oppaga

Justification Review

February 2001 **Report No. 01-10**

Growth in Medicaid Prescription Drug Costs Indicates Additional Prudent Purchasing Practices Are Needed

at a glance

Over the past few years the Legislature has enacted several prescription drug cost control initiatives to curtail inappropriate prescribing, detect fraud, reduce prescription prices, and increase drug manufacturer rebates.

However, continued rapid growth in Medicaid spending for prescription drugs is a major factor driving projected deficits in the Medicaid budget in Fiscal Years 2000-01 and 2001-02. Most of the growth is due to an increase in the average cost of prescriptions driven primarily by doctors switching to higher-cost drugs.

Despite obtaining lower retail drug prices than other state Medicaid programs, Florida's prescription drug costs per recipient are among the highest.

To help control the rapid increases in the cost of Medicaid prescriptions and to promote effective drug therapies for the least cost, we recommend that the Legislature

- authorize the Agency for Health Care Administration to develop a mandatory preferred drug list and negotiate supplemental rebates,
- direct the agency to develop and implement strategies to encourage compliance with using the preferred drug list, and
- require the agency to competitively bid contracts for Medicaid pharmacy networks.

These steps could save up to $306.1 million annually in Medicaid prescription drug costs, of which $113.1 million would be state general revenue savings.

Purpose

Section 11.513, *Florida Statutes,* directs the Office of Program Policy Analysis and Government Accountability to complete a program evaluation and justification review for each state agency that is operating under a performance-based program budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

This report is one of four that reviews the Medicaid program administered by the Agency for Health Care Administration. The remaining reports address program accountability and performance; use of disease management organizations to improve health outcomes and reduce costs; and effectiveness of fraud and abuse activities. This report

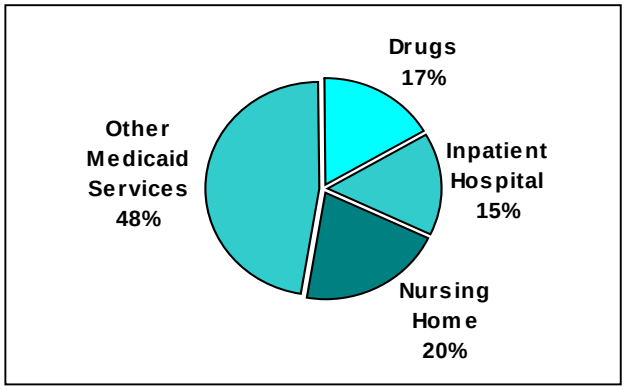
- highlights the rising cost of prescription drugs as a contributing factor to deficits in the Medicaid budget;
- identifies causes of rapid growth in prescription drug expenditures;
- examines cost control policies used in Florida and other states; and

- recommends additional steps to reduce costs of Medicaid prescription drug services.

Background

Florida provides prescription drug coverage as part of its Medicaid program.[1] In the General Appropriations Act, the Legislature authorizes the Agency for Health Care Administration to reimburse participating pharmacies for prescriptions for individuals eligible for Medicaid.[2] In the 1999-2000 fiscal year, spending for prescription drugs reached $1.3 billion, comprising 17% of the total spending for Medicaid services. (See Exhibit 1.) In Fiscal Year 2000-01, prescription drug expenditures are expected to grow to about $1.5 billion.

Exhibit 1
Prescription Drugs Accounted for 17% of $7.8 Billion in Medicaid Expenditures in Fiscal Year 1999-2000



Source: Agency for Health Care Administration.

Medicaid covers most prescription drugs and selected over-the-counter medicines on an outpatient basis. Drugs for eligible individuals provided by health maintenance organizations and by hospitals, nursing homes, and other institutional settings are covered under those Medicaid service categories. Appendix A summarizes Florida's Medicaid prescription drug services.

[1] The prescription drug program is an optional program in that federal regulations governing states' Medicaid programs do not require states to provide prescription drug coverage.

[2] The average monthly Medicaid caseload for prescription drug services in Fiscal Year 1999-2000 was 1.2 million clients.

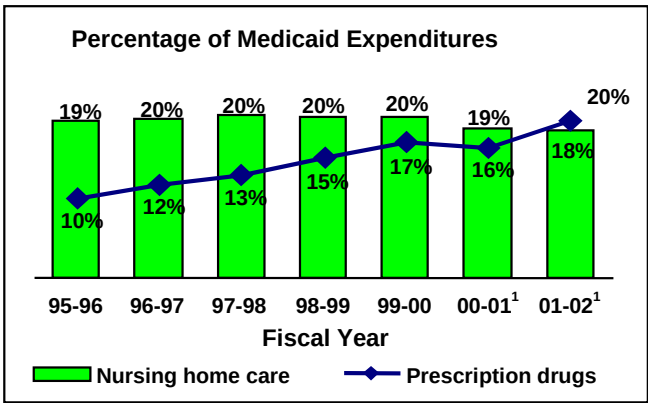
Findings

Prescription Drug Costs Drive Up Medicaid Deficits

Rapid rise in prescription drug spending accounts for a large share of Medicaid budget deficits, which could jump from $640.6 million in 2000-01 to $1.5 billion in 2001-02 if left unchecked.

Florida's spending for Medicaid prescription drugs is growing rapidly, averaging 21% annual increases over the past five fiscal years. For Fiscal Year 1999-2000, expenditures for prescription drugs exceeded all Medicaid services except for nursing home care. As shown in Exhibit 2, in Fiscal Year 2001-02, prescription drug costs are projected to surpass those for nursing home care, consuming 20% of all Medicaid services expenses.[3]

Exhibit 2
Spending on Prescription Drugs Is Projected to Outpace Spending on Nursing Home Care by Fiscal Year 2001-02



[1] These are Social Service Estimating Conference projections.

Source: Agency for Health Care Administration and Consensus Estimating Conference, November 2000.

Rapid growth in spending for prescription drugs is an important factor contributing to deficits in the Medicaid budget. In Fiscal Year 1999-2000, Medicaid experienced an estimated $78.7 million deficit. In this year, the Medicaid

[3] Medicaid prescription drug expenditures are projected to reach $1.9 billion in Fiscal Year 2001-02.

program overspent its prescription drug allocation by $68.8 million.

Prescription drug costs are expected to continue to contribute to Medicaid deficits. The state's Social Services Consensus Estimating Conference projects a Medicaid deficit of $640.6 million in Fiscal Year 2000-01 and $1.5 billion in Fiscal Year 2001-02. Prescription drug spending is projected to account for 21% and 37% of these deficits, respectively. As such, it is important to identify reasons for and develop strategies to control the rapid growth in spending for prescription drugs.

Reasons for Rapid Growth in Medicaid Spending for Prescription Drugs

Since the 1995-96 fiscal year, most of the growth in spending for prescription drugs has been due to increases in the cost of prescriptions driven primarily by doctors switching to higher-cost drugs.

Over the past five years, annual prescription costs more than doubled, rising from $529 to $1,137 per Medicaid client receiving prescription drug services. Higher average prescription prices, an increase from $34.40 to $59.27, accounted for 78.6% of the growth in spending. (See Exhibit 3.) An increase in the number of prescriptions accounted for significantly less growth, 21.4%.

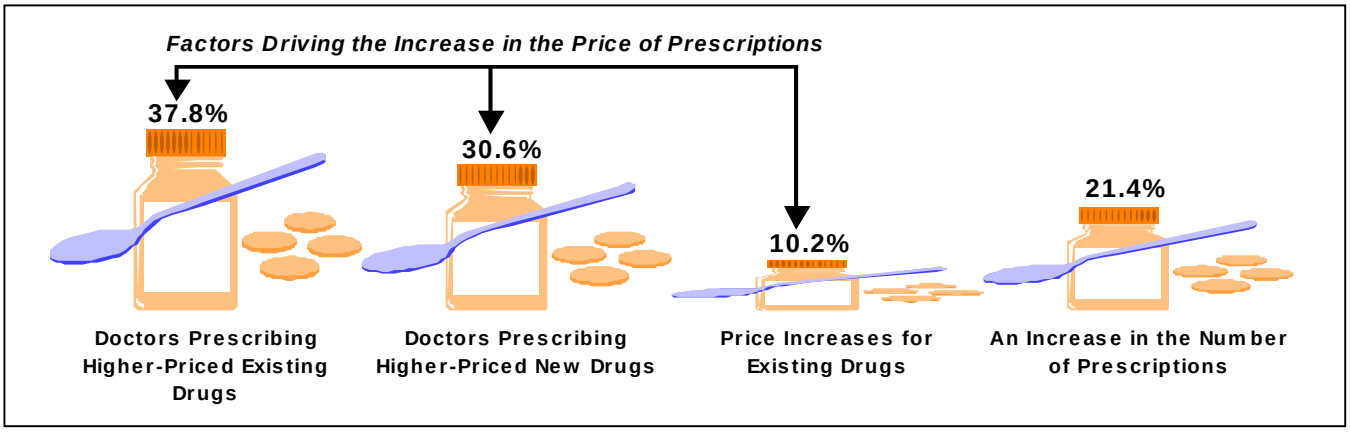
Increased prescription costs. Using pharmacy claims data from the 1995-96 and 1999-2000 fiscal years, we determined that the change in the average price of prescriptions was due to

- doctors prescribing more expensive dosage forms of existing drugs or switching to other more expensive existing drugs; [4]
- doctors prescribing new drugs which are typically more expensive than existing drugs; and
- annual price increases for existing drugs.

The largest factor contributing to increased prescription prices was that doctors switched prescriptions to new dosage forms or other more expensive existing drugs. This accounted for 37.8% of the total increase in prescription costs. As experience is gained with the use of drugs, manufacturers often produce different dosage strengths or new dosage forms to increase a drug's use. For example, a manufacturer might develop a nasal spray or liquid to deliver a drug to replace the initial tablet form. Although new drug forms tend to be more expensive, doctors may prescribe them because of patient preference or marketing promotions.

[4] Existing drugs are those drugs that were available in Fiscal Year 1995-96; new drugs are those that became available after Fiscal Year 1995-96.

Exhibit 3
Since Fiscal Year 1995-96, Factors Driving the Increase in the Price of Prescriptions Accounted for Most of the Increase in Expenditures for Medicaid Prescription Drugs



Source: OPPAGA analysis of Medicaid claims, Fiscal Year 1995-96 through Fiscal Year 1999-2000.

The second largest factor contributing to higher prescription drug costs was that doctors prescribe higher-priced new drugs in the place of older drugs; this accounted for 30.6% of the overall cost increase. New drugs represent new approaches to treating illness and may be more effective or reduce side effects. However, they are typically more expensive. For example, Celebrex, an anti-inflammatory pain reliever, is a new drug that has rapidly gained market share and accounted for 44% of Medicaid spending on anti-inflammatory drugs in Fiscal Year 1999-2000. The average prescription cost for Celebrex was $87.13 compared to an average prescription cost of $31.14 for the previously existing anti-inflammatory drugs.

Price increases for existing drugs also contributed to the increased prescription drug costs. However, these price increases were below the overall inflation rate. Price increases for existing prescription drugs were 10.2% over the 1995-2000 period, compared to 15.3% for the medical care commodities component of the Consumer Price Index. [5]

Finally, the number of prescriptions filled per client grew over the past five years, rising from 1.28 prescriptions per month to 1.60 prescriptions. This increase accounted for 21.4% of the growth in spending, primarily because doctors are tending to rely more on drugs than other therapies. [6] For example, doctors use cholesterol-reducing drugs to prevent surgery for clogged arteries.

Cost Control for Prescription Drug Spending

Florida's Medicaid pharmacy program obtains good prices and uses many standard industry practices to control prescription drug costs.

Florida's Medicaid pharmacy program has taken several steps to help control prescription drug costs. The program takes advantage of **discounted retail prices** and federally mandated **drug manufacturer rebates** to lower prescription costs. Medicaid retail drug prices include two components, ingredient costs per unit (e.g., tablet, capsule, gram) of the drug and a dispensing fee. Florida pays retail pharmacies a $4.23 dispensing fee, unless the total pharmacy charge is lower, plus the lowest of four different prices for drug ingredients (see Appendix A for a detailed explanation of drug unit pricing):

- the average wholesale price per drug unit minus 13.25%,
- the wholesaler acquisition cost per drug unit plus 7%,
- the direct price per drug unit plus 7% for drugs purchased directly from the manufacturer, or
- the federal or state maximum allowable cost.

Florida's Medicaid pricing policies have helped Florida obtain relatively low prices for prescription drugs. Compared to other states' Medicaid programs, the prices Florida pays for prescriptions are among the lowest in the nation. For example, in 1999 only Maryland, Massachusetts, Michigan, Ohio, and Rhode Island had lower prescription unit costs than did Florida. (See Appendix B, Table B-1.) On average, Florida's unit costs for prescriptions were 15% lower than other states' Medicaid programs for the same drugs.

Drug manufacturer rebates also lower the cost of Medicaid prescriptions in Florida. Federal law requires drug manufacturers to participate in a rebate program for their products to be eligible for Medicaid reimbursement. (Appendix C summarizes relevant federal legislation.)

Including these rebates, Florida's Medicaid drug prices tend to be lower than prices paid by Florida's state employees' self-insured benefit program. (See Exhibit 4.) The state's self-insured employee health benefit plan is a competitive bid contract with a private pharmacy benefit manager.

[5] The 15.3% represents the medical care commodities index of the Consumer Price Index for urban consumers in the South.

[6] To a lesser extent, an increase in Medicaid clients and a shift to a greater percentage of elderly and disabled individuals increased the number of prescriptions.

Exhibit 4
Florida's Medicaid Prescription Drug Prices Are Typically Lower Than Those Paid by the Florida State Employees' Self-Insured Benefit Plan

Type of Drugs	Florida's Medicaid Drug Prices[1]	Florida's State Employee Benefit Plan Drug Prices[2]
Generic drugs	AWP – 49%	AWP – 25%
With rebates	AWP – 51%	N/A
Brand name drugs	AWP – 19%	AWP – 18%
With rebates	AWP – 37%	AWP – 21%

[1] Average price for drugs purchased in Fiscal Year 1999-2000; prices derived by converting the lowest of the average wholesale price, wholesaler acquisition cost, maximum allowable cost, or direct price to a percentage discount from the average wholesale price (AWP).
[2] Fiscal Year 1999-2000 contract prices and rebates.

Source: OPPAGA analysis of information provided by Florida's Medicaid program and Florida's State Employee Self-Insured Benefit Plan program.

To ensure appropriate use and reduce costs, the Medicaid Pharmacy Program also uses federally required and **standard industry management practices**. These practices focus on controlling drug utilization and include controls discussed below.

- ***Prospective drug utilization reviews.*** The program maintains on-line access to a database of all drugs prescribed for recipients to assist pharmacists in identifying potential drug interactions, therapeutic overlap, and compliance with prescription limits.
- ***Retrospective drug utilization reviews and Medicaid Prescribing Review Panel.*** The program conducts periodic reviews of doctors' prescribing habits to assist in improving quality of care and containing costs as well as doctor and pharmacist education on cost-effective drug therapies.
- ***Case management.*** The program provides case management for recipients who routinely take a high number of drugs or who have certain chronic conditions such as hemophilia, asthma, or diabetes.
- ***Prescription limits.*** The program imposes monthly limits on the total number of prescriptions that may be filled per client (see Appendix A for a description of the current limits).
- ***Drug exception policy.*** The program allows physicians to prescribe drugs for patients who have reached the monthly limit if excepted by the pharmacy benefit manager.

Despite lower retail unit costs for prescriptions compared to other states' Medicaid programs, Florida's prescription drug costs per recipient are among the highest, indicating additional cost control practices are needed.

Despite these practices, Florida's drug costs per recipient consistently rank among the most expensive in the nation.[7] (See Appendix B, Table B-3.) States such as Florida that have relatively low unit costs for drugs but high overall pharmacy costs per recipient tend to allow doctors to prescribe more costly drugs or have not implemented other types of stringent cost controls.

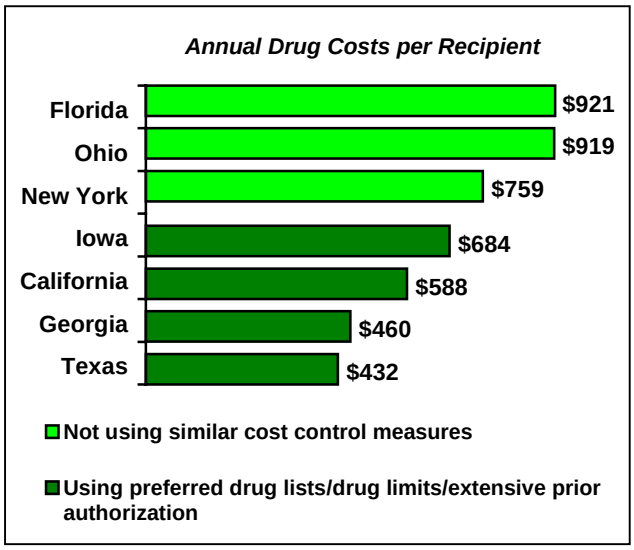
As shown in Exhibit 5, some states using stringent controls such as mandatory preferred drug lists or restrictive monthly limits on recipient prescriptions spend less per recipient than states that have not implemented similar controls.[8] For example, California has a preferred drug list, limits prescriptions to six per month, and negotiates for additional rebates from manufacturers wishing to add their drugs to the preferred list. While Texas does not have a preferred drug list, it has lowered costs by using practices such as limiting prescriptions to three per month for non-institutionalized adults, requiring generic substitution for certain brand name drugs, and through volume purchasing by pharmacy chains.[9]

[7] Pharmacy management practices, benefit limitations, and differences in the percentage of persons in various Medicaid eligibility categories account for the variation in drug costs across state Medicaid programs. Adjusting states' drug costs per recipient for differences in Medicaid populations resulted in similar rankings for states with the lowest and highest costs per recipients.

[8] Mandatory preferred drug lists or formularies restrict payment for drugs not on the preferred list.

[9] *Florida Medicaid Prescribed Drug Program, Medicaid Formulary Study Panel, A Final Report to the Governor and the Legislature,* Agency for Health Care Administration, March 3, 2000.

Exhibit 5
Medicaid Pharmacy Management Practices Account for Cost Differences Between States' Medicaid Programs



Source: Health Care Financing Administration 2082 Report, Fiscal Year 1998.

Recent Legislative Actions to Reduce Prescription Drug Costs

In Fiscal Years 1998-99 and 1999-2000, the legislature directed Agency for Health Care Administration to enhance its pharmacy fraud detection activities. In response, the agency increased the number of on-site pharmacy audits and the number of direct mail audits to recipients, investigated pharmacies sanctioned by the Florida Board of Pharmacies, and terminated pharmacies involved in fraudulent activities. According to the agency, these activities resulted in recoveries and cost avoidance of $43.4 million.

In Fiscal Year 1999-2000, the Legislature also directed the agency to profile and evaluate doctors' prescribing patterns through peer review. The Legislature reduced the Fiscal Year 1999-2000 appropriations for prescription drugs by $40.7 million.

The 2000 Florida Legislature expanded its efforts to control drug costs by enacting a drug cost control program. Once implemented, these cost control measures are expected to reduce recurring prescription drug expenditures by an estimated $231.2 million. (See Appendix D for information related to these cost control measures.)

As of December 2000, the agency had implemented most of the measures required by the drug cost control program. While it is too early to assess the extent to which expected savings will be realized, preliminary analyses suggest that while the rate of increase in the average cost of prescriptions is slowing, prescription costs per eligible are still high, averaging around $1,120 during the third quarter of 2000. [10]

Additional Measures for Reducing Prescription Drug Costs

The Legislature can take further action to lower Medicaid prescription drug spending by lowering drug ingredient costs and dispensing fees and by requiring a mandatory preferred drug list. These options could save up to $306.1 million annually, of which $113.1 million would be state general revenue savings.

Lower retail drug ingredient costs and dispensing fees. Several states help control Medicaid prescription drug costs by negotiating lower drug ingredient costs and providing for lower drug dispensing fees. In 1999, Michigan, Texas, and Rhode Island had lower drug ingredient pricing than Florida. Michigan required participating pharmacies to provide a 13.5% to 15.1% discount from average wholesale price (depending on the number of stores in the pharmacy chain). Texas set its ingredient pricing at the lower of the average wholesale price minus 15% or the wholesaler acquisition cost plus 12%, and Rhode Island at the wholesaler acquisition cost plus 5%. In contrast, Florida required participating pharmacies to provide the lower of the average wholesale price minus 11.25% or the wholesaler acquisition cost plus 7%. [11]

It is likely that the Florida Medicaid program could negotiate lower prices. Most of the

[10] Based on drugs for which the agency paid $1,000 or more during the quarter.

[11] The 2000 Florida Legislature changed drug ingredient pricing. See Appendix A for current pricing policy.

vendors responding to a recent competitive bid proposal for the Florida state employees' self-insured benefit plan offered a lower drug ingredient cost for brand name drugs (average wholesale price minus 18%) than that set by the 2000 Legislature (average wholesale price minus 13.25%) for the state's Medicaid program.

Nearly half of the states have lower Medicaid dispensing fees (see Appendix B, Table B-2) Florida pays pharmacies $4.23 to fill a Medicaid prescription, compared to these states, which pay between $2.50 and $4.21 per prescription.

Lower ingredient costs and dispensing fees can be accomplished in two ways, through legislation and/or through competitive bidding. While the 2000 Legislature gave the Agency for Health Care Administration authority to competitively bid pharmacy networks, the agency had not done so as of December 2000. By restricting the Medicaid pharmacy network through competitive bidding, the agency could take advantage of Florida's purchasing power to negotiate lower ingredient prices and dispensing fees.

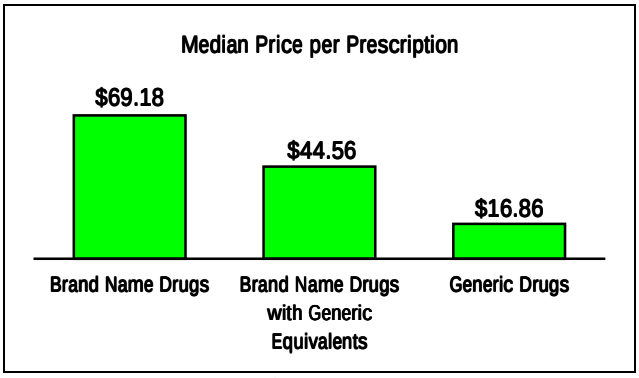
Considering what other states' Medicaid programs pay for drug ingredient costs, as well as the drug ingredient costs paid by the Florida state employees' self-insured benefit plan, the agency may be able to negotiate drug ingredient pricing as low as the average wholesale price minus from 15% to 18%.[12] In so doing, the state would save from $17.2 - $55.0 million (general revenue savings, $7.4 - $23.7 million).

Require a mandatory preferred drug list and negotiate supplemental rebates. The 2000 Legislature directed the agency to implement a limited voluntary preferred drug list. Currently, this list contains drugs in 50 therapeutic categories. However, 51% of 1999-2000 fiscal year's prescriptions were for drugs in therapeutic categories that are not covered by the list. Because the current preferred drug list is voluntary, doctors can prescribe non-preferred drugs without obtaining prior approval thereby providing little incentive for doctors to prescribe a preferred drug.

It is common practice for hospitals, health maintenance organizations, and pharmacy benefit managing companies to control costs by restricting the use of drugs not on a preferred drug list. These organizations have committees comprising doctors and pharmacists that select preferred drugs based on efficacy and cost. Using preferred drug lists might also encourage drug manufacturers to negotiate additional drug rebates making their products more competitive with alternatives.

Preferred drug lists can be particularly effective in curbing the use of potentially less cost-effective drugs. While new brand name drugs offer new treatment approaches and may improve health outcomes, they are typically more expensive than older generic drugs. (See Exhibit 6.) The committees responsible for selecting preferred drugs have the expertise to choose less costly older drug therapies that are as effective as the newer drugs.

Exhibit 6
New Brand Name Drugs Are Typically More Expensive



Source: OPPAGA analysis of Medicaid pharmacy claims, Fiscal Year 1999-2000.

Achieving a high degree of compliance with a mandatory Medicaid preferred drug list is critical to reducing pharmacy costs. To encourage the use of drugs on the preferred drug list, the agency could use incentives. For example, the agency could exempt preferred drugs from the four brand name prescription limit, give higher pharmacy dispensing fees for preferred drugs, or require patient co-payments for non-preferred drugs.

[12] This would affect only those drugs in which the "lowest price" is the one derived by using average wholesale price minus a discount of from 15% to 18%.

As shown in Exhibit 7, by making the current voluntary preferred drug list mandatory, the state could reduce Medicaid prescription drug spending by an estimated $48.1 - $72.1 million (general revenue savings, $17.1 - $25.7 million). Expanding the current list to include all major therapeutic categories will reduce spending by an estimated $92.5 - $138.8 million (general revenue savings, $32.9 - $49.4 million). In addition, supplemental manufacturer rebates for preferred drugs could result in additional rebates of up to 6% of annual pharmacy expenditures, an estimated $112.3 million (general revenue savings, $40.0 million).

Exhibit 7
A Preferred Drug List Will Reduce Medicaid Spending for Prescription Drugs

	Cost Savings (in millions)	
Type of Preferred Drug List	50% Compliance[1]	75% Compliance[1]
Limited therapeutic categories[2]	$48.1	$ 72.1
General revenue savings	*17.1*	*25.7*
All major therapeutic categories	$92.5	$138.8
General revenue savings	*32.9*	*49.4*

[1] Percentage of claims not using a preferred drug switching to a preferred drug based on Fiscal Year 1999-2000 Medicaid pharmacy claims.

[2] Estimate does not include therapeutic categories that are exempt by Ch. 2000-367, *Laws of Florida.*

Source: OPPAGA analysis.

Some cost control efforts would require changes in federal law. Additional major cost control initiatives are possible, but would likely require federal action changing Medicaid laws or enacting a national cost control program for prescription drugs. Wrestling with high drug prices, other states have explored bulk purchasing arrangements, Federal Supply Schedule pricing, and price controls. However, these initiatives are encountering several barriers.

- Manufacturers have opposed federal Medicaid waivers that extend Medicaid drug rebates to persons not eligible for Medicaid. [13]
- Federal laws currently restrict the use of federal supply schedule and public health services drug pricing to a limited number of public entities and forbidding these entities from reselling these drugs. [14]
- Lawsuits have challenged state legislation that attempted to establish price controls on the grounds that these laws interfere with the interstate commerce of prescription drugs. [15]

Conclusions and Recommendations

Rapid growth in Medicaid spending for prescription drugs is an important factor contributing to deficits in the Medicaid budget. Most of the growth in spending is due to increases in the cost of prescriptions driven primarily by doctors prescribing more costly drugs. Despite achieving good drug ingredient prices, Florida's Medicaid prescription drug costs per recipient are among the highest compared to other states' Medicaid programs. This indicates that additional cost control practices are needed.

The Agency for Health Care Administration's pharmacy management practices should promote drug therapies that are effective for the least cost. To promote using cost-effective therapies we recommend the Legislature take three actions.

- ***Authorize the Agency for Health Care Administration to develop and use a mandatory preferred drug list and negotiate supplemental rebates.*** A mandatory preferred drug list will reduce spending by addressing the primary factor contributing to the rapid growth in Medicaid spending for prescription drugs—the use of higher-cost drugs when effective lower-cost alternatives are available.

  A preferred drug list will reduce spending. We estimate that making the current

[13] Pharmaceutical Research and Manufacturers of America filed a complaint in U.S. District Court against the Health Care Financing Administration's Medicaid waiver allowing Vermont to extend Medicaid prescription drug rebates to non-Medicaid eligible low-income seniors.

[14] Refer to Appendix C for a summary of the Federal Supply Schedule.

[15] Pharmaceutical Research and Manufacturers of America v. State of Maine.

voluntary preferred drug list mandatory will reduce prescription drug spending by an estimated $48.1 - $72.1 million (general revenue savings, $17.1 - $25.7 million) while expanding the current list to include all major therapeutic categories will reduce spending by an estimated $92.5 - $138.8 million (general revenue savings, $32.9 - $49.4 million). In addition, supplemental manufacturer rebates for preferred drugs could result in additional rebates of up to 6% of annual pharmacy expenditures, an estimated $112.3 million (general revenue savings, $40.0 million).

Developing and implementing a mandatory preferred drug list will require the agency to meet federal Medicaid law which requires a committee of doctors, pharmacists, and other appropriate experts to develop the preferred drug list. Federal law also requires that non-preferred drugs be made available through prior approval. Appendix C summarizes the federal requirements for a state establishing a preferred drug list and a prior authorization program.

- ***Direct the agency to develop and implement strategies to encourage compliance with using drugs on the preferred drug list.*** Medicaid provider compliance with a preferred drug list is critical to reducing pharmacy costs. The agency can encourage high compliance by providing incentives such as
  - exempting preferred drugs from the four brand name prescription limit,
  - giving higher dispensing fees for preferred drugs, and
  - instituting patient co-payments for non-preferred drugs.
- ***Require the agency to competitively bid contracts for Medicaid pharmacy networks.*** The 2000 Legislature gave the Agency for Health Care Administration authority to limit its pharmacy network based on competitive bidding, price negotiations, credentialing, or other similar criteria. By limiting the state's Medicaid pharmacy network through competitive bidding, the agency could take advantage of Florida's purchasing power to negotiate lower ingredient prices and dispensing fees. With increased purchasing power, the agency might be able to negotiate drug ingredient pricing as low as the average wholesale price minus from 15% to 18%. In so doing, we estimate the state could save from $17.2 - $55.0 million (general revenue savings, $7.4 - $23.7 million).

These steps could save up to $306.1 million annually in Medicaid prescription drug costs of which $113.1 million would be state general revenue savings.

While additional major cost controls are possible, such actions are constrained by federal laws. These laws prevent the federal Medicaid program from receiving the lower drug prices obtained by the United States Department of Veteran Affairs, the Department of Defense, the Public Health Service, and certain other public entities. Florida's Medicaid Pharmacy Program can reduce costs using the additional prudent purchasing practices we recommend, but national action is required for states' Medicaid programs to get the lower prices received by other federal programs. The Legislature should consider a resolution urging the U.S. Congress to address the issue of high prescription drug costs.

Appendix A

Florida's Medicaid Prescription Drug Services

Summary

Medicaid covers prescription drugs and some over-the-counter drugs that are medically necessary and prescribed for medically accepted indications and dosages as explained by the drug labeling and in accompanying information. Some of the over-the-counter drugs covered are food supplements, iron supplements, diabetic supplies, contraceptive supplies, and vitamins/phosphate binding antacids for dialysis. Generally, Medicaid does not cover cosmetic items, cough and cold medications for adults, appetite suppressants, adult laxatives, and fertility enhancement drugs. A complete list of covered items is available in the *Medicaid Provider Coverage, Limitations, and Reimbursement Handbook*. The handbook is available at http://www.floridamedicaid.consultec-inc.com.

Prescription limits

- Four brand name prescriptions per month per outpatient recipient age 21 or older
- Prescriptions limited to 34-day supply

Limits are adjustable through drug exception requests to the agency's pharmacy benefit manager. Anti-retroviral agents and prescription drugs used to treat severe mental illnesses such as schizophrenia, severe depression, or bipolar disorder are not subject to prescription limits or prior authorization requirements.

Prior authorization

In order to be reimbursed providers must obtain prior authorization before dispensing Albumin, Neupogen®, Neutrexin®, Procrit®, Provigil®, Regranex®, Botox®, Cytogam®, Growth Hormone for HIV/AIDS Wasting, Panretin™, Proleukin™, Targretin™ Gel and Capsules, and Xenical®.

Drug pricing and dispensing fees

Florida reimburses pharmacies for drug ingredient costs plus a $4.23 dispensing fee, unless the total pharmacy charge is lower. For drug ingredient costs, Florida pays the lower of the four prices noted below.

- Average wholesale price (AWP) minus 13.25%. The AWP is the drug manufacturers' sticker price for a product. It is routinely discounted when manufacturers' sell their products to drug wholesalers and retailers.
- Wholesaler acquisition cost (WAC) plus 7%. The WAC is the average price drug wholesalers' pay drug manufacturers for a product.
- Direct price plus 7%. The direct price is the average price retail pharmacies pay for a drug purchased directly from drug manufacturers.
- Federal or state maximum allowable cost (MAC). MAC prices are applied to drugs available from multiple manufacturers (brand name drugs and their generic equivalents). In general, the MAC price is 150% of the lowest price available nationally for a drug.

Appendix B

State Comparison of Medicaid Pharmacy Costs

Table B-1
Five States Attained Lower Median Retail Drug Unit Costs Per Prescription in 1999 Than Did Florida[1]

State	Median Drug Unit Cost: Comparison State	Median Drug Unit Cost: Florida
Ohio	**$0.2369**	**$0.2508**
Michigan	**0.2467**	**0.2688**
Massachusetts	**0.2574**	**0.2877**
Rhode Island	**0.2703**	**0.2889**
Maryland	**0.2843**	**0.3010**
Tennessee	0.2426	0.2372
California	0.2703	0.2582
Alabama	0.3005	0.2673
Wisconsin	0.3010	0.2816
Illinois	0.3040	0.2660
Nebraska	0.3088	0.2682
Washington	0.3100	0.2758
Missouri	0.3117	0.2659
Kansas	0.3142	0.2693
New Mexico	0.3167	0.2624
Colorado	0.3180	0.2926
Iowa	0.3198	0.2568
Virginia	0.3210	0.2637
Arkansas	0.3213	0.2711
Georgia	0.3217	0.2785
South Carolina	0.3220	0.2686
Minnesota	0.3261	0.2805
New York	0.3278	0.2686
Oklahoma	0.3293	0.2788
West Virginia	0.3307	0.2861
Utah	$0.3314	$0.2746
Montana	0.3320	0.2799
Vermont	0.3379	0.2936
Wyoming	0.3403	0.2701
Maine	0.3433	0.3109
Indiana	0.3438	0.2690
New Hampshire	0.3440	0.2913
Oregon	0.3495	0.2758
North Carolina	0.3507	0.2801
Kentucky	0.3550	0.2629
Mississippi	0.3638	0.2756
South Dakota	0.3655	0.2892
Nevada	0.3716	0.2939
Connecticut	0.3755	0.2931
Louisiana	0.3798	0.2793
New Jersey	0.3841	0.2908
Delaware	0.3980	0.3147
North Dakota	0.4022	0.2997
Idaho	0.4126	0.2964
Hawaii	0.4311	0.3270
Pennsylvania	0.4638	0.2624
Alaska	0.4870	0.3271
Arizona[2]	--------	--------
Texas[3]	--------	--------

Note: States in boldface type have lower median retail drug costs than Florida.

[1]The analysis matched drugs from the states' drug utilization data by their National Drug Code (NDC). The median unit price was calculated for those drugs common to Florida and the comparison state. Drug unit prices include drug ingredient costs and dispensing fees (expenditures for drug / units of drug).

[2]Arizona does not participate in the federal Medicaid drug manufacturer rebate program and does not report drug utilization data.

[3]Texas has not reported Fiscal Year 1999 drug utilization data due to computer problems.

Source: OPPAGA analysis of Health Care Financing Administration State Drug Utilization Data, Fiscal Year 1999.

Table B-2
Some States Have Attained Lower Medicaid Pharmacy Payments Than Has Florida

State	Ingredient Reimbursement	Dispensing Fee
Alabama	WAC + 9.2%	$5.40
Alaska	AWP-5%	**$3.45**
Arizona[1]	AWP-10%	------
Arkansas	AWP-10.5%	$5.51
California	AWP-5%	**$4.05**
Colorado	Lowest of AWP-10% or WAC + 18%	**$4.08**
Connecticut	AWP-12%	**$4.10**
Delaware	AWP-12.9%	**$3.65**
Florida[2]	Lowest of AWP-11.5% or WAC + 7%	$4.23
Georgia	AWP-10%	$4.63
Hawaii	AWP-10.5%	$4.67
Idaho	AWP-11%	$4.94 ($5.54 for unit dose)
Illinois	AWP-10%, AWP-12% for multi-source drugs	**Generic $3.75 Brand $3.45**
Indiana	AWP-10%	**$4.00**
Iowa	AWP-10%	$4.10-$6.38
Kansas	AWP-10%	$4.94
Kentucky	AWP-10%	Outpatient $4.75 Long term care $5.75
Louisiana	AWP-10.5%	$5.77
Maine	AWP-10%	**$3.35**
Maryland	AWP-10%	**$4.21**
Massachusetts	WAC + 10%	**$3.00**
Michigan	**AWP-13.5% (1-4 stores); AWP-15.1% (5 + stores)**	**$3.72**
Minnesota	AWP-9%	**$3.65**
Mississippi	AWP-10%	$4.91
Missouri	AWP-10.43%	**$4.09**
Montana	AWP-10%	**$4.20**
Nebraska	AWP-8.71%	$4.66
Nevada	AWP-10%	$4.76
New Hampshire	AWP-12%	**$2.50**
New Jersey	AWP-10%	**$3.73**
New Mexico	AWP-12.5%	**$4.00**
New York	AWP-10%	Generic $4.50 Brand $3.50
North Carolina	AWP-10%	$5.60
North Dakota	AWP-10%	$4.60
Ohio	AWP-11%	**$3.70**
Oklahoma	AWP-10.5%	**$4.15**
Oregon	AWP-11%	$3.91-$4.28 (based on annual # of Rxs)
Pennsylvania	AWP-10%	**$4.00**
Rhode Island	**WAC + 5%**	**Outpatient $3.40 Long term care $2.85**
South Carolina	AWP-13%	**$4.05**
South Dakota	AWP-10.5%	$4.75 ($5.55 for unit dose)
Tennessee[1]	------	------
Texas	**Lowest of AWP-15% or WAC + 12%**	$5.27 + 2% of ingredient and dispensing fee
Utah	AWP-12%	$3.90-$4.40 (based on geographic area)
Vermont	AWP-10%	$4.25
Virginia	AWP-9%	$4.25
Washington	AWP-11%	$3.90-$4.82 (based on annual # of Rxs)
West Virginia	AWP-12%	**$3.90**
Wisconsin	AWP-10%	$4.88
Wyoming	AWP-4%	$4.70

Note: States in boldface type have lower ingredient reimbursement rates and/or lower dispensing fees than Florida.

[1]Within federal and state guidelines, individual managed care and pharmacy benefit management organizations make formulary/drug decisions.

[2]The 2000 Florida Legislature changed ingredient reimbursement. See Appendix A for current pricing policy.

Source: As reported by state drug program administrators in the 1999 National Pharmaceutical Council survey.

Table B-3
Most States Have Lower Medicaid Annual Prescription Fee-for-Service Drug Costs per Recipient Than Does Florida

	FY 1995-96		FY 1996-97		FY 1997-98	
State	Costs	Rank	Costs	Rank	Costs	Rank
Connecticut	$700.79	3	$1,382.88	1	$1,722.44	1
New Jersey	$720.88	2	$1,065.50	3	$1,375.11	2
Rhode Island	$874.44	1	$1,114.25	2	$1,368.99	3
Missouri	$599.59	9	$810.82	5	$1,080.84	4
Wisconsin	$663.57	5	$772.61	6	$1,048.84	5
Indiana	$670.76	4	$831.37	4	$1,005.87	6
Florida	**$609.83**	**7**	**$754.26**	**7**	**$920.55**	**7**
Ohio	$574.86	11	$738.34	8	$918.79	8
Pennsylvania	$625.77	6	$723.57	10	$904.45	9
Washington	$564.61	13	$700.23	12	$890.75	10
Maine	$605.83	8	$734.91	9	$883.58	11
Minnesota	$510.37	21	$686.39	13	$854.26	12
Maryland	$577.07	10	$673.50	14	$842.01	13
Massachusetts	$574.66	12	$711.85	11	$810.76	14
New Hampshire	$558.92	14	$632.73	19	$787.25	15
Kansas	$505.17	22	$614.86	22	$762.31	16
New York	$522.10	18	$654.06	16	$758.81	17
Alaska	$530.41	16	$672.85	15	$752.00	18
Colorado	$475.19	29	$619.06	21	$749.22	19
Vermont	$466.20	30	$533.26	31	$748.59	20
Kentucky	$548.09	15	$640.24	17	$745.71	21
Virginia	$530.25	17	$629.21	20	$741.32	22
North Dakota	$521.80	19	$636.17	18	$733.10	23
Montana	$492.62	25	$571.26	24	$722.50	24
Iowa	$482.54	28	$560.30	26	$683.71	25
Nevada	$404.56	40	$476.99	40	$678.13	26
South Dakota	$492.24	26	$576.68	23	$667.69	27
Louisiana	$501.22	23	$559.43	27	$638.55	28
Nebraska	$516.79	20	$524.61	34	$636.54	29
Michigan	$462.01	31	$530.25	33	$634.34	30
Idaho	$485.23	27	$563.30	25	$633.49	31
Mississippi	$437.24	35	$533.00	32	$628.68	32
North Carolina	$451.22	33	$518.22	36	$609.93	33
Illinois	$433.74	36	$519.03	35	$607.88	34
Delaware	$451.99	32	$505.50	37	$599.05	35
Alabama	$494.07	24	$547.82	28	$598.74	36
Oregon	$432.90	37	$489.87	38	$592.25	37
California	$343.12	45	$422.71	44	$587.50	38
Arkansas	$450.89	34	$534.31	30	$573.94	39
South Carolina	$393.54	42	$443.46	43	$560.15	40
West Virginia	$416.66	39	$474.23	41	$557.08	41
Utah	$421.18	38	$480.96	39	$542.15	42
Wyoming	$385.02	43	$444.68	42	$527.19	43
Georgia	$358.15	44	$400.56	45	$459.80	44
Texas	$324.32	46	$377.64	46	$431.57	45
New Mexico	$309.63	47	$343.33	47	$429.52	46
Oklahoma[1]	$401.07	41	$534.51	29	---------	--
Arizona[1]	---------	--	---------	--	---------	--
Hawaii[1]	---------	--	---------	--	---------	--
Tennessee[1]	---------	--	---------	--	---------	--

[1]States did not report data or data is not compatible from year to year.

Source: OPPAGA analysis of Health Care Financing Administration 2082 Report, Fiscal Year 1995-96, Fiscal Year 1996-97, Fiscal Year 1997-98.

Appendix C

Federal Legislation

This appendix summarizes federal law related to Medicaid drug manufacturer rebates, requirements for Medicaid drug formularies, and to restricting the use of federal supply and public health services drug pricing.

Title XIX Section 1927 of Social Security Act

Summary of Medicaid drug manufacturer rebate program

For their products to be eligible for Medicaid reimbursement, drug manufacturers must participate in the federal Medicaid rebate program. For single source and multiple-source brand name drugs, the manufacturer pays the state a rebate equal to the difference between the nationwide average manufacturer price wholesalers pay for drugs distributed for the retail pharmacy class of trade and the manufacturer's "best price."[16] The best price is the lowest price offered by the manufacturer to any purchaser at any time during the year, excluding the special prices for federal purchasers and certain other covered entities under the Veterans Health Care Act of 1992. The minimum rebate for brand name drugs must be at least 15.1% of the average manufacturer price nationwide. For generic drugs, the rebate must be 11% of the average manufacturer price nationwide. In Medicaid managed care arrangements the managed care organizations negotiate directly with drug manufacturers for pricing and rebates. Table C-1 shows Florida's average rebate as a percentage of Florida expenditures for last fiscal year.

Table C-1
Drug Manufacturer Rebates to Florida's Medicaid Program
Average 20% of Prescription Drug Expenditures

Type of Drugs	Percent Rebate
Single Source Brand Name Drugs	22.7%
Multiple Source Brand Name Drugs	19.8%
Generic Drugs	3.8%
All Drugs	19.7%

Source: Agency for Health Care Administration, Fiscal Year 1999-2000.

Summary of requirements for drug formularies and prior authorization programs

Federal law requires that a state's Medicaid drug formulary be developed by a committee of physicians, pharmacists, and other appropriate individuals appointed by the governor of the state or the state's drug utilization review board. The committee can only exclude drugs that do not have a significant clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome over other drugs included in the formulary. Further, the committee must provide written explanation to the public that explains the basis for exclusions.

[16] The average manufacturer price includes cash discounts and rebates, excluding Medicaid rebates. The retail pharmacy class of trade excludes direct sales to hospitals, health maintenance organizations, and wholesalers that repackage and label the drugs prior to selling.

Drugs excluded from the formulary must be available through a prior authorization program. A state's prior authorization program must provide a response to requests within 24 hours and provide for dispensing at least a 72-hour supply of the drug in emergency situations.

Veterans Health Care Act of 1992

Summary of federal supply schedule and public health services drug pricing

The **Federal Supply Schedule** generally sets the lowest prices available in the United States. Under the Veterans Health Care Act of 1992 the Federal Supply Schedule sets prescription drug prices paid by the Veterans Administration, the Department of Defense, other federal agencies, and certain other entities, such as Indian tribal governments. The Veterans Administration negotiates prices with manufacturers but federal law limits what manufacturers may charge. For generic and multiple source brand name drugs, with some exceptions, the price may be no higher than the lowest contractual price charged by the manufacturer to any nonfederal purchaser under similar terms and conditions. For single source brand name drugs a price ceiling is set at the average manufacturer price paid by wholesalers nationwide distributed for the retail pharmacy class of trade minus 24%.

The Veterans Health Care Act of 1992 also limits the prices paid by federally qualified health centers, state-operated **public health services**, and other public health service organizations that receive certain types of federal grants. Prescription drug prices for these entities are limited to the average manufacturer price nationwide minus the federal Medicaid rebate percentages.

Appendix D

Prescribed-Drug Spending-Control Program, Chapter 2000-367, *Laws of Florida*

Table D-1
2000 Legislature Medicaid Prescription Drug Cost Control Initiatives

Budget Reduction	Amount
Limit of four brand-name drugs per month per recipient and 34-day supply per prescription	$ 70,000,000
Management of drug therapies of Medicaid recipients receiving nine or more prescriptions per month	41,000,000
Implement voluntary preferred drug list	25,000,000
Drug ingredient cost reimbursement to pharmacies set at average wholesale price less 13.25%	24,126,993
Limit the size of pharmacy network based on need, competitive bidding, price negotiations, credentialing, or similar criteria	22,585,849
Use of counterfeit-proof prescription pads for Medicaid prescriptions	18,000,000
Establish guidelines implementing federal Food and Drug Administration drug utilization standards	17,500,000
Limit the use of drugs as indicated by labeling	10,000,000
Supplemental drug manufacturer rebates of at least 15.1% for generic drugs	2,996,082
Total of Budget Reductions	**$231,208,924**
General Revenue Reductions	**$100,323,701**
Trust Fund Reductions	**130,885,223**

Source: Chapters 2000-166 and 2000-367, *Laws of Florida.*

Appendix E

Response from the Agency for Health Care Administration

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was submitted to the Secretary of the Agency for Health Care Administration to review and respond.

The Secretary's written response is reprinted herein beginning on page 18.

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., SECRETARY

February 13, 2001

Mr. John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability
111 West Madison Street, Room 312
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

Thank for you the opportunity to respond to your report entitled *Growth in Medicaid Prescription Drug Costs Demands Prudent Purchasing Practices.* Your recommendations to the Legislature and our responses follow.

Recommendation:
Authorize the Agency for Health Care Administration to develop and use a mandatory drug list and negotiate supplemental rebates.

Agency Response:
The Agency supports the recommendation to implement a mandatory drug list with supplemental rebates. Based on our experience in developing the current voluntary preferred drug list and related supplemental rebates, the Agency will need additional statutory authority to effectively employ a mandatory drug list with supplemental rebates.

Recommendation:
Direct the agency to develop and implement strategies to encourage compliance with using drugs on the preferred drug list.

Agency Response
The Agency supports the recommendation.

Recommendation:
Require the agency to competitively bid contracts for Medicaid pharmacy networks.

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

Visit AHCA Online at
www.fdhc.state.fl.us

Mr. John W. Turcotte
Page Two
February 13, 2001

Agency Response
The Agency supports this recommendation. Any effort to limit provider participation through bids and networks will require a federal waiver. The Agency would like to pursue the development and submission of such a waiver. This waiver would also require definition of the unique credentialing criteria and selection process for a pharmacy's inclusion in such a network.

Each of these recommendations is included in the fiscal year 2001-02 Governor's Budget Recommendations. If you have any questions regarding this material, please call Kathy Donald at 922-8448.

Sincerely,

for

Ruben J. King-Shaw, Jr.
Secretary

RJKS/kd

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

Visit the *Florida Monitor*, OPPAGA's online service. See http://www.oppaga.state.fl.us. This site monitors the performance and accountability of Florida government by making OPPAGA's four primary products available online.

- OPPAGA publications and contracted reviews, such as policy analyses and performance reviews, assess the efficiency and effectiveness of state policies and programs and recommend improvements for Florida government.
- Performance-based program budgeting (PB^2) reports and information offer a variety of tools. Program evaluation and justification reviews assess state programs operating under performance-based program budgeting. Also offered are performance measures information and our assessments of measures.
- Florida Government Accountability Report (FGAR) is an Internet encyclopedia of Florida state government. FGAR offers concise information about state programs, policy issues, and performance. Check out the ratings of the accountability systems of 13 state programs.
- Best Financial Management Practice Reviews for Florida school districts. OPPAGA and the Auditor General jointly conduct reviews to determine if a school district is using best financial management practices to help school districts meet the challenge of educating their students in a cost-efficient manner.

Subscribe to OPPAGA's electronic newsletter, Florida Monitor Weekly, a free source for brief e-mail announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475). ***Florida Monitor:*** http://www.oppaga.state.fl.us/

Project supervised by Yvonne Bigos, Chief Legislative Analyst (850/487-9230)

Project conducted by Steve Harkreader (850/487-9225)

John W. Turcotte, OPPAGA Director