Medicaid Issues -

MEDICAID REIMBURSEMENT FOR PRESCRIPTION DRUGS

KPMG Peat Marwick
Government Services Management Consultants
for
North Carolina General Assembly
Government Performance Audit Committee
December 1992

Issue Statement

The growth of expenditures for prescription drugs is a major concern for state Medicaid programs throughout the country. North Carolina Medicaid expenditures for prescription drugs were nearly $150 million in FY92, an increase of 140 percent since FY87. (See Exhibit 1.) Although Medicaid programs across all states experienced comparable expenditure growth, North Carolina Medicaid expenditures per recipient increased at a rate greater than the national average. As one of the fastest growing program areas within Medicaid, the State should consider reimbursement and purchasing options which control Medicaid expenditures for prescription drugs. This paper assesses such options.

Background

North Carolina Medicaid reimbursement for prescription drugs is equal to 90 percent of the Average Wholesale Price (AWP), plus a $5.60 dispensing fee for each different drug dispensed during a month. Most states pay for Medicaid drugs based on the Average Wholesale Price (AWP). Six states pay the full AWP for drugs, while 37 pay AWP less a percentage. Of the states which pay AWP less a percentage, the percentage ranges from 5 - 12 percent. The North Carolina program is at the upper end of this range, paying AWP less 10 percent. Four states pay Wholesale Acquisition Cost (WAC) plus a percentage.

One cost containment initiative employed by many state Medicaid programs is mandatory substitution of generic drugs. The North Carolina Medicaid program requires generic substitution for brand-name drugs unless the prescribing physician authorizes dispensing of the brand-name only. Although mandatory substitution is required by federal law, only 24 states have adopted policies to address this federal requirement.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) requires manufacturers, in order for their product lines to be eligible for coverage by Medicaid, to provide rebates to all state Medicaid programs. The rebate agreement requires the manufacturer to pay a rebate based on the price of the drug product and the units of the drug product utilized by a state's Medicaid population. In exchange, states entering a rebate agreement must permit coverage of all of a manufacturer's prescription drug products. Thus, one major avenue for prescription drug cost containment -- closed formularies -- was closed. With a closed formulary, states could restrict the drugs for which Medicaid recipients receive coverage; price very often controlled a product's availability on a formulary.

OBRA 1990 also requires states to implement retrospective and prospective drug utilization review programs by January 1, 1993. Additionally, federal regulation prohibits states from altering existing reimbursement methodologies for prescription drugs until 1996. Peat Marwick contacts with the Health Care Financing Administration on behalf of other states have indicated willingness of HCFA to consider waiver requests that states might make

EXHIBIT 1

NORTH CAROLINA MEDICAID PROGRAM EXPENDITURES 1987 - 1992
PRESCRIPTION DRUGS

Fiscal Year	Payments	% Increase (Decrease)	Recipients	% Increase (Decrease)	$ Per Recipient	% Increase (Decrease)
1987	$62,240,597.56	N/A	1,237,849	N/A	$50.28	N/A
1988	$71,779,665.11	15.33%	1,324,436	6.99%	$54.20	7.79%
1989	$83,771,914.40	16.71%	1,446,654	9.23%	$57.91	6.85%
1990	$97,415,528.85	16.29%	1,596,439	10.35%	$61.02	5.38%
1991	$120,237,490.82	23,43%	1,873,941	17.38%	$64.16	5.15%
1992	$149,403,248.96	24.26%	2,222,225	18.59%	$67.23	4.78%
1987-1992		140.04%		79.52%		33.71%

Source: Division of Medical Assistance

with regard to charges in the prescription drug reimbursement policies, particularly with regard to managed prescription drug programs.

Prospective drug utilization review (DUR) is defined as the review of drug therapy for each prescription filled or delivered, usually at the point-of-sale or point of distribution. The review must screen for potential drug therapy problems due to the following:

- Therapeutic duplication
- Drug-disease contraindications (potential for patient-specific adverse reactions)
- Interactions with other drugs
- Incorrect drug dosage
- Improper duration of drug treatment
- Allergic reactions
- Clinical abuse/misuse

Drug utilization review was mandated because Congress estimates that significant program dollars are wasted in avoidable hospitalizations caused by elderly Medicaid patients taking contraindicated medications from different sources. In addition to DUR, Congress required the establishment of drug use review boards, annual reports on each state's programs, drug counseling by pharmacists, and prohibition from decreasing dispensing fees. Drug utilization review is an emerging field, in both the public and private sectors. An effective DUR program can increase the quality of prescription drug services and reduce costs.

Findings

Finding 1: North Carolina Medicaid expenditures per prescription are higher than in other states.

According to data collected by the Health Care Financing Administration, North Carolina Medicaid expenditures per prescription are among the highest in the country. (See Exhibit 2.) North Carolina Medicaid expenditures per prescription in 1990 were nearly three dollars higher than the national average.

Exhibit 3 presents the average cost per prescription over the past five years. As Exhibit 3 indicates, growth in expenditures is due to increases in the number of prescriptions as well as increases in the cost per prescription.

Finding 2: The North Carolina Medicaid dispensing fee is the highest in the country.

The North Carolina General Assembly has increased the prescription dispensing fee almost annually over the past several years. The dispensing fee has increased by 50 percent since 1986.

EXHIBIT 2

STATE MEDICAID PROGRAM COMPARISON
COST PER PRESCRIPTION

	1989	1990	Percent Change
Kentucky	$12.17	$13.53	11.2
Tennessee	$19.52	$15.78	-19.2
Virginia	$15.19	$16.80	10.6
Georgia	$17.07	$17.68	3.6
National Average	$17.35	$18.31	5.5
HCFA Region IV	$19.36	$21.11	9.0
North Carolina	$18.88	$21.15	12.0
South Carolina	$18.08	$32.49	79.7

Source: Health Care Financing Administration, Medicaid expenditures reports

EXHIBIT 3

NORTH CAROLINA MEDICAID PROGRAM EXPENDITURES 1987 - 1992
PRESCRIPTION DRUGS

Fiscal Year	Payments	% Increase (Decrease)	Prescriptions	Cost Per Prescription	$ Per Prescription	% Increase (Decrease)
1987	$62,240,597.56	N/A	3,735,627	N/A	$16.66	N/A
1988	$71,779,665.11	15.33%	4,066,858	8.87%	$17.65	5.93%
1989	$83,771,914.40	16.71%	4,486,152	10.31%	$18.67	5.80%
1990	$97,415,528.85	16.29%	4,765,383	6.22%	$20.44	9.47%
1991	$120,237,490.82	23.43%	5,477,820	14.95%	$21.95	7.37%
1992	$149,403,248.96	24.26%	6,318,804	15.35%	$23.64	7.72%
1987-1992		140.04%		69.15%		41.91%

Source: Division of Medical Assistance

The dispensing fees are shown below have been implemented on the following dates:

July 1, 1986	$3.67
July 1, 1987	$3.85
July 1, 1988	$4.04
July 1, 1989	$4.24
October 1, 1990	$4.85
January 1, 1992	$5.60

Several states have increased dispensing fees in recent years. However, as presented in Exhibit 4, the North Carolina Medicaid dispensing fee remains the highest.

Finding 3: ***North Carolina Medicaid has implemented other cost containment strategies, including a six prescription limit per month and a copayment amount of $1.00 per prescription.***

Many states have attempted to contain drug expenditures by limiting the scope of benefits covered by their Medicaid programs. A number of states place absolute limits on the number of prescriptions per month. Oklahoma and South Carolina allow 3/month; Mississippi allows 4/month; Missouri and Nevada allow 5/month; Arkansas, Georgia, North Carolina and Oregon allow 6/month; and Tennessee allows 7/month. States with prescription limits generally place no limitations on recipients in nursing homes. Other states implement limits, but at different (higher) levels. In addition, a number of states place limitations on the number of refills allowed.

A more stringent limit on the number of prescriptions per month could produce significant program savings. However, the impact of such action on the health status of recipients should be considered. To the extent that medications are needed for the maintenance of health where chronic conditions exist, individuals impacted by the limitation may find their health status worsening. Some of these individuals may ultimately require more expensive treatment in a hospital setting. A recent study published in the New England Journal of Medicine examined the impact and benefit limitations on prescription drugs in New Hampshire. This study found that the coverage costs of health care increased as availability to prescription drugs was limited.

Another approach used by North Carolina to control utilization is the imposition of copayments. States which require copayments for prescription drugs generally set nominal copayment amounts, such as fifty cents or one dollar. Copayments are implemented to reduce the State's share of health care expenditures by requiring recipients to share in the cost of services. The evidence is inconclusive, however, in determining whether savings accrue due to a reduction in service utilization. Because pharmacists cannot, by federal law, refuse to serve recipients who cannot afford to pay the copayment, the cost of the

EXHIBIT 4

RANKING OF STATES BY DISPENSING FEE, 1992

Under $3.00

Montana	$2.00-4.08
New York	2.60
West Virginia	2.75

Under $4.00

Nebraska	$2.85-5.05
Ohio	3.23
New Hampshire	3.25-3.65
Maine	3.35
Rhode Island	3.40
Alaska	3.45-11.46
Washington	3.45-4.38
Pennsylvania	3.50
Illinois	3.58
Delaware	3.65
Oregon	3.67-4.02
Michigan	3.72
New Jersey	3.73-4.07
Kansas	3.85-6.97
Utah	3.90-4.40
Tennessee	3.91

Under $5.00

Indiana	4.00
New Mexico	4.00
Iowa	4.02-6.25
California	4.05
South Carolina	4.05
Massachusetts	4.06
Colorado	$4.08
Missouri	4.09
Connecticut	4.10
Minnesota	4.10
Florida	4.23
Vermont	4.25
North Dakota	4.25
Idaho	4.30
Virginia	4.40
Georgia	4.41
Nevada	4.42
D.C.	4.51 + .103 EAC
Arkansas	4.67
Hawaii	4.69
Wisconsin	4.70
Wyoming	4.75
South Dakota	4.75
Kentucky	4.75
Texas	(EAC + $4.55) divided by 0.970
Maryland	4.94-6.51

$5.00 and Over

Louisiana	5.00
Oklahoma	5.10
Mississippi	5.16
Alabama	5.40
North Carolina	5.60

Arizona -- all plans capitated under AHCCCS

Note: When reviewing total pharmacy reimbursement, both the dispensing fee and the ingredient reimbursement basis, or EAC (Estimated Acquisition Cost) must be considered.

Source: National Pharmaceutical Council

copayment is often shifted back to the pharmacist. Exhibit 5 displays prescription copayments employed by other states.

Recommendations

Recommendation 1: Freeze the dispensing fee at the current amount.

The North Carolina Medicaid dispensing fee is the highest in the country. North Carolina Medicaid spent more than $35 million in FY92 for dispensing fees alone. The most recent increase approved by the legislature resulted in additional Medicaid expenditures of $4.5 million. North Carolina should not increase the dispensing fee until its fee is more in line with the fees of other states.

Recommendation 2: Implement alternative purchasing approaches for prescription drugs.

Several states are exploring the wholesale purchase of drugs in order to control expenditures. Under this approach, maintenance/routine drugs are purchased from a distributor who has contracted with the State to provide drugs to patients on a mail order basis. Contractors typically charge a $2.50 packaging and shipping fee, which is considerably less than the $5.60 dispensing fee which North Carolina currently pays for each prescription.

Alternative purchasing approaches for prescription drugs can produce cost savings. One purchasing approach, currently under development in Oklahoma focuses on maintenance medications, which include drugs taken regularly to treat chronic conditions such as arthritis, diabetes or high blood pressure. Under this approach, maintenance level medications would be obtained through mail order pharmacy services or community pharmacies. In very recent years, marketplace forces have leveled the economic differences between mail order and community pharmacies, with significant discounts now provided by many community pharmacies. Thus, cost savings may be achieved without major disruption to community providers.

To continue to involve local pharmacies, the State should rely on pharmacists to "manage" the program. The core of this managed drug plan is a trial therapy period that limits the supply of the drug during its initial period of use in order to ensure that the drug is tolerated and effective before a maintenance supply is dispensed.

The "trial period" addresses the problem of wastage in mail order purchasing, which occurs when a portion of the supply of the drug (usually a 90-day supply) is wasted due to a change in the prescription dosage, discontinued use of the drug, or a change in the prescription due to therapeutic saturation.

EXHIBIT 5

COMPARISON OF STATE MEDICAID PRESCRIPTION REIMBURSEMENT METHODOLOGIES

	North Carolina	Kentucky	South Carolina	Georgia	Tennessee	Virginia
Payment Methodology	90% of AWP Plus Dispensing Fee	90% AWP Plus Dispensing Fee	91.5% of AWP Plus Dispensing Fee	90% of AWP Plus Dispensing Fee	Lesser of: -90% of AWP Plus Dispensing Fee -MAC Price Plus Dispensing Fee* -UCR or Charge to the general public	Lesser of: -UCR or charge to general public -91.% of AWP Plus Dispensing Fee -HCFA-Upper Limit (inclusive of State only maximum)
Copayment	$1	None	$1	None	None	$1
Dispensing Fee	$5.60	$4.75	$4.05	$4.41	$3.91	$4.40
Limits	6/Month	No more than 5 refills	3/Month	6/month	7/Month	None

Sources: - Peat Marwick telephone survey
- Commerce Clearing House Medicare/Medicaid Guide

* Maximum allowable cost (MAC) is defined as the lowest price at which multiple source drugs (generic drugs) are widely and consistently available.

Initially, local pharmacists would dispense a one-month supply of the prescription drug and instruct the recipient regarding potential adverse effects. After the 30-day trial period, and upon subsequent refill, the pharmacist would approve the purchase of the drug through wholesale outlets, either mail order or community. The maintenance level medications would be dispensed in 60-day or 90-day supplies, and the dispensing fee would be adjusted upward slightly to account for fewer total dispensing fees paid. Although the single dispensing fee is already very high, pharmacists should be given some incentive to participate in the managed care approach.

The State would develop its own network to supply the maintenance drugs. Alternatively, the State could contract with existing networks current providing services in North Carolina. A freedom-of-choice waiver is required because recipients will not be able to obtain services from all pharmacists, only those who agree to supply the maintenance level drugs at an agreed upon, discounted price. If community pharmacists are not willing to participate, then the mail order company serves as the alternative. In addition, the State would have to work closely with the Health Care Financing Administration to address concerns regarding the OBRA 90 requirements. As indicated earlier, in discussions with HCFA representatives, Peat Marwick consultants have been advised HCFA will consider requests to waive the "no change in reimbursement" provision of OBRA 90. The states of Virginia and Oklahoma are both currently contemplating such waivers.

This purchasing approach has several limitations:

- In general, about 67 percent of all medication dispensed are maintenance drugs. The remainder would continue to be dispensed as they are currently.

- Certain portions of the State might be excluded, based on the lack of presence of competing community pharmacies.

- Some recipients may not maintain regular residences, making it difficult to require mail order.

Implications:

- Community pharmacists will be opposed to this approach unless efforts are made to include them in the network. Only if they refuse to participate should mail order be considered.

- This approach is an important first step in trying to manage this growing program.

- This approach could be expanded to include other drug benefits purchased by the State, for example, State employees, to give the State greater clout in negotiating discounts.

- Through the establishment of networks, Medicaid recipients may have greater access to other managed care interventions, such as on-line drug utilization review and patient- and drug-specific exclusions.

Cost Savings

Projected cost savings from implementation of alternative purchasing approaches are presented in Exhibit 6. The cost savings were estimated using the following assumptions:

- Estimated growth in expenditures per recipient for prescription drugs were based on increases of average payment per recipient from 1987-1992.

- Estimated growth in claims would increase 13.8 percent based on average growth in claims between 1987-1992.

- By moving from a 30-day to a 90-day supply for maintenance drug prescriptions the number of claims would decrease by two thirds. However, to provide an incentive for pharmacists to continue to participate in the Medicaid program, the monthly dispensing fee would be increased to 150 percent of the current dispensing fee.

- Ten percent savings on maintenance expenditures.

Initial cost savings for the first year of implementation of the new prescription policy would net $5.7 million in State dollars. Cumulative savings to the prescription drug program would total $102.1 million over ten years.

EXHIBIT 6

PROJECTED COST SAVINGS

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current Program Expenditures	$40.0	$42.7	$45.6	$48.7	$52.0	$55.5	$59.2	$63.2	$67.4	$72.0
Savings on Dispensing Fee	$4.4	$5.0	$5.7	$6.5	$7.4	$8.4	$9.5	$10.9	$12.4	$14.1
Savings Prices for Maintenance Drugs	$1.3	$1.4	$1.5	$1.6	$1.7	$1.8	$2.0	$2.1	$2.2	$2.4
Total Savings Per Year	$5.7	$6.4	$7.2	$8.1	$9.1	$10.2	$11.5	$12.9	$14.6	$16.4
Cumulative Savings	$5.7	$12.1	$19.3	$27.4	$36.5	$46.7	$58.2	$71.1	$85.7	$102.1

Assumptions:

- Maintenance drugs claims represent one-third of total claims
- Estimated growth in expenditures 6.7 percent - Based on average payment per recipient 1987-1992
- Estimated growth in maintenance drug claims would increase claims 13.8 percent - Based on average growth in claims 1987-1992
- Assuming a 150 percent dispensing fee incentive provided for 90 days
- Assuming a 2/3 reduction in the number of claims per year
- Estimated 10 percent savings on maintenance expenditures (Private business savings range from 30 percent to 60 percent)