially focused on a smaller number of drugs (both brand-name and generic) that had only a few different forms and dosages but a larger pricing spread in order to focus on drugs where there is a greater ability to contain costs such as hemophilia drugs, prenatal vitamins, and immunoglobulins. The state MAC program also initially targeted generic drugs with the highest sales volume and will continue to do this, while at the same time including numerous more generic drugs.

Once the state MAC program expansion is implemented, AHCA predicts that reimbursement under the WAC and AWP methodologies will decrease significantly. Drugs typically not covered under the FUL that otherwise would have been reimbursed using the WAC or AWP methodologies will now be reimbursed using the state MAC methodology which can be set by the state at a lower rate.

An advantage of expanding the state MAC program is that the MAC for a drug is set by the state and can only be changed by the state. There is no room for manipulation, unlike AWP, which is controlled by drug manufacturers and could potentially be adjusted to reflect changes in a state's AWP reimbursement formula. Additionally, the expansion of the program means that more drugs, as well as more forms of drugs, will be covered. The inclusion of more forms of drugs will limit pharmacy providers' ability to dispense a different form of a specific drug for which they can get reimbursed by Medicaid at a higher rate.

Medicare Part D

The President signed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) into law in December 2003, which implements, among other things, a prescription drug benefit under the Medicare program (Part D). The new law will require changes in state Medicaid and prescription drug assistance

[22] The Usual and Customary charge refers to the common charge to the public or the prevailing fee for services. This may include a comparison to cash prices as well as the reimbursement paid by private payers.

[23] Provider Synergies currently manages Florida's Preferred Drug List, supports its Pharmaceuticals and Therapeutics Committee, and negotiates Florida's supplemental rebate agreements.

programs. Starting in 2006, state federal matching funds will not be available to states for Medicaid drug coverage provided for all full-benefit dual eligibles, a provision that presumably will shift this population into the newly created Medicare Part D program. States will be able to continue offering prescription drug coverage with state-only funds and can continue to receive Medicaid federal matching funds to supplement some gaps in the Part D coverage.

While a Medicare drug benefit might have saved states a large amount of money, states will not realize most of these potential savings. For example, the state will have the administrative responsibility of enrolling the dual eligibles in the Part D benefit. The state will also have to make payments to the federal government supporting the Part D program (the "clawback" provision). The U.S. Congressional Budget Office estimates that the states will save $115 billion in Medicaid costs in total between 2004 and 2013, but that 85 percent of the savings will be offset by new costs in administering the Medicare changes at the state level as well as the clawback provision. The CBO predicts that the true savings will occur in 2010-2013 at about $17.2 billion to be divided among all of the states.

CONCLUSIONS

Florida has been aggressively pursuing a variety of strategies to manage prescription drug expenditures under its Medicaid program. Cost containment by Florida Medicaid has focused on limiting Medicaid reimbursements for drugs, shifting use from higher to lower cost alternatives, and limiting the amount of prescription drugs a recipient can obtain in a given time period.

Related to reimbursement, the Florida Medicaid program has made efforts to contain drug costs by lowering the reimbursement rate to pharmacies for drugs to more accurately reflect the EAC of the drugs. Changes were made to the AWP during the last Legislative Session to address HHS' concerns that states' Medicaid reimbursement for generic drugs under AWP was to high. Changes were also made to the WAC to bring it more in line with AWP. Savings to the program from the changes to date amount to approximately $1.7 million.

Florida has also expanded its MAC program, which should provide a large savings to the state once it is fully implemented. The expanded program should be operating in November 2004, and will include both brand-name and generic drugs, as well as more forms and doses of each drug covered under the program. It will be a few months before we know how much the expanded program will save Medicaid.

A pressing issue that the Medicaid program will need to continue to focus on is prescription drug utilization. This means, not only the number of Medicaid recipients using prescription drugs, which will likely increase as Florida's aging population increases, but also the number of prescription drugs each individual uses. As discussed earlier, prescription drug utilization is skewed to a small percentage of Medicaid recipients who account for a large share of total drug payments. The state should examine the drug use of these individuals, who are a high cost to the program, and also consider tighter controls on prescription drug utilization for all Medicaid recipients.

RECOMMENDATIONS

This report reviewed the pricing, distribution, and reimbursement of prescription drugs under the Medicaid program. It focused specifically on prescription drug reimbursement for outpatient drugs purchased by the fee-for-service component of Medicaid. Based on the findings and conclusions discussed in the report, staff makes the following recommendations.

Study and Report on the Results of the Expansion of the State MAC Program

Florida Medicaid estimates a savings of $24 million per year to the state due to the expansion of the state MAC program. The Medicaid Bureau of Pharmacy Services should track actual savings to the prescription drug program after the expansion is implemented and report these figures to the Legislature on a quarterly basis.

The Medicaid Bureau of Pharmacy Services should continue to review the drugs covered under the state MAC list and refine the list as necessary for cost savings. This review should look at drugs on the list with FUL prices, as well as those without FUL prices. States can reimburse at amounts lower than the FUL price, as well as cover numerous drugs without an FUL price. The review should also assess whether the state has as complete an accounting as possible of the available strengths and forms for each drug entity.

Expanding the state MAC list by adding strengths and forms for existing drugs may be less resource intensive than adding new drugs to the state MAC list. The Bureau could also engage in detailed cost-benefit accounting of MAC list procedures to determine if the state MAC list yields smaller returns as it expands due to higher maintenance costs or whether savings continue to accumulate as the list becomes broader.

Florida should study the feasibility of partnering with other states on administration of their MAC lists. For example, some states have adopted Texas's state MAC list because it is so extensive. States could also pool resources to run state MAC programs.

Target Prescription Drug Utilization

The state Medicaid program should continue to focus efforts and initiatives on prescription drug utilization, with an initial focus on those individuals using the most prescription drugs and the most expensive prescription drugs. Data from Medicaid show that elderly and disabled individuals are on average more likely to be users of prescription drugs and are likely to have more prescriptions filled each month than other Medicaid recipients.

Although the Medicare program should start covering these individuals in 2006 under the Part D prescription drug benefit, it is not fully clear what impact this change will have on Florida. The Medicaid program should continue to monitor federal implementation efforts of the MMA.