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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

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Inflated Pricing and Confidential Information Prevent Medicaid from Ensuring Lowest Prescription Drug Prices

at a glance

Medicaid prescription drug expenditures, which were $2.5 billion in Fiscal Year 2004-05, have nearly doubled since Fiscal Year 2000-01, growing an average of 15.1% per year. Legislative actions have helped to slow the growth rate of these expenditures, which rose at an average rate of 21.2% annually during the previous five-year period (Fiscal Years 1995-96 to 1999-00). Much of this slowed growth has been the result of specific cost-containment actions directed at lowering the price that Medicaid pays for drugs.

However, the state's ability to obtain the lowest possible prices for prescription drugs is hindered by inflated manufacturer pricing information and lack of access to confidential information. The Legislature should consider requiring pharmaceutical manufacturers to submit more accurate pricing information to the Agency for Health Care Administration (AHCA) as well as requiring AHCA to strengthen cost-containment strategies to achieve lower prescription drug prices.

Scope

As required by Chapter 2005-133, *Laws of Florida,* this report discusses Medicaid prescription drug pricing, issues that contribute to inflated prescription drug prices, and options for obtaining savings in Medicaid's prescription drug program by paying prices that are closer to pharmacy costs.

Background

Florida's Medicaid program, administered by the Agency for Health Care Administration (AHCA), is among the largest in the country, serving approximately 2.3 million persons each month. Medicaid provides health care coverage to low-income persons who meet federal and state eligibility requirements, including low-income families and children, elderly persons who need long-term care services, and persons with disabilities.

For Fiscal Year 2005-06, the Legislature appropriated $15.6 billion, including nearly $4.5 billion in general revenue, to operate the Medicaid program.[1] Most of these funds ($15.4 billion) will pay for health care services for Medicaid recipients, while $225 million (1.4%) will pay for administrative functions such as program planning, data processing, and contract management.

Florida provides prescription drug coverage as part of its Medicaid program.[2] For outpatient services, Medicaid pays for most prescription drugs and selected over-the-counter medicines.[3]

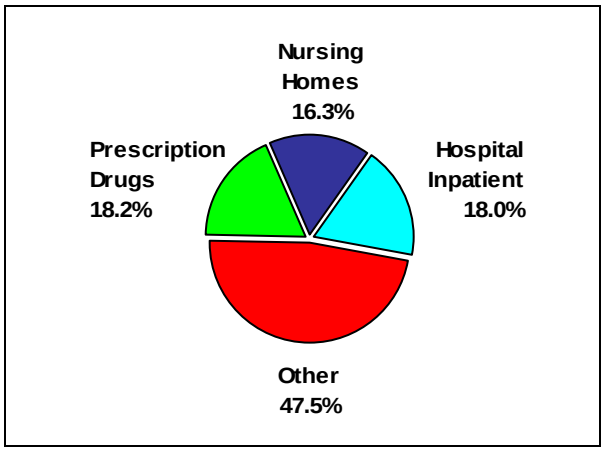
[1] The remaining $11.1 billion comes from trust funds that include federal matching funds as well as other state funds from hospital taxes, drug rebates, and county contributions.

[2] The prescription drug program is an optional Medicaid service, but all states provide prescription drug coverage.

[3] Medicaid does not make specific prescription drug payments to health maintenance organizations and hospitals as prescription drug costs are included as part of their reimbursement.

In Fiscal Year 2004-05, the Florida Medicaid program paid $2.5 billion for prescription drugs. As shown in Exhibit 1, this represented 18.2% of the expenditures for all Medicaid services that year.

Exhibit 1
Prescription Drugs Accounted for 18.2% of Total Expenditures for Medicaid Services in Fiscal Year 2004-05



Source: OPPAGA analysis of AHCA expenditure data.

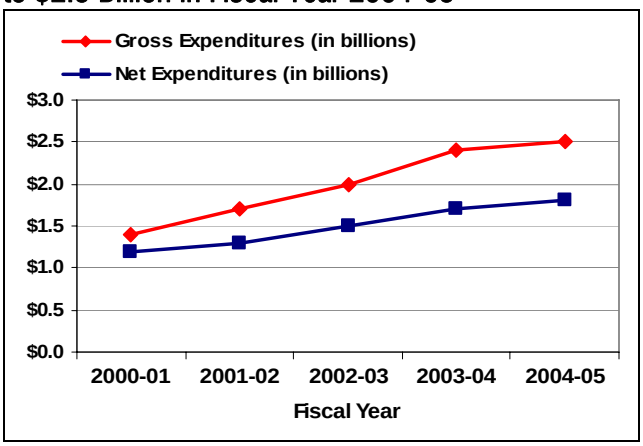
Findings

Prescription drug expenditures have continued to increase, but legislative actions have slowed the growth of these expenditures

Prescription drug expenditures have been one of the fastest growing components of health care and continue to increase annually. To address this rapid growth in the Medicaid program, the Legislature has directed AHCA to implement several cost-containment strategies to slow increases in the price of prescription drugs. These strategies have been successful in slowing both the rate of growth in drug expenditures and the average price per prescription.

Exhibit 2 shows that Medicaid gross prescription drug expenditures increased from around $1.4 billion in Fiscal Year 2000-01 to $2.5 billion in Fiscal Year 2004-05 (or 76%). [4] This represents an average annual growth rate of 15.1% compared to 21.2% annually during the prior five-year period (Fiscal Year 1995-96 to Fiscal Year 1999-00).

Exhibit 2
Medicaid Gross Prescription Drug Expenditures Increased from $1.4 Billion in Fiscal Year 2000-01 to $2.5 Billion in Fiscal Year 2004-05



Source: OPPAGA analysis of AHCA expenditure data.

Net drug expenditures, which take into account federal and state rebates, grew by 54% between Fiscal Year 2000-01 and Fiscal Year 2004-05. (See Exhibit 2.) The annual growth rate during this period was 11.4% which is substantially lower than the 20.9% average net cost increase experienced between Fiscal Years 1995-96 to 1999-00.

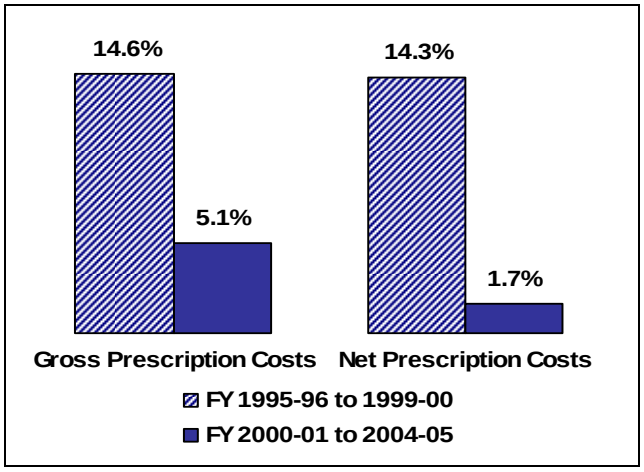
This slower rate of expenditure growth likely resulted from legislatively mandated strategies to control drug price increases. In recent years, the Legislature has mandated that AHCA implement a preferred drug list, which shifts utilization to lower cost drugs and requires brand name drug manufacturers to pay additional cash rebates to the state. The Legislature also has directed AHCA to adjust its pharmacy reimbursement formulas to yield greater discounts and to establish state maximum prices for generic drugs.

The slowed growth in the average price per prescription over the last five years demonstrates the overall success of these strategies. The average price per prescription, without considering rebates, grew by 5.1% during the past five years compared to 14.6% for

[4] Gross expenditures represent total reimbursements to providers and do not account for federal and state rebates. Both Fiscal Year 2004-05 gross and net pharmacy expenditures may change as providers submit final invoices and the state reconciles federal and state rebates.

the previous five-year period. Due to savings achieved from federal and state supplemental rebates, the net cost per prescription grew at a much slower average rate (1.7%) over the past five years compared to the previous five-year period (14.3%). (See Exhibit 3.)

Exhibit 3
Average Prescription Costs Grew at a Slower Rate Between Fiscal Years 2000-01 and 2004-05 Compared to the Prior Five Years



Source: OPPAGA analysis of AHCA drug expenditure data.

Appendix A summarizes Florida's strategies to control Medicaid prescription drug costs and how they have slowed the rate of price increases.

Fundamental flaws related to manufacturer pricing information prevent the state from ensuring that it pays the lowest possible price for prescription drugs

Florida, like all states, seeks to obtain the lowest possible prices for Medicaid prescription drugs. [5] Pricing for prescription drugs is highly complex and is based on the prices paid to pharmacies as well as manufacturer rebates that are required by the federal and some state governments. However, Florida's ability to ensure that it is paying the lowest possible cost for Medicaid prescription drugs is hindered because it must establish pharmacy reimbursement rates using manufacturers' published prices that are inflated and unreliable. While the federal government collects data on manufacturer prices based on actual sales transactions, this information is confidential. As a result, Florida's Medicaid program can not be certain that it obtains the lowest possible prices for prescription drugs.

Pharmacy reimbursements and manufacturer rebates determine how much Florida's Medicaid program pays for prescription drugs. The amount that Florida's Medicaid program spends for prescription drugs depends on two factors: (1) how much Medicaid pays pharmacies for these drugs, and (2) how much Medicaid receives from drug manufacturers in cash rebates. Each state's Medicaid program determines, within federal guidelines, what to pay pharmacies for dispensed drugs. In addition, all states receive manufacturer rebates that are prescribed by federal law, and some states, including Florida, also negotiate with manufacturers for additional rebates (state supplemental rebates). Florida's gross expenditures for Medicaid drugs are reduced by the amount of these manufacturer rebates. In Fiscal Year 2004-05, Florida received $735 million in federal and state manufacturer rebates. [6]

Florida's Medicaid program pays pharmacies the lower of two costs: (1) what it estimates pharmacies pay for drugs (referred to as acquisition costs) plus a $4.23 dispensing fee, or (2) the pharmacy's usual and customary price for the drug. [7] As illustrated in Exhibit 4, AHCA's prescription drug pricing algorithm first selects the lowest estimated acquisition cost and adds the dispensing fee. The algorithm then compares this price to the pharmacy's usual and customary price and pays the lower of these prices. AHCA estimates acquisition costs using two nationally published prices, the Average Wholesale Price (AWP) and the Wholesale Acquisition Cost (WAC); and two maximum prices, the federal upper limit (FUL) and the state maximum

[5] Federal legislation intends for the Department of Veteran's Affairs, the Department of Defense, the Public Health Service, and the U.S. Coast Guard to receive the lowest prices for prescription drug purchases.

[6] Final rebates for Fiscal Year 2004-05 could change as rebates are received and reconciled.

[7] The usual and customary charge reflects the prescription price for persons without insurance.

allowable cost (SMAC). [8] Appendix B provides a glossary of prescription drug pricing terms, and Appendix C details the agency's methods for estimating pharmacy acquisition costs. Appendix D describes the federal and state rebate processes.

Exhibit 4
AHCA Reimburses Pharmacies by Paying the Lower of AHCA's Estimated Prescription Cost or the Usual and Customary Price

Definitions

- Average Wholesale Price (**AWP**). Retail list price (sticker price) or the average price manufacturers recommend that wholesalers sell to physicians, pharmacies, and others.
- Wholesale Acquisition Cost (**WAC**). The average cost at which a manufacturer sells a drug to wholesalers.
- Federal Upper Limit (**FUL**). The maximum amount that the federal government establishes for selected multi-source generic drugs.
- State Maximum Allowable Cost (**SMAC**). The maximum amount a particular state establishes for payment of selected multi-source generic drugs; these can be lower than FUL prices.

[1] Because AWP prices are generally 25% over WAC prices, the state's pricing formulas create equivalent AWP and WAC price estimates.

Source: OPPAGA.

Both federal law and Florida law require manufacturers to provide cash rebates in order for Medicaid to cover their products. These rebates must reach a minimum percentage of the average manufacturer price (AMP). [9] The AMP reflects the average price at which manufacturers sell their products, after accounting for purchasers' discounts and rebates. The Centers for Medicare and Medicaid Services (CMS) calculates federal rebates using AMP information, which manufacturers report quarterly to CMS. Florida statute also requires AHCA to establish state supplemental rebates for brand name drugs based on a minimum percentage of the AMP.

Unreliable information, inflated prices, and confidential manufacturer prices prevent Medicaid from ensuring that it pays the lowest price. To estimate the price that pharmacies pay for drugs, Florida, as most states, generally uses published prices (AWP and WAC) provided by manufacturers that are reported in commercial publications. [10] However, pharmacies' actual purchase prices are sometimes significantly lower than these published prices. Research conducted by the Congressional Budget Office and the U.S. Department of Health and Human Services' Office of the Inspector General suggests that pharmacies sometimes purchase drugs at prices significantly lower than published prices. Since states set pharmacy reimbursements by estimating acquisition costs using published prices, states could sometimes reimburse pharmacies at rates that are high relative to pharmacy costs.

Recently settled federal and state lawsuits have shown that some manufacturers have intentionally inflated the AWP and WAC prices reported to companies that publish manufacturer prices. For example, in September 2005, the United States Department of Justice settled with one manufacturer for $150 million for fraudulent and inflated pricing of two drugs. Florida's Attorney General has subpoenaed six manufacturers for reporting inflated AWP and WAC prices. The results of these suits are pending but could represent over $100 million in

[8] AHCA obtains manufacturer prices from First DataBank, a supplier of electronic drug information that publishes AWP and WAC prices, which represent manufacturers' published list prices to wholesalers and pharmacies.

[9] Federal rule stipulates that manufactures pay rebates at a minimum of 15.1% of the AMP for brand name drugs and 11% for generic drugs. State law requires that total federal and state rebates for brand name drugs reach a minimum of 29% of the AMP. Florida does not negotiate generic rebates.

[10] In addition to *First DataBank*, other industry publications include the *Red Book* , the *Blue Book,* and *Medi-Span.*

overpayments plus additional fines. In addition, at least 16 states besides Florida have filed lawsuits against manufacturers for inflated pricing practices. [11]

Manufacturers that inflate AWP and WAC published prices do so to encourage pharmacies to purchase their products. By selling drugs to pharmacies at much lower prices, manufacturers achieve higher sales volume and pharmacies achieve a greater profit margin. However, this occurs at the expense of the Medicaid program which pays more than it should for prescription drugs. For example, in an April 2005 Florida lawsuit, the Attorney General's Office charged one manufacturer with reporting prices nearly 600% higher than a pharmacy's actual cost to purchase the drug. One instance cited in this lawsuit showed that Florida's Medicaid program reimbursed a pharmacy based on an inflated AWP published price, resulting in the state paying $683 for a drug that only cost the pharmacy $97.88. While such price inflation can occur in both brand name and generic markets, the competitive nature of the generic market is much more susceptible to this practice. [12]

A more ideal benchmark for Florida to use when estimating pharmacy drug purchase costs is the Average Manufacturer Price (AMP). This price takes into account available discounts and rebates, and policy experts generally consider it to be the most accurate market price. However, manufacturers generally keep these prices confidential except to the federal government which uses them to determine rebates. Thus, states cannot use AMP information to estimate pharmacy costs unless they require such access in state law. The U.S. Congress is currently considering making AMP information available to states. If this legislation passes, states would have access to AMP information without having to require access in state law. [13]

Texas state law requires manufacturers to submit AMP information to its Medicaid program quarterly. The Texas Medicaid program retains the confidentiality of manufacturer information but uses this data to compare against the 'net wholesaler price' that Texas also requires manufacturers to report. Texas uses this 'net wholesaler price' instead of the published WAC to estimate wholesaler acquisition costs. The 'net wholesaler price' differs from the commonly published WAC as it includes all forms of manufacturer discounts. In instances when an AMP is significantly lower than the 'net wholesaler price,' the Texas Medicaid program, in conjunction with the Texas Attorney General's Office, requires the manufacturer to revise the 'net wholesaler price.' By doing this, Texas can better ensure that it reimburses pharmacies at prices that more appropriately reflect pharmacy costs.

Despite pricing flaws, Florida should continue efforts to reduce the cost of Medicaid prescription drugs

Even though current pricing information is flawed, Florida can work toward achieving even lower Medicaid prescription drug prices by modifying its formula for reimbursing both brand and generic drugs, expanding its maximum pricing for generic drugs, negotiating supplemental rebates for generic drugs, and/or forming or joining a multi-state purchasing pool to retain its negotiating leverage after Medicare Part D becomes effective.

The state could modify its formulas for estimating acquisition costs that use published AWP and WAC prices. The Legislature could reduce pharmacy reimbursements for some drugs by mandating a higher discount off the AWP, a lower markup on the WAC, and/or that AHCA develop separate formulas to estimate the acquisition costs for brand name and generic drugs. AHCA currently reimburses pharmacies

[11] These states are Alabama, Arizona, Arkansas, California, Connecticut, Illinois, Kentucky, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New York, Ohio, West Virginia, and Wisconsin.

[12] Unlike brand name drugs in which only one manufacturer produces and markets, numerous manufacturers produce and market generic drugs. Thus, generic drug manufacturers must compete for market share, and therefore, are more likely to offer pharmacies deep discounts to purchase their products.

[13] This issue is expected to be voted on when Congress reconvenes at the end of January 2006.

at AWP-15.4% for both brand name and generic drugs. However, as of March 2005, other states were reimbursing pharmacies for brand name drugs using AWP discounts ranging from 5% to 17%. In addition, six states reimbursed pharmacies for generic drugs using AWP discounts ranging from 20% to 40%. [14] If Florida had reimbursed pharmacies at the high end of these ranges, Medicaid could have saved $24.6 million in Fiscal Year 2004-05. [15] (See Exhibit 5.)

Exhibit 5
Medicaid Could Have Saved $24.6 Million in Pharmacy Expenditures by Increasing the Discount Off the AWP in Fiscal Year 2004-05

Drug Type	Revised Discount Price	Approximate Savings Against Fiscal Year 2004-05 Expenditures
Brand Name Drug	AWP-17%	$ 4.6 million
Generics[1]	AWP-40%	20.0 million
Total		**$24.6 million**

[1]These estimates were developed only for those drugs in which the 'lowest price' would have been derived by using AWP-17% for brand named drugs and AWP-40% for generics.

Source: OPPAGA analysis using AHCA drug expenditure data.

Increasing the discount off the AWP to 17% and 40% for brand and generic drugs, respectively, would enable AHCA to reimburse pharmacies at a price that is closer to what they actually pay to purchase drugs while still allowing pharmacies to make a profit. [16] Florida could set even more aggressive discounts for estimating acquisition costs. Recent research conducted by the U.S. Department of Health and Human Services stated that manufacturer prices are on average equal to AWP-23% and AWP-70% for brand name drugs and generics, respectively. [17]

The agency should continue to expand state maximum pricing for generic drugs and update these prices more frequently. Florida sets state maximum allowable costs (SMAC) for some generic drugs that meet specific criteria, and these SMAC prices should be lower than federal upper limit prices and estimated acquisition costs using published prices. [18] As directed by the Legislature, AHCA has increased efforts to set SMAC prices for generic drugs. In the last quarter of Fiscal Year 2004-05, the SMAC price was the lowest price for 17% more generic products compared to the first quarter of that fiscal year. [19] AHCA updates SMAC prices quarterly and, between June and December 2005, nearly doubled the number of products with maximum prices. [20]

Because the generic drug market operates like a commodities market, maximum prices should be updated often. According to an industry source, generic drug prices can change frequently, with up to 25% of the prices changing weekly mainly due to competition for market share. As shown in Exhibit 6, in the last quarter of Fiscal Year 2004-05, the state maximum price was not the lowest price for over half (53%) of these products, indicating that Florida may benefit from changing SMAC prices more often than quarterly.

[14] One additional state, Washington, reimburses generics produced by five or more manufacturers at AWP minus 50%.

[15] This analysis does not estimate savings for Fiscal Year 2005-06, because implementation of the Medicare Part D Prescription Drug Plan will significantly change Medicaid drug expenditures.

[16] An equivalent adjustment also could be made to the WAC price by reducing its markup from the current 5.75%.

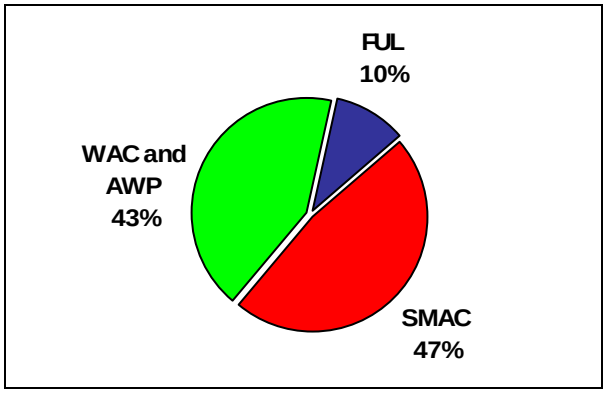
[17] *Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices,* June 2005, U.S. Department of Health and Human Services, Office of Inspector General.

[18] The specific criteria are related to the number of manufacturers that produce the generic drug. Unlike the federal government, states are not limited to a percentage of published prices when setting maximum prices.

[19] As directed by the 2004 Legislature, AHCA expanded the SMAC program during the last quarter of the fiscal year after contracting with Provider Synergies in October 2004. Prior to contracting with Provider Synergies, AHCA set maximum prices on an ad hoc basis.

[20] The number of products refers to the total number of unique drug formulations based on characteristics such as forms (capsules, pills, liquids, etc.), dosages (50 mg, 100 mg, etc.), manufacturer, and package size.

Exhibit 6
The SMAC Price Was the Lowest Price for Only 47% of Drugs With SMAC Prices During the Last Quarter of Fiscal Year 2004-05



Source: OPPAGA analysis using AHCA drug expenditure data.

Michigan contracts with a vendor for daily price surveillance. By doing so, it has established maximum prices on two and one-half times as many drug products as Florida and changes maximum prices to follow market fluctuations. These efforts saved Michigan's Medicaid program an estimated $47 million in the first year of the contract with the vendor.

The agency could negotiate generic drug supplemental rebates. In addition to setting maximum prices for generic drugs, AHCA could negotiate supplemental rebates for generic drugs. The Legislature has authorized AHCA to negotiate generic rebates, but it has not done so. [21] In contrast, Texas has negotiated rebates for generic drugs since December 2004. The Texas Medicaid program increased its dispensing fee by $0.50 to encourage pharmacies to fill prescriptions with generic drugs for which Texas receives a supplemental rebate. Texas Medicaid officials estimate that every 1% shift from brand name to generic drugs generates about $15 million in savings. [22]

ACHA should evaluate forming or joining a purchasing pool to preserve negotiating power. In January 2006 with the implementation of the Medicare Part D Prescription Drug Plan, approximately 377,000 Medicaid 'dual eligibles' will transition onto the Medicare plan thereby reducing Medicaid prescription drug volume and shifting drug purchasing patterns. [23] Overall state expenditures are expected to decrease by nearly $1.2 billion representing 19.1 million prescriptions or 50% of the expenditures, with purchases in some therapeutic classes likely to decrease by up to 75%. This change in spending could reduce Florida's ability to continue negotiating the same level of supplemental rebates.

Some states have increased their negotiating power with drug manufacturers by forming multi-state purchasing pools. [24] For example, Michigan is part of a nine-state pool that contracts with a pharmacy benefit manager to manage their pool. The vendor negotiates supplemental rebates based on the total number of lives covered in the pool. Should Florida's Medicaid program lose negotiating power with supplemental rebates after implementation of Medicare Part D, AHCA should evaluate the possible benefits of joining or creating a multi-state purchasing pool.

[21] Section 409.912(39)(a)6., *F.S.* To accomplish this, the agency might need to establish an administrative structure to negotiate and invoice these rebates.

[22] While Florida Medicaid generic prescription drugs comprise only 15% of the total drug expenditures, they comprise almost 50% of total drug claims.

[23] Medicaid dual eligibles are Medicaid recipients who qualify for Medicare and Medicaid and have relied on Medicaid to pay for prescription drugs.

[24] There are currently two multi-state purchasing pools. One includes Louisiana, West Virginia, Wisconsin and Maryland. A second pool includes Michigan Alaska, Hawaii, Minnesota, Montana, Nevada, New Hampshire, Tennessee, and Kentucky.

Recommendations

To achieve lower Medicaid prescription drug prices, we recommend that the Legislature take the actions discussed below.

- Require manufacturers to report 'net wholesaler prices' and average manufacturer prices (AMP) to AHCA and direct the agency to use this information to reimburse pharmacies. Texas uses 'net wholesaler prices' which take into account all discounts to more accurately estimate pharmacy acquisition costs and, thereby, reduce its Medicaid prescription drug costs. Texas also uses AMP information to ensure that 'net wholesaler prices' reported by manufacturers are reasonable.
- Direct AHCA to lower pharmacy reimbursements by modifying its formulas for estimating pharmacy acquisition costs. AHCA currently reimburses pharmacies at AWP-15.4% for both brand name and generic drugs. Revising these formulas by increasing the discount off the AWP, reducing the markup on the WAC, and/or developing different formulas for brand name and generic drugs would estimate pharmacy costs that are closer to what pharmacies actually pay for drugs.
- Direct AHCA to continue expanding state maximum pricing for generic drugs and update the maximum pricing list more frequently. To improve maximum pricing efforts for generic drugs, AHCA should continue to increase the number of generic drugs for which it sets a maximum price. To ensure that a greater percentage of the maximum prices are the lowest price, AHCA should consider adjusting maximum prices more often than quarterly in order to respond to frequent price fluctuations in the generic drug market.
- Direct AHCA to negotiate generic drug supplemental rebates. Current Florida law authorizes the agency to negotiate generic rebates, but it has not done so. AHCA could model Texas' generic rebate program which allows pharmacies to dispense any generic drug without prior authorization, but encourages pharmacies to dispense rebated generics by increasing the dispensing fee for these drugs.
- Direct AHCA to evaluate participation in a purchasing pool. Under Medicare Part D, the state will reduce prescription drug purchases by nearly 50%, which may affect the state's ability to negotiate the current level of state supplemental rebates. Because of changes in volume and purchasing patterns due to Medicare Part D, AHCA should evaluate the benefits of joining or creating a multi-state purchasing pool.

Appendix A

Medicaid Pharmacy Cost-Containment Strategies Have Slowed Price Increases for Prescription Drugs

Two major factors contribute to increases in Medicaid prescription drug expenditures, price and volume. Volume takes into account utilization (or the number of prescriptions used per person), and enrollment (or the number of persons participating in the Medicaid program). Since 2000, Florida has implemented many strategies to slow growth in Medicaid prescription drug expenditures. Many of these strategies have focused specifically on controlling drug prices. For example, the Legislature required the Agency for Health Care Administration (AHCA) to take the actions described below.

- Implement a mandatory Preferred Drug List (PDL). The 2001 Legislature directed the agency to develop a mandatory PDL and negotiate state supplemental rebates with manufacturers. OPPAGA found that the PDL saved $81 million in its first year of implementation. [25] The PDL includes drugs by therapeutic class that are efficacious and have a low cost relative to other drugs in the class. Brand name drug manufacturers can have their drugs placed on the PDL by offering the state cash rebates, which lowers the net cost of their drugs to the state. The PDL essentially shifts utilization to lower cost drugs that are equally effective which lowers Medicaid's overall cost for prescription drugs. The Legislature has continued to strengthen the PDL, including requiring the agency to negotiate only *cash* supplemental rebates and including previously exempt mental health drugs on the preferred drug list.
- Expand the State Maximum Allowable Cost Program (SMAC). In Fiscal Years 2003-04 and 2004-05, the Legislature directed the agency to expand the SMAC program and reduced the agency's budget $11.8 million and $25 million, respectively, in anticipation of savings. Because pharmacies receive deep discounts from wholesalers or manufacturers of generic drugs, states set maximum prices below the price that would be paid using the standard discount off published prices. In October 2004, AHCA contracted with a private vendor to develop a more comprehensive state maximum pricing program. By the fourth quarter of Fiscal Year 2004-05, the lowest price for approximately 17% of generic drugs was the SMAC price compared to less than 1% during the first quarter of Fiscal Year 2004-05.
- Modify formulas that estimate pharmacy acquisition costs. In both 2000 and 2004 the Legislature directed AHCA to modify its formulas for estimating acquisition costs. The most recent modification lowered pharmacy reimbursements by (1) increasing the discount off the Average Wholesale Price (AWP) from AWP-13.25% to AWP-15.4% and (2) reducing the markup to the Wholesale Acquisition Cost (WAC) from WAC+7% to WAC + 5.75%. [26]

[25] *Progress Report: Changes to Medicaid Preferred Drug List Requirements and Competitive Bidding Pharmacy Contracts Could Save an Additional $86.6 Million in 2003-04,* Report No. 03-27, April 2003.

[26] In 2000, the Legislature directed AHCA to increase the discount off the AWP from AWP-11.5% to AWP-13.25%.

Together, these efforts have slowed the rate of price increases for Medicaid prescription drugs. An analysis of the relative contribution of price and volume shows that efforts to control prices have been effective. Table A-1 shows that over the past five years, only 15.4% of the increase in prescription drug spending was due to increases in the cost of prescriptions, while 84.6% was due to increases in volume. In contrast, during the five years prior to the Legislature taking these price control actions, 70.3% of expenditure increases were due to higher drug prices, with the remaining 29.7% due to volume.

Table A-1
Relative Contribution of Price and Volume to Drug Expenditures Has Reversed

Source of Increase	Fiscal Year 1995 -96 to Fiscal Year 1999-00	Fiscal Year 2000– 01 to Fiscal Year 2004-05
Price	70.32%	15.41%
Volume	29.68%	84.59%
Utilization	29.12%	68.91%
Enrollment	0.56%	15.68%

Source: OPPAGA analysis of AHCA pharmacy summary data.

Appendix B

Medicaid Pharmaceutical Pricing Includes Many Terms

The table below provides an alphabetical listing of terms that define the different pharmaceutical prices. The table also includes a description of how each price is used as well as the advantages, limitations, or other considerations associated with the price.

Table B-1
Pharmaceutical Pricing Terms Reflect Different Calculation Methods for Different Uses

Short Title	Pricing Term	Definition	Use	Advantages, Limitations, or Other Issues	Publicly Available
AMP	Average Manufacturer Price	The average price at which manufacturers sell drugs to wholesalers and other purchasers that distribute to pharmacies. The AMP is net of customary prompt pay discounts and rebates.	Used by the federal government to calculate rebates that drug manufacturers are required to give to state Medicaid programs	This price is defined as the average price paid to manufacturers by wholesalers for drugs distributed to retail pharmacies. This price is generally considered the most accurate market price, as it accounts for discounts and rebates.	No
ASP	Average Sales Price	The weighted average price manufacturers sell drugs to all purchasers excluding government entities. The ASP is net of all price concessions for volume, prompt pay, cash discounts, and rebates.	As of January 2005, used by the federal government to reimburse providers for drugs covered under Medicare Part B that are not covered on a cost or prospective payment basis	This price is considered to be closely aligned with the actual costs of drugs because it accounts for all discounts and rebates. However, while it is collected on a quarterly basis, there is a three- to six-month time lag.	Yes
AWP	Average Wholesale Price	Retail list price (sticker price) or the average price that manufacturers recommend wholesalers sell to physicians, pharmacies and others, such as hospitals.	Used by states to estimate pharmacy acquisition costs.	This price is not defined in law or statute and is developed by manufacturers. This price does not accurately reflect actual market prices because it excludes discounts available to various purchasers.	Yes
Best Price	Best Price	The lowest price available from the manufacturer to any purchaser, excluding certain government purchasers.	Used by the federal government to calculate rebates that manufacturers are required to give to state Medicaid programs	This price should reflect the lowest price paid by any private-sector purchaser and must include certain discounts, such as volume discounts, that are available to purchasers.	No
EAC	Estimated Acquisition Cost	State Medicaid programs' best estimate of what a pharmacy pays for a drug.	Federal Medicaid law directs states to use an estimated acquisition cost to reimburse pharmacies.	States develop formulas that try to account for likely discounts and rebates. Research suggests that pharmacies generally receive larger discounts than those estimated, so states pay significantly more than actual pharmacy acquisition costs.	Yes

Short Title	Pricing Term	Definition	Use	Advantages, Limitations, or Other Issues	Publicly Available
FUL	Federal Upper Limit	The maximum amount that states should pay pharmacies for selected multi-source generic drugs.	Ensures that all states pay no more that the established maximum price for both the generic and brand name version of a drug.	The Centers for Medicare and Medicaid Services (CMS) sets maximum prices for generic drugs that are available from at least three manufacturers and provides this information to states. However, CMS has not set maximum prices for all eligible drugs and research suggests FUL prices are still too high.	Yes
NWAC	Net Wholesale Acquisition Cost	This is the net price that manufacturers quote to wholesalers, distributors, and direct purchasers, such as nursing homes and chain warehouses. The prices must be the net of all discounts and rebates.	The Texas Medicaid program uses this information to estimate acquisition costs.	This price is only available in Texas, as mandated by Texas state law. By requiring manufacturers to submit accurate purchaser costs, the Medicaid program can estimate acquisition costs more accurately.	Yes
SMAC	State Maximum Allowable Cost	The maximum amount a state will pay for selected multi-source generic drugs.	Ensures that the state pays no more than the state-established maximum price for both the generic and brand name version of a drug.	States set prices for selected generic drugs. Prices can be lower than the federal maximum price. Maximum price programs are difficult to develop and maintain, because generic drug prices change frequently and pharmacy purchase prices are not readily accessible.	Yes
U&C	Usual and Customary	The full retail price that individuals without insurance would pay a pharmacy for a particular drug.	Used in determining pharmacy reimbursement by comparing to the states' estimated acquisition costs and selecting the lowest price.	This price is seldom used to reimburse pharmacies for Medicaid prescription drugs as it is rarely the lowest price.	Yes
WAC	Wholesale Acquisition Cost	The average price at which a manufacturer sells a drug to wholesalers.	Used by states to estimate pharmacy acquisition costs.	This price is developed by manufacturers. It does not include prompt pay or other discounts, rebates or reductions.	Yes

Source: OPPAGA analysis of Medicaid pharmaceutical pricing terms, 2005.

Appendix C

Florida Reimburses Pharmacies the Lowest Estimated Cost

Federal Medicaid rules require states to reimburse pharmacies the lower of the estimated acquisition cost or the usual and customary cost that a pharmacy charges for a drug. [27] To estimate pharmacy acquisition costs, states use one or both of two prices reported by manufacturers to commercial companies such as First Data Bank. However, because these prices do not include the discounts and rebates that manufacturers provide to purchasers, a pharmacy's actual purchase price is lower than published prices. [28] Florida uses several approaches to estimate acquisition costs taking into account anticipated discounts.

- Average Wholesale Price (AWP) is the suggested or sticker price and represents the average price manufacturers suggest to wholesalers for selling prescription drugs to physicians, pharmacies, and others. Florida estimates that pharmacies purchase drugs at AWP-15.4%.
- Wholesale Acquisition Cost (WAC) is the reported average cost at which the manufacturer sells the drug to wholesalers. Florida estimates that pharmacies purchase drugs at WAC+5.75%
- Federal Upper Limit (FUL) is a maximum price set by the Centers for Medicare and Medicaid Services for some generic drugs. In general, the FUL price is 150% of the lowest price available nationally for a drug.
- State Maximum Allowable Cost (SMAC) is a state set maximum price for some generic drugs. Florida sets SMAC prices at the mid-range or average of several manufacturer prices.
- Florida also pays a dispensing fee of $4.23 for every prescription to cover pharmacy overhead costs for filling the order.

Florida compares each price estimate and pays pharmacies the lowest price plus the dispensing fee or the usual and customary price, whichever is lower.

[27] The usual and customary charge reflects the full retail price that a person without insurance would pay a pharmacy.

[28] Discounts and rebates may be awarded for prompt payment, volume purchasing, and other factors.

Appendix D

Federal and State Rebates Reduce Prescription Drug Costs

Rebates do not affect the price Medicaid pays to pharmacies but reduce state costs because manufacturers refund part of the payment price. Florida receives mandatory federal rebates and state supplemental rebates which manufacturers must pay to have their drugs included on the state's Medicaid preferred drug list. Together these rebates can substantially reduce state costs. Receiving these federal and state supplemental rebates resulted in net prescription drug expenditures for Fiscal Year 2004-05 of $1.77 billion, approximately 29.5% less than Florida's gross expenditures ($2.5 billion).

Federal rebates. The federal government requires both brand and generic drug manufacturers to provide rebates to states in order to participate in the Medicaid program. [29] Drug manufacturers report price information to the Centers for Medicare and Medicaid Services (CMS) quarterly. For each brand name drug, manufacturers report the average manufacturer price (AMP) which reflects the average price manufacturers receive from wholesalers after discounts and rebates and the Best Price, which represents the lowest price charged to any private purchaser after discounts and rebates.

For both single source and multiple source brand name drugs, manufacturers pay a basic rebate of 15.1% of the AMP or the difference between the AMP and Best Price, whichever is greater. In addition to the basic rebate, manufacturers must pay an additional rebate if the AMP price increases faster than the consumer price index for urban consumers. CMS uses a baseline AMP determined by the drug's original market date as a reference point for calculating any inflation-adjusted rebate. Because prices for many brand name drugs have increased faster than inflation, the additional rebate can be substantial. For generic drugs, manufacturers pay rebates equal to 11% of the AMP. Currently, manufacturers are not required to pay additional rebates for generic drugs based on an inflation adjustment.

Using the quarterly price information provided by manufacturers, CMS calculates and then sends states a list containing the unit rebate amount for each drug. Medicaid programs invoice each manufacturer with whom they do business. The invoice amount is determined by multiplying the number of units reimbursed by Medicaid by the unit rebate.

State supplemental rebates. The 2001 Florida Legislature directed AHCA to establish a mandatory preferred drug list (PDL) and negotiate state supplemental rebates. The PDL includes drugs by therapeutic classes that have a low cost relative to other similar drugs. Brand name drug manufacturers can get their drugs placed on the PDL by offering the state cash rebates, which lowers the net cost of the drugs to the state. The PDL essentially shifts utilization to lower cost drugs and lowers the cost of all drugs provided by the Medicaid program.

[29] The Omnibus Budget Reconciliation Act of 1990, created the federal Medicaid Drug Rebate Program, which was implemented in 1991.

To have their products considered for the PDL, manufacturers must negotiate state supplemental rebates with AHCA. According to state law, the supplemental rebate must equal no less than 14% of the AMP unless the federal or supplemental rebate, or both, equal at least 29% of the AMP. [30] AHCA contracts with Providers Synergies to negotiate a guaranteed net price for manufacturers' drugs to achieve, at a minimum, 29% of the AMP. After the state reimburses pharmacies and receives the federal rebate, manufacturers then pay the state any additional amount necessary to reach the guaranteed net price. For some drugs, the federal rebate alone almost achieves the negotiated guaranteed net price, so the state may receive a minimal supplemental rebate from manufacturers. Other times, the federal rebate is a fairly small amount compared to the negotiated price, so the supplemental rebate owed by the manufacturer will be significant.

Once AHCA and Provider Synergies negotiate the guaranteed net unit prices, the Pharmaceutical and Therapeutics Committee reviews the medical efficacy and pricing of the drugs. [31] For all drugs within a therapeutic category that are clinically similar, the committee recommends that AHCA include the lower priced drugs on the PDL. Drugs with high prices relative to peer drugs are excluded.

Since 2001, the state has expanded the PDL to cover more therapeutic classes and now requires that all supplemental rebates be cash rebates. [32] The most recent change to the PDL occurred in 2005 when the Legislature required manufacturers to negotiate supplemental rebates for mental health drugs. [33] In addition, the agency applies more stringent standards before allowing physicians to prescribe drugs that are not on the PDL.

Table D-1 shows Florida's average federal and state rebates as a percentage of Medicaid expenditures for last fiscal year. Combined these rebates reduced expenditures by 29.5%.

Table D-1
Drug Manufacturer Rebates to Florida's Medicaid Program Average 29.5% of Fiscal Year 2004-05 Prescription Drug Expenditures

Type of Drugs	Percentage Federal Rebate	Percentage State Rebate	Total Rebate
Single Source Brand Name Drugs	28.22%	5.84%	34.06%
Multiple Source Brand Name Drugs	39.51%	0.18%	39.69%
Generic Drugs	3.18%	0.13%	3.31%
All Drugs	24.56%	4.97%	29.53%

Source: Agency for Health Care Administration, Fiscal Year 2004-05; OPPAGA analysis.

[30] There is no upper limit on the supplemental rebate.

[31] The Pharmaceutical and Therapeutics Committee, composed of doctors and pharmacists, is required by state law to recommend the drugs that AHCA should place on the PDL.

[32] The 2001 legislation allowed drug manufacturers to offer supplemental rebates in the form of Medicaid program benefits that offset a Medicaid expenditure, such as disease management programs, drug product donation programs, and drug utilization control programs. State law was amended in 2004 to limit supplemental rebates to cash rebates.

[33] Prior to 2005, manufacturers were exempted from negotiating prices and paying supplemental state rebates for mental health drugs.

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