BY DENISE MYSHKO

Transition Time for MEDICAID

MEDICAID REFORM IS TAKING HOLD AT BOTH THE STATE AND FEDERAL LEVELS, and the use of managed-care and cost-containment strategies is gaining momentum among state prescription plans.

DR. DAVID MEDVEDEFF

Formularies are starting to take hold within Medicaid. Reform has involved employing a managed-care strategy to cap costs, says David Medvedeff, Pharm.D., President of Informed Decisions.

With a July 1, 2007, deadline looming, officials at the Department of Health and Human Services are working on a regulation to change how certain prescription drugs in the Medicaid program are paid. In December 2006, HHS announced a proposal with changes that are expected to save $8.4 billion in state and federal funds over five years.

The Deficit Reduction Act of 2005 (DRA) changes how the federal government limits payments to state Medicaid agencies for the aggregate costs of prescription drugs when a generic substitute is available.

Currently, Federal Upper Limits (FULs) — the ceiling up to which the federal government reimburses for outpatient prescription drugs — are calculated based on published drug prices and cover those drugs that have at least three therapeutically equivalent versions sold by at least three suppliers. The Centers for Medicare and Medicaid Services (CMS) uses the lowest of the average wholesale price (AWP). About 600 drugs are currently subject to the FULs.

The DRA establishes a new calculation that is based on 250% of the lowest average manufacturer's price (AMP) in a drug class. The FUL does not mandate prices for individual drugs; rather, the FUL is based on the aggregate costs of all drugs.

"Pharmacies were reimbursed by average wholesale price, or AWP," says Pravin Chandran, partner, contracts management practice, at BusinessEdge Solutions Inc. "AWP was a set price pharma companies could put out there for one product, and it would stay in place. It's being changed to average manufacturer's price."

The proposed rule also addresses Medicaid agencies' ability to collect rebates from drug manufacturers for drugs administered by physicians. Currently, some state Medicaid programs are unable to collect rebates on drugs dispensed by doctors and hospital outpatient departments because of insufficient information. The proposed rule outlines new steps to allow Medicaid agencies to bill for these rebates.

There are many troubling issues with the pending proposal, says Donna Lee Yesner, partner of McKenna Long & Aldridge LLP.

"The idea of the Medicaid rebate statute was to come up with a formula that approximates what pharmacies pay, reduced by the best price, and rebate the difference," she says. "This is not what the proposed rule does. There is a fundamental lack of understanding of how drug prices work and how drugs are distributed."

She says the proposed rule doesn't recognize the fact that a manufacturer can give different prices to different entities in the distribution chain.

"A PBM pays the pharmacy for a prescription and then gets a rebate from a manufacturer," she says. "The prescription is a net price, but the manufacturer has no control over what the pharmacy is paid by a PBM. For purposes of determining a price to a PBM, if one is going to look at price the manufacturer can control, it's

STATES SEEK EFFICIENCY IN PHARMACY PROGRAMS

MAJOR CHANGES ON THE NATIONAL LEVEL, COMBINED WITH INDIVIDUAL STATE INITIATIVES, ARE REQUIRING STATES TO ADAPT THEIR POLICIES AND REWORK THEIR SYSTEMS AND INFRASTRUCTURES TO MEET THE CHANGING NATURE OF PHARMACY BENEFITS.

This is according to a new report, State Perspectives on Emerging Medicaid Pharmacy Policies and Practices, that was released in November 2006 by the National Association of State Medicaid Directors (NASMD).

The report, powered by Avalere Health LLC, is the first annual Medicaid pharmacy policy survey that provides comprehensive information on a number of categories important to states and other key stakeholders.

Forty-seven states responded to the survey conducted in June and July 2006.

The report looks at states' responses to questions in five major areas: the impact of the Medicare Part D prescription drug program on states' Medicaid pharmacy programs; the new pharmacy cost sharing and price transparency provisions included in the Deficit Reduction Act of 2005; various drug rebate policies; the role of managed care organizations in the provision of prescription drugs; and states' efforts to implement medication management and quality initiatives.

Among the major findings of the report are:

- **SEVERAL STATES IMPLEMENTED POLICIES** to supplement Medicare Part D coverage for certain low-income Medicare beneficiaries.
- **TO DATE, MOST STATES REPORT** that the shift of dual eligibles to the Medicare Part D drug benefit has not had a substantial financial impact.
- **STATES ARE STILL WAITING FOR GUIDANCE** from the Centers for Medicare and Medicaid Services on the Deficit Reduction Act of 2005 to assess the law's impact on Medicaid pharmacy policies.
- **MORE THAN TWO-THIRDS OF STATES**, however, noted that they do not expect the DRA to reduce their spending on pharmacy benefits significantly.
- **SEVERAL STATES PARTICIPATE IN** or are considering joining bulk-purchasing pools.
- **STATES USE A VARIETY OF MECHANISMS** to manage both cost and use of prescription drugs, while coordinating such efforts with evidence-based pharmacy quality programs.

Source: National Association of State Medicaid Directors, Washington, D.C. For more information, visit nasmd.org.

the rebate. The proposed rule seems to confuse the prices that are available to different entities because of the odd nature of sales in a world that involves insurance and third-party payers."

She says manufacturers may see a decrease in the rebates they pay, but everything needs to be explained better.

"Manufacturers need, more than anything else, clarification because the rules are difficult to understand," she says.

According to Mr. Chandran, the fact that pharmaceutical companies will need to calculate AMP adds to their workload.

"Biotech and pharma manufacturers need to take millions of lines of transactions of data, summarize and filter the information, code the data, and then come up a mathematical calculation," he says.

Ms. Yesner concurs. "This is such a difficult and cumbersome program for manufacturers to administer," she says. "Companies will have to make this calculation on a monthly basis. It's going to absorb a huge amount of resources to constantly have to make these calculations."

MEDICAID OUTLOOK

CMS officials are projecting that Medicaid cost increases will decline. This reflects lower Medicaid spending growth in recent years. For the fiscal year (FY) 2006-2015 period, projected Federal Medicaid costs will be $224 billion lower than they had originally projected, CMS officials estimate.

The slowdown in Medicaid spending growth has resulted from many steps to deliver needed benefits more efficiently. Reform has resulted in greater use of private-sector health plans rather than government-run fee for service that rewards providers for driving demand and creating incentives for over use.

Drug-spending growth has declined from a rate of 18.1% between fiscal year 2003 and fiscal year 2004 to 7.5% between fiscal year 2004 and fiscal year 2005 and a projected decrease of 17.7% between fiscal year 2005 and fiscal year 2006 as a result of decreased spending on dual eligibles.

The slowdown in cost increases is a result of collaboration between the states and the federal government to implement steps to slow drug spending before the shift of dual eligibles to Medicare, and these steps are expected to continue to restrain spending growth.

CMS has provided the states with new tools to substantially reduce the growth in the cost of prescription drugs, including steps to encourage greater use of generics, preferred drug lists, and multistate drug purchasing pools.

Another reason for the lower growth rate is that states are paying much less than had been predicted for drug coverage for dual eligible beneficiaries who are now getting coverage through Medicare.

"Superficially, it looks as though Medicaid drug costs have gone down because of the transition of dual-eligibles to Medicare," says David Medvedeff, Pharm.D., president of Informed Decisions LLC. "From a gross expenditure perspective, costs have not gone up. But when we look at what's happening with the individual Medicaid beneficiary, costs are still growing."

STATE EFFORTS

In July 2006, the CMS announced a plan to provide states with $150 million in 2007 and 2008 to fund research and design ways to transform their Medicaid systems to increase quality and efficiency of care.

Funds for the Medicaid "transformation grants" were authorized by the DRA and are aimed at state adoption of innovative systems to get more value out of the money they spend to provide healthcare to their citizens who are low-income elderly, children, and people with disabilities.

States are considering or have enacted a variety of changes in their Medicaid pharmacy programs. Recent state legislation related to Medicaid prescription drugs generally is designed around new or expanded applications of management tools already available to states through federal law, according to a review by the National Conference of State Legislatures. Among the strategies receiving legislative attention are the use of preferred drug lists, generic substitution, multistate purchasing, pharmacy benefit managers, and supplemental rebates from manufacturers.

Preferred drug lists are in use in more than half of all states now.

"By and large, formularies are starting to take hold within Medicaid," Dr. Medvedeff says. "Medicaid reform has involved employing a managed care strategy to cap costs. States are getting block grants from CMS, and they then bid that business out to managed care. When that happens, formularies do go into place, and preferred drug lists get highly splintered."

The plan patients are in dictates what drug coverage they have; there isn't a universal preferred drug list for Medicaid beneficiaries.

"The world where a product manager could talk with a Medicaid director to make sure there was quid quo pro for his or her product is coming to an end," Dr. Medvedeff says. "There have to be more disease management and compliance programs, where manufacturers do the right thing whether their product is on the list or not. The good will — which is hard to measure and sometimes hard for pharma to justify the expenditure — will continue to develop and bear some fruit."

He says companies will have to have a proven disease-management program with proven data.

"I'm talking about disease-management programs that save on total medical dollars whether or not there is a higher pharmacy spend," Dr. Medvedeff says. "I'm talking about a compliance program that demonstrates patients are more compliant and have fewer emergency room visits."

But he points out that pharmaceutical companies will need to have different strategies for reaching Medicaid beneficiaries, especially given that Medicaid has become fragmented, with states using different strategies for controlling costs.

"There has to be a different language when communicating with Medicaid beneficiaries," Dr. Medvedeff says. "It's not Websites and high-tech interventions. There is an emotional component and companies need to meet people where they are. Medicaid used to be very straightforward." ✦

PharmaVOICE welcomes comments about this article. E-mail us at feedback@pharmavoice.com.

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