NATIONAL CENTER FOR POLICY ANALYSIS

Reforming Michigan's Medicaid Drug Program

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Michigan is moving to cover Medicaid enrollees in privately-administered managed care plans. The state should also continue to move enrollees to managed drug plans. Virtually all state Medicaid programs distribute some drugs on a fee-for-service (FFS) basis separately from any health plan. Nearly half of the states carve out and administer drug benefits separately, distributing all Medicaid drugs this way.

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Nationally, more than half of Medicaid drugs are distributed FFS, compared to about one-third in Michigan.

Reforming Medicaid Drug Programs. State Medicaid programs that carve out drug benefits often ignore drug therapy coordination and management. By contrast, integrating prescription drugs benefits with Medicaid managed care health plans improves quality and increases efficiency. A Lewin Group analysis for Medicaid Health Plans of America, a trade association of managed care providers, found that integrating health and drug plans in 14 states that currently carve out drug benefits would collectively save nearly $12 billion over a decade.

Private health plans that provide medical care to Medicaid enrollees are the logical entities to manage drug benefits. The health plans are paid a set fee per enrollee to provide Medicare care; thus, the plans are liable for the cost of nondrug therapies, whereas a drug regime is often a less costly substitute for surgery or other treatment.

Drug therapies also often reduce the need for hospitalization, and avoid expensive emergency room visits and medical complications — especially for such chronic conditions as asthma, diabetes and schizophrenia.

An IMS Health analysis of Medicaid managed pharmacy benefits in several states found utilization rates for many of these therapies is higher under managed care than fee for service. For instance, use of generic versions of antipsychotic medications was 3 percent to 14 percent higher than in fee-for-service Medicaid, on average. Drug utilization for diabetes was also higher.

The Role of Medicaid Drug Plan Administrators. Medicaid managed care plans frequently contract with pharmacy benefit managers (PBMs), private firms that act as third-party prescription drug plan administrators. PBMs process and reimburse claims, and negotiate drug prices and rebates with drug manufacturers. They also negotiate dispensing fees — the amount paid to pharmacies for the service of filling a prescription.

Private health plans use a variety of techniques to control drug costs, including preferred-drug lists (PDL), formularies, required use of mail-order drug suppliers, negotiated prices with drug companies and drug distributors, and contracting with exclusive pharmacy network providers. Regardless of how the program is structured, Medicaid enrollees fill many of their prescriptions at local pharmacies that are reimbursed for each prescription filled.

A recent analysis by the Menges Group, another consultancy, identified ways in which privately managed Medicaid drug programs are more efficient than state-administered Medicaid drug

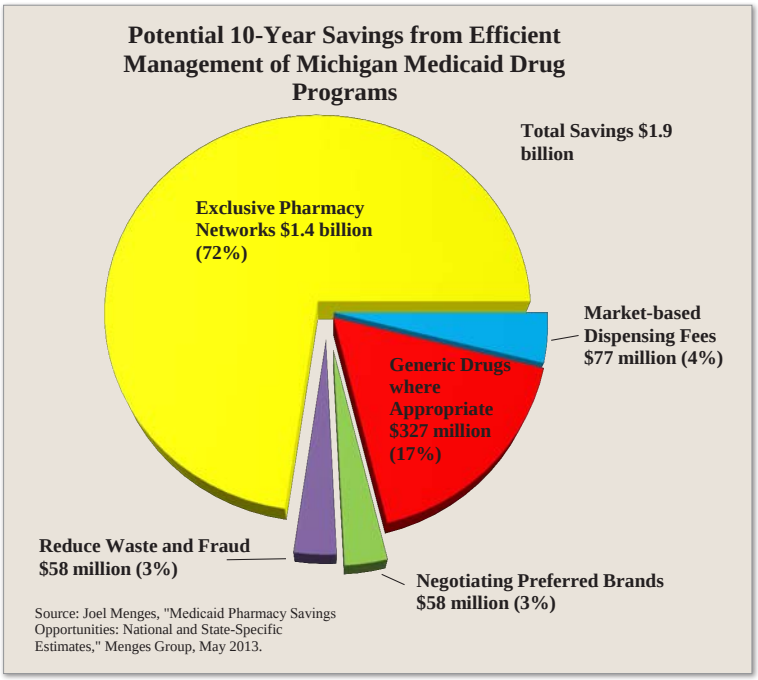
benefits. Rather than negotiating with pharmacy networks, state FFS Medicaid programs often arbitrarily pay much higher dispensing fees than they would in a competitive market. Utilization of generic drugs is often lower in state FFS Medicaid and the number of prescriptions per member is higher. Moreover, FFS Medicare programs face political opposition to negotiating exclusive pharmacy network contracts that deliver lower drug prices to taxpayers.

For instance:

- Just over two-thirds (71 percent) of drug prescriptions in Michigan's FFS Medicaid are filled with generic drugs, whereas the national average for managed Medicaid drug benefits is about 80 percent.
- Michigan's FFS Medicaid pays pharmacies $2.75 to dispense a prescription, whereas the average for private Medicare Part D plans is nearly one-third less — about $2.00.
- The number of prescriptions per Medicaid enrollee is generally higher among enrollees in FFS Medicaid compared to managed care.

According to Menges, integrating drug and health benefits in a statewide managed care program could save Michigan Medicaid $1.9 billion over 10 years in federal and state spending. Specifically [see the figure]:

- Some 4 percent of the savings would come from paying market-based, competitive dispensing fees.
- Nearly one-fifth (17 percent) would come from use of generic drugs where appropriate.
- Nearly three-quarters (72 percent) would come from negotiating steep discounts with exclusive (limited) networks.



This analysis makes clear that Michigan should avoid the mistake of allowing *any willing pharmacy* to participate in the Medicaid drug program rather than authorizing drug plan managers to negotiate lower prices with exclusive pharmacy networks. Any willing pharmacy laws that allow outsiders to participate in a drug plan's network reduce the power of managers to negotiate lower prices and unnecessarily facilitates waste, fraud and abuse. For example, an unlimited supply of pharmacies allows unscrupulous patients to shop for multiple doctors willing to prescribe narcotics — avoiding detection by filling each prescription at a different pharmacy. Requiring Medicaid drug plans to reimburse large networks (with numerous small pharmacies) also makes it more difficult to detect billing fraud by pharmacy operators (or fake pharmacies).

Despite the potential savings, community pharmacists and pharmacy trade associations often oppose moving from FFS Medicaid drug programs to privately managed drug programs. Small community pharmacies often specialize in serving Medicaid beneficiaries and depend on Medicaid dispensing fee revenue. Community pharmacists cannot compete on price and efficiency without reducing profitability, so they fight to maintain the status quo. Trade associations for small pharmacies advocate laws to prohibit exclusive Medicaid pharmacy networks. Community pharmacists also lobby lawmakers to discourage cost-efficient, mail-order drug programs commonly found under managed care. The pharmacy industry has launched another initiative in recent years: to limit the ability of drug plans to audit pharmacies that bill for drug plan member prescriptions. If taxpayers are to be insulated from fraudulent operators, drug plans must be allowed to audit for compliance.

Conclusion. As Michigan moves more Medicaid enrollees into managed care, it should also integrate drug benefits into enrollees' health plans. In addition, legislators should avoid the temptation to enact protectionist regulations designed to limit competition among pharmacies participating in the Medicaid program.

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